Medicare-Related Products Certification

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Medicare-Related Products Certification

The Texas Department of Insurance requires specific continuing education for persons marketing Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans. This requirement is necessary to maintain effective regulation of the insurance industry by safeguarding Texas' senior citizens and other individuals eligible for Medicare plans (Medicare beneficiaries) who are confronting significant healthcare decisions. The Centers for Medicare & Medicaid Services (CMS) Guidelines and now the Medicare Improvements for Patients and Providers, Public Law 110 – 275 (MIPPA) §103(d)(1), which amends §1851(h) of the Social Security Act (42 U.S.C. 1395w–21(h), require that Medicare Advantage organizations only use agents who have been licensed under state law to sell Medicare plans.

The regulations use the term *market* rather than *sell* with respect to licensed agents because *marketing* is used in the CMS Marketing guidelines and fully encompasses the concept of *soliciting*, which is a primary function of an agent under the Insurance Code §4001.051(b). Thus, to the extent that federal law and CMS guidelines require that a Medicare Advantage organization utilize a state-licensed agent to market or sell a Medicare plan, this proposal designates that the general life, accident, and health insurance agent and general property and casualty insurance agent license types are the only Texas license types eligible to comply with that federal requirement. A licensed agent not holding a general life, accident, and health insurance agent or general property and casualty insurance agent license as required in this proposal would not be authorized to market a Medicare plan unless federal law and CMS guidelines authorize an unlicensed person to engage in that specific marketing activity.

Medicare Overview

Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are aged 65 and over, or who meet other special criteria. The program also funds residency training programs for the vast majority of physicians in the United States. Medicare operates as a single-payer health care system.

Single-Payer System

The financing of the costs of delivering health care for an entire population through a single insurance pool out of which costs are met describes a "single-payer" system. It is a form of monopsony, a market form in which only one buyer faces many sellers. It is an example of imperfect competition, similar to a monopoly. There may be many contributors to the single pool (insured persons, employers, government, etc.) Single-payer health insurance collects all medical fees and then pays for all services through a single government (or government-related) source. The Medicare program is an example of a single-payer system for a specified, limited group of persons.

The Centers for Medicare and Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the

State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Amendments (CLIA). Along with the Departments of Labor and Treasury, CMS also implements the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Social Security Administration is responsible for determining Medicare eligibility and processing premium payments for the Medicare program.

The Chief Actuary of CMS is responsible for providing accounting information and cost-projections to the Medicare Board of Trustees to assist them in assessing the financial health of the program. The Board is required by law to issue annual reports on the financial status of the Medicare Trust Funds, and those reports are required to contain a statement of actuarial opinion by the Chief Actuary.

Since the beginning of the Medicare program, CMS has contracted with private companies to operate as intermediaries between the government and medical providers. These contractors are commonly already in the insurance or health care area. Contracted processes include claims and payment processing, call center services, clinician enrollment, and fraud investigation.

Taxes imposed to finance Medicare

Medicare is partially financed by payroll taxes imposed by the Federal Insurance Contributions Act (FICA) and the Self-Employment Contributions Act of 1954. Taxes pay for current government programs.

In the case of employees, the tax is equal to 2.9% (1.45% withheld from the worker and a matching 1.45% paid by the employer) of the wages, salaries and other compensation in connection with employment. Until December 31, 1993, the law provided a maximum amount of compensation on which the Medicare tax could be imposed each year. Beginning January 1, 1994, the compensation limit was removed. A self-employed individual must pay the entire 2.9% tax on self employed net earnings, but may deduct half of the tax from the income in calculating income tax. Beginning in 2013, the 2.9% hospital insurance tax rises to 3.8% for individuals making over $200,000 or jointly filing couples making in excess of $250,000.

Pay-As-You-Go

Payment of taxes today does not entitle a taxpayer to services in years to come; a common misconception about benefits under Social Security, Medicare, and other government programs. PAYGO is the practice of financing expenditures with funds that are currently available rather than borrowed. The Part A program is financed on a "pay-as-you-go" basis, with taxes paid into the program being used to pay for the benefits received by current retirees, and the excess used to reduce the federal deficit. Medicare Part B is financed largely by payments from federal general revenues supplemented by premiums that beneficiaries pay calculated to cover only about 25% of the outlays. The "pay-as-you-go" financing of Part A is similar to a chain letter in that it promises future benefits to those who fund services for current beneficiaries, and there is a continual need for a growing number of new contributors to fund the growing number of beneficiaries. Chain letters eventually collapse from an insufficient influx of new

participants. Likewise, the number of workers contributing payroll taxes to finance the Part A trust fund is declining.

Eligibility

In general, all persons 65 years of age or older who have been legal residents of the United States for at least 5 years are eligible for Medicare. However, if neither they nor their spouse have paid Medicare taxes for a minimum of 10 years (40 quarters), then they must pay a monthly premium to be enrolled in Medicare. Medicare part 'A' premiums are waived if the following circumstances apply:

- They are 65 years or older **and** U.S. citizens or have been permanent legal residents for 5 continuous years, **and** they or their spouse has paid Medicare taxes for at least 10 years.

or

- They are under 65, disabled, and have been receiving either Social Security benefits or the Railroad Retirement Board disability benefits for at least 24 months from date of entitlement (first disability payment).

or

- They get continuing dialysis for end stage renal disease or need a kidney transplant.

or

- They are eligible for Social Security Disability Insurance and have amyotrophic lateral sclerosis (known as ALS or Lou Gehrig's disease).

The 24 month exclusion means that people who become disabled must wait 2 years before receiving government medical insurance, unless they have one of the listed diseases or they are eligible for Medicaid.

Many beneficiaries are dual-eligible. This means they qualify for both Medicare and Medicaid. In some states for those making below a certain income, Medicaid will pay the beneficiaries' Part B premium for them (most beneficiaries have worked long enough and have no Part A premium), and also pay for any drugs that are not covered by Part D.

In 2017, Medicare provided health care coverage for approximately 58.5 million Americans, making it the largest single health care payer in the nation. Enrollment is expected to reach 77 million by 2031.

Benefits

Medicare has four parts: Part A is Hospital Insurance. Part B is Medical Insurance. Medicare Part D covers prescription drugs. Medicare Advantage plans, also known as Medicare Part C, are another way for beneficiaries to receive their Part A, B and D benefits. All Medicare benefits are subject to medical necessity. The original program was only Parts A and B. Part D was new in January 2006; before that, Parts A and B covered prescription drugs in only a few special cases.

Part A: Hospital Insurance

Part A covers inpatient hospital stays (at least overnight), including semiprivate room, food, tests, and doctor's fees. Part A covers brief stays for convalescence in a skilled nursing facility if certain criteria are met:

1. A preceding hospital stay must be at least three days, three midnights, not counting the discharge date.
2. The nursing home stay must be for something diagnosed during the hospital stay or for the main cause of hospital stay.
3. If the patient is not receiving rehabilitation but has some other ailment that requires skilled nursing supervision then the nursing home stay would be covered.
4. The care being rendered by the nursing home must be skilled. Medicare part A does not pay for custodial, non-skilled, or long-term care activities, including activities of daily living (ADL) such as personal hygiene, cooking, cleaning, etc.

The maximum length of stay that Medicare Part A will cover in a skilled nursing facility per ailment is 100 days. The first 20 days would be paid for in full by Medicare with the remaining 80 days requiring a co-payment (as of 2018, $167.50 per day). Many insurance companies have a provision for skilled nursing care in the policies they sell. If a beneficiary uses some portion of their Part A benefit and then goes at least 60 days without receiving facility-based skilled services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period.

Part B: Medical Insurance

Part B medical insurance helps pay for some services and products not covered by Part A, generally on an outpatient basis. Part B is optional and may be deferred if the beneficiary or their spouse is still working. There is a lifetime penalty (10% per year) imposed for not enrolling in Part B unless actively working. Part B coverage begins once a patient meets his or her deductible, then typically Medicare covers 80% of approved services, which the remaining 20% is paid by the patient.
Part B coverage includes physician and nursing services, x-rays, laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportation, immunosuppressive drugs for organ transplant recipients, chemotherapy, hormonal treatments, and other outpatient medical treatments administered in a doctor's office. Medication administration is covered under Part B only if it is administered by the physician during an office visit.

Part B also helps with durable medical equipment (DME), including canes, walkers, wheelchairs, and mobility scooters for those with mobility impairments. Prosthetic devices such as artificial limbs and breast prosthesis following mastectomy, as well as one pair of eyeglasses following cataract surgery, and oxygen for home use are also covered.

Complex rules are used to manage the benefit, and advisories are periodically issued which describe coverage criteria. On the national level these advisories are issued by CMS, and are known as National Coverage Determinations (NCD). Local Coverage Determinations (LCD) only apply within the multi-state area managed by a specific

regional Medicare Part B contractor, and Local Medical Review Policies (LMRP) were superseded by LCDs in 2003.

Part C: Medicare Advantage plans

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as “Medicare+Choice” or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as “Medicare Advantage” (MA) plans. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships. In exchange for these extra benefits, enrollees may be limited in the providers they can receive services from without paying extra. Typically, the plans have a "network" of providers that patients can use. Going outside that network may require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members’ annual out-of-pocket spending on medical care, providing insurance against catastrophic costs over $5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if you want to use the provider included in the plan's network or "panel" of providers.

The 2003 Medicare payment formulas overpay plans by 12 percent or more compared to traditional Medicare (Medicare Payment Advisory Commission Annual Reports to Congress, 2006, 2007, and 2008). In 2006 enrollees in Medicare Advantage Private Fee-for-Service plans were offered a net extra benefit value (the value of the additional benefits minus any additional premium) of $55.92 a month more than the traditional Medicare benefit package; enrollees in other Medicare Advantage plans were offered a net extra benefit value of $71.22 a month more. However, Medicare Advantage members receive additional coverage and medical benefits not enjoyed by traditional Medicare members, and savings generated by Medicare Advantage plans may be passed on to beneficiaries to lower their overall health care costs. Other important distinctions between Medicare Advantage and traditional Medicare are that Medicare Advantage health plans encourage preventive care and wellness and closely coordinate patient care.

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD. Enrollment in Medicare Advantage plans grew from 5.6 million in 2005 to 19 million in 2017. In 2017, one in three (33%) Medicare beneficiaries- 19.0 million people- are enrolled in a Medicare Advantage plan. Total Medicare Advantage enrollment grew by about 1.4 million beneficiaries, or 8 percent, between 2016 and 2017. The growth reflects the ongoing expansion of the role of Medicare Advantage plans in the Medicare program. This represents 19% of Medicare beneficiaries. A third of beneficiaries with Part D coverage are enrolled in a Medicare Advantage plan. Medicare Advantage enrollment is higher in urban areas; the enrollment rate in urban counties is twice that in rural counties (22% vs. 10%). Almost all Medicare beneficiaries have access to at least two Medicare Advantage plans; most have access to three or more. In 2016, eight in 10 beneficiaries in traditional Medicare (81%) had some type of supplemental insurance, including employer-sponsored insurance (30%), Medigap (29%), and Medicaid (22%).

Part D: Prescription Drug plans

Medicare Part D went into effect on January 1, 2006. Anyone with Part A or B is eligible for Part D. It was made possible by the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. In order to receive this benefit, a person with Medicare must enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD). These plans are approved and regulated by the Medicare program, but are actually designed and administered by private health insurance companies. Unlike Original Medicare (Part A and B), Part D coverage is not standardized. Plans choose which drugs (or even classes of drugs) they wish to cover, at what level (or tier) they wish to cover it, and are free to choose not to cover some drugs at all. The exception to this is drugs that Medicare specifically excludes from coverage, including but not limited to benzodiazepines, cough suppressant and barbiturates. Plans that cover excluded drugs are not allowed to pass those costs on to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases. Note that for beneficiaries who are dual-eligible (Medicare and Medicaid eligible) Medicaid may pay for drugs not covered by part D of Medicare, such as benzodiazepines, and other restricted controlled substances.

Neither Part A nor Part B pays for all of a covered person's medical costs. The program contains premiums, deductibles and coinsurance, which the covered individual must pay out-of-pocket. Some people may qualify to have other governmental programs (such as Medicaid) pay premiums and some or all of the costs associated with Medicare.

Premiums

Most Medicare enrollees do not pay a monthly Part A premium, because they (or a spouse) have had 40 or more 3-month quarters in which they paid Federal Insurance Contributions Act taxes. Medicare-eligible persons who do not have 40 or more quarters of Medicare-covered employment may purchase Part A for a monthly premium of:

- $232.00 per month (2018) for those with 30-39 quarters of Medicare-covered employment, or

- $422.00 per month (in 2018) for those with fewer than 30 quarters of Medicare-covered employment and who are not otherwise eligible for premium-free Part A coverage.

All Medicare Part B enrollees pay an insurance premium for this coverage; the standard Part B premium for 2018 is $134.00 per month. A new income-based premium plan has been in effect since 2007, wherein Part B premiums are higher for beneficiaries with incomes exceeding $85,000 for individuals or $170,000 for married couples. Medicare Part B premiums are commonly deducted automatically from beneficiaries' monthly Social Security checks. Part C and D plans may or may not charge premiums, at the programs' discretion. Part C plans may also choose to rebate a portion of the Part B premium to the member.

Deductible and coinsurance

Part A - For each benefit period, in 2018 a beneficiary will pay:

- A Part A deductible of $1,340 for a hospital stay of 1–60 days.
- A $335 per day co-pay for days 61-90 of a hospital stay.
- A $682 per day co-pay for days 91-150 of a hospital stay, as part of their limited Lifetime Reserve Days.
- All costs for each day beyond 150 days.
- Coinsurance for a Skilled Nursing Facility is $167.50 per day for days 21 through 100 for each benefit period.
- A blood deductible of the first 3 pints of blood needed in a calendar year, unless replaced. There is a 3 pint blood deductible for both Part A and Part B, and these separate deductibles do not overlap.

Part B - After a beneficiary meets the yearly deductible of $183.00 (in 2018), they will be required to pay a co-insurance of 20% of the Medicare-approved amount for all services covered by Part B with the exception of most lab services which are covered at 100%, and outpatient mental health which is currently covered at 20%. They are also required to pay an excess charge of 15% for services rendered by non-participating Medicare providers. The deductibles and coinsurance charges for Part C and D plans vary from plan to plan.

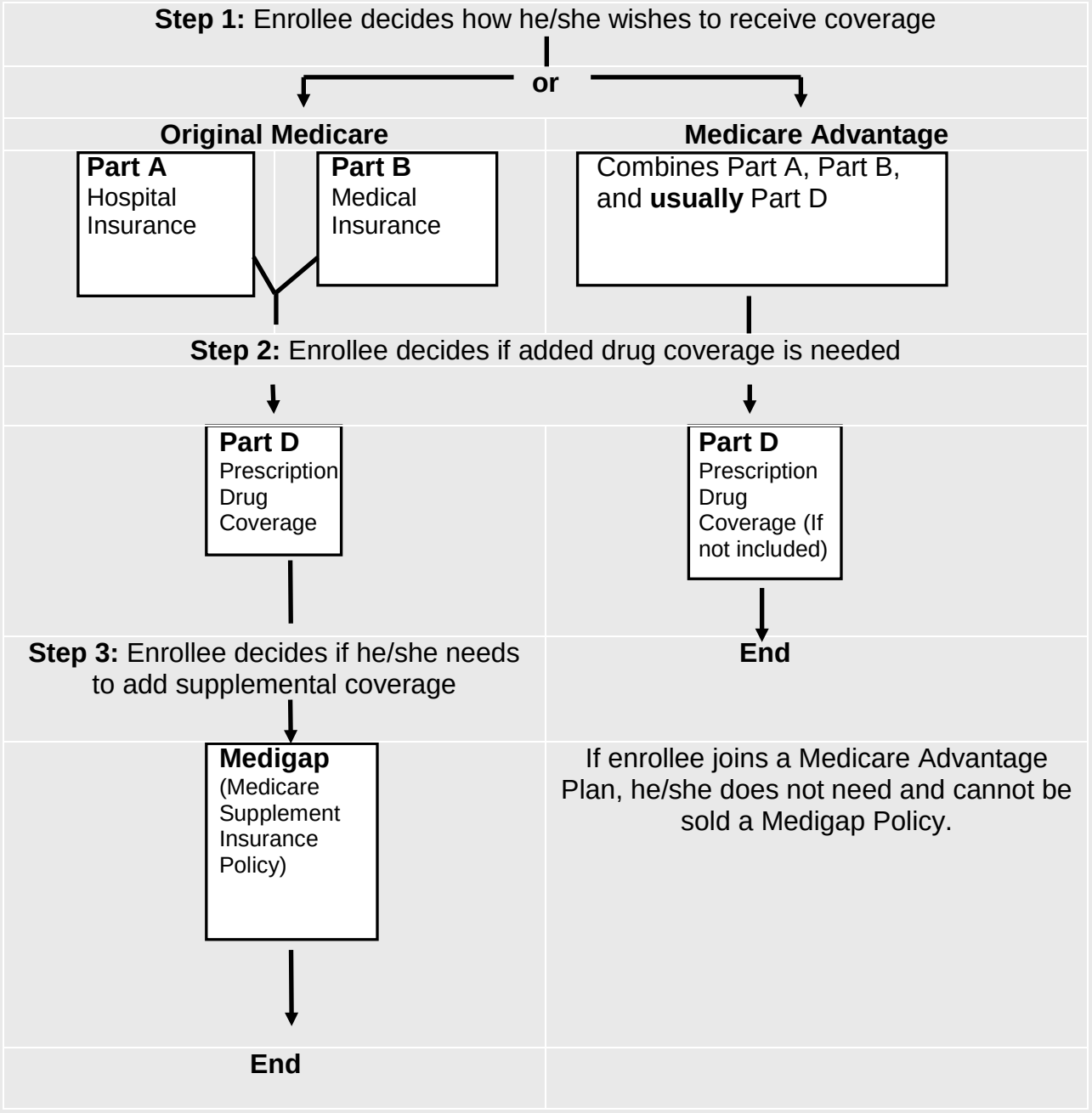
Medicare supplement (Medigap) policies

Some people elect to purchase a type of supplemental coverage, called a Medigap plan, to help fill in the holes in Original Medicare (Part A and B). These Medigap insurance policies are standardized by CMS, but are sold and administered by private companies. Some Medigap policies sold before 2006 may have included coverage for prescription drugs. Medigap policies sold after the introduction of Medicare Part D in 2006 are prohibited from covering drugs. Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy. Medigap Policies may only be purchased by beneficiaries that are receiving benefits from Original Medicare (Part A & Part B).

Payment for services

Medicare contracts with regional insurance companies who process over one billion fee-for-service claims per year. In 2018, Medicare accounted for 14% ($583 billion) of the federal budget. Medicare spending is expected to average 7% annual growth over the next decade — reaching $1.2 trillion in 2028, according to a Congressional Budget Office report (*The Budget and Economic Outlook, 2018-2028).*

Chart 1 Medicare Basics



Medicare Summary

Title XVIII of the Social Security Act, designated “Health Insurance for the Aged and Disabled,” is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act. When first implemented in 1966, Medicare covered most persons aged 65 or older. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise noncovered aged persons who elect to pay a premium for Medicare coverage. Beginning in July 2001, persons with Amyotrophic Lateral Sclerosis (Lou Gehrig’s disease) are allowed to waive the 24-month waiting period. This very broad description of Medicare eligibility is expanded in the next section. Medicare originally consisted of two parts:

- **Hospital Insurance (HI), or Part A**: Part A helps pay for inpatient hospital, home health agency, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage.
- **Supplementary Medical Insurance (SMI), or Part B:** Part B helps pay for physician, outpatient hospital, home health agency, and other services. To be covered by Part B, all eligible people must pay a monthly premium.
- **Medicare Advantage, or Part C:** This was established as the Medicare+Choice program by the Balanced Budget Act of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries’ options for participation in private-sector health care plans.
- **Drug Coverage, Part D:** The MMA also established a fourth part of Medicare, known as Part D, to help pay for prescription drugs not otherwise covered by Part A or Part B. Part D initially provided access to prescription drug discount cards, on a voluntary basis and at limited cost to all enrollees (except those entitled to Medicaid drug coverage) and, for low-income beneficiaries, transitional limited financial assistance for purchasing prescription drugs and a subsidized enrollment fee for the discount cards.

Entitlement and Coverage

Part A is generally provided automatically and free of premiums to persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in federal, state, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. (As noted previously, the waiting period is waived for persons with Lou Gehrig’s disease. It should also be noted that, over the years, there have been certain liberalizations made to both the waiting period requirement and the limit on earnings allowed for entitlement to Medicare

coverage based on disability.) Part A coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage.

Part A Coverages

The following health care services are covered under Part A:

- Inpatient hospital care. Coverage includes costs of a semiprivate room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).
- Skilled nursing facility (SNF) care. Coverage is provided by Part A only if it follows within 30 days (generally) a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital care, and include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21 through 100. Part A does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.
- Home health agency (HHA) care (covered by Parts A and B). The Balanced Budget Act transferred from Part A to Part B those home health services furnished on or after January 1, 1998, that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Parts A and B has no copayment and no deductible. HHA care, including care provided by a home health aide, may be furnished part time by an HHA in the residence of a homebound beneficiary, if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment may also be provided, although beneficiaries must pay a 20 percent coinsurance for durable medical equipment, as required under Part B of Medicare. There must be a plan of treatment and periodic review by a physician. Full-time nursing care, food, blood, and drugs are not provided as HHA services.
- Hospice care. Coverage is provided for services to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program but does pay small coinsurance amounts for drugs and inpatient respite care.

Benefit Period

An important Part A component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive

days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61 through 90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, the beneficiary can elect to use days of Medicare coverage from a nonrenewable lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

Part B Coverages

All citizens (and certain legal aliens) aged 65 or older, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B.

Part B covers certain medical services and supplies, including the following:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists;
- Services provided by Medicare-approved practitioners who are not physicians, including certified Registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician;
- Services in an emergency room, outpatient clinic, or ambulatory surgical center, including same-day surgery;
- Home health care not covered under Part A;
- Laboratory tests, X-rays, and other diagnostic radiology services;
- Certain preventive care services and screening tests;
- Most physical and occupational therapy and speech pathology services;
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it;
- Radiation therapy; renal (kidney) dialysis and transplants; heart, lung, heart-lung, liver, pancreas, and bone marrow transplants; and, as of 2001, intestinal transplants;
- Approved durable medical equipment for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, casts, and braces;
- Drugs and biologicals that are not usually self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered);
- Certain services specific to people with diabetes;
- Ambulance services, when other methods of transportation are contraindicated; and
- Rural health clinic and federally qualified health center services, including some telemedicine services.

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for

certain outpatient hospital services). The preceding description of Part B-covered services should be used only as a general guide, due to the wide range of services covered under Part B and the quite specific rules and regulations that apply. Medicare Parts A and B, as described above, constitute the original fee-for-service Medicare program.

SMI Components

For 2006 and later, Part D provided subsidized access to prescription drug insurance coverage on a voluntary basis for all beneficiaries upon payment of a premium, with premium and cost-sharing subsidies for low-income enrollees. Part D activities are handled within the SMI trust fund but in an account separate from Part B. It should thus be noted that the traditional treatment of “SMI” and “Part B” as synonymous is no longer accurate, since SMI now consists of Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other. When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2018, almost 60 million are enrolled in one or both of Parts A and B of the Medicare program, and almost 43 million of them have chosen to participate in a Medicare Advantage plan.

Part C Benefits

Medicare Part C, also known as Medicare Advantage, is an alternative to traditional Medicare. Although all Medicare beneficiaries can receive their benefits through the traditional fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. Medicare Advantage plans are offered by private companies and organizations and are required to provide at least those services covered by Parts A and B, except hospice services. These plans may (and in certain situations must) provide extra benefits (such as vision or hearing) or reduce cost sharing or premiums.

The primary Medicare Advantage plans are:

- Local coordinated care plans, including health maintenance organizations (HMOs), provider-sponsored organizations, local preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law. Generally, each plan has a network of participating providers. Enrollees may be required to use these providers or, alternatively, may be allowed to go outside the network but pay higher cost-sharing fees for doing so.
- Regional PPO plans, which began in 2006 and offer coverage to one of 26 defined regions. Like local PPOs, regional PPOs have networks of participating providers, and enrollees must use these providers or pay higher cost-sharing fees. However, regional PPOs are required to provide beneficiary financial protection in the form of limits on out-of-pocket cost sharing, and there are specific provisions to encourage regional PPO plans to participate in Medicare.
- Private fee-for-service plans, which for the most part do not have provider networks. Rather, members of a plan may go to any Medicare provider willing to accept the plan's payment.
- Special Needs Plans (SNPs), which are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain severe and disabling conditions.

For individuals entitled to Part A or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provided access to prescription drug discount cards, at a cost of no more than $30 annually, on a voluntary basis. For low-income beneficiaries, Part D initially provided transitional financial assistance (of up to $600 per year) for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards.

Part D Benefits

Beginning in 2006, Part D provided subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. In 2018, Part D provided protection against the costs of prescription drugs to about 43 million people. Part D benefits will total about $99 billion in 2019. Part D coverage includes most FDA-approved prescription drugs and biologicals. (The specific drugs currently covered in Parts A and B remain covered there.)

Plans may set up formularies for their prescription drug coverage, subject to certain statutory standards. At its most basic level, a **formulary** is a list of medicines. Traditionally, a formulary contained a collection of formulas for the compounding and testing of medication (a resource closer to what would be referred to as a pharmacopoeia today). The main function of formularies today is to specify which medicines are approved to be prescribed under a particular contract. The development of formularies is based on evaluations of efficacy, safety, and cost-effectiveness of drugs.
Part D coverage can consist of either standard coverage or an alternative design that provides the same actuarial value. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

Not Covered

It should be noted that some health care services are not covered by any portion of Medicare. Noncovered services include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, and hearing aids. These services are not a part of the Medicare program, unless they are a part of a private health plan under the Medicare Advantage program.

Program Financing, Beneficiary Liabilities, and Payments to Providers

All financial operations for Medicare are handled through two trust funds, one for Hospital Insurance (HI, Part A) and one for Supplementary Medical Insurance (SMI, Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare’s financing provisions, beneficiary cost-sharing

requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The Part A tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Since 1994 this tax is paid on all covered wages and self-employment income without limit (Prior to 1994, the tax applied only up to a specified maximum amount of earnings). The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

Part A also receives income from the following sources:

(1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries,
(2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily,
(3) reimbursements from the general fund of the U.S. Treasury for the cost of providing Part A coverage to certain aged persons who retired when Part A began and thus were unable to earn sufficient quarters of coverage (and those federal retirees similarly unable to earn sufficient quarters of Medicare-qualified federal employment),
(4) interest earnings on its invested assets, and
(5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

Trust Fund Differences

The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. SMI is composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily financed by contributions from the general fund of the U.S. Treasury and (to a much lesser degree) by beneficiary premiums.

For Part B, the contributions from the general fund of the U.S. Treasury are the largest source of income, since beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. The standard Part B premium rate was $134 per beneficiary per month in 2018. There are, however, three provisions that can alter the premium rate for certain enrollees. First, penalties for late enrollment (that is, enrollment after an individual’s initial enrollment period) may apply, subject to certain statutory criteria. Second, after 2007, beneficiaries whose income was above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their standard monthly premium. The 2018 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries, according to income level and filing status, are shown in Table 1. Finally, a “hold-harmless” provision affects premiums.

Hold-Harmless Provision

The “hold-harmless” provision, which prohibits increases in the standard Part B premium from exceeding the dollar amount of an individual’s Social Security cost-of-living adjustment, lowers the premium rate for most individuals who have their premiums deducted from their Social Security checks. If an individual collects Social Security benefits and Medicare Part B premiums are deducted from those benefits each month, the hold harmless rule may apply. Under the hold-harmless provision, the Part B premium for 2019 will be handled as follows;

Millions of people pay less than they are supposed to for Part B insurance, and that means a Social Security benefit increase could go to Medicare. For instance, the average person who is held harmless is paying a premium of $130, rather than $134, in 2018, so if they pay the $135.50 premium in 2019, their premium will increase 4.2%, not 1.1%. The premium increase paid by high-income earners could be even bigger. The table close by shows how much high-income earners will pay in Part B premiums in 2019. Americans in the highest income bracket will pay Part B premiums that are 7.4% higher than they were in 2018. Those not protected include most new enrollees during the year; enrollees with high incomes who are subject to the income-related monthly adjustment amount; and enrollees- such as certain federal, state, and local government retirees- who do not have their Part B premium withheld from a Social Security check. Also not protected are dual Medicare-Medicaid beneficiaries for whom premiums are paid by state Medicaid programs.

General Fund Contributions

For Part D, as with Part B, general fund contributions account for the largest source of income, since Part D beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The Part D base beneficiary premium for 2019 will be around $32.50. The actual Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. As of this writing, it is estimated that the average monthly premium for basic Part D coverage, which reflects the specific plan-by-plan premiums and the estimated number of beneficiaries in each plan, will be about $32.50 in 2019. Penalties for late enrollment may apply. (Late enrollment penalties do not apply to enrollees who have maintained creditable prescription drug coverage.)

Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced premiums or no premiums at all (and are not subject to late enrollment penalties) In addition to contributions from the general fund of the U.S. Treasury and beneficiary premiums, Part D also receives payments from the states. With the availability of prescription drug coverage and low-income subsidies under Part D, Medicaid is no longer the primary payer for prescription drugs for Medicaid beneficiaries who also have Medicare, and states are required to defray a portion of Part D expenditures for those beneficiaries. During the Part D transitional period that began in mid-2004 and phased out during 2006, the general fund of the U.S. Treasury financed the transitional assistance benefit for low-income beneficiaries. Funds were transferred to, and paid from, a Transitional Assistance account within the SMI trust fund.

Table 1 Part B income-related monthly adjustment amounts

And total monthly premium amounts to be paid by beneficiaries, by filing status and income level

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	Payment Each Month
$85,000 or less	$170,000 or less	$85,000 or less	$135.50
Above $85,000 up to $107,000	Above $170,000 up to $214,000	Not applicable	$189.60
Above $107,000 up to $133,500	Above $214,000 up to $267,000	Not applicable	$270.90
Above $133,500 up to $160,000	Above $267,000 up to $320,000	Not applicable	$352.20
Above $160,000 up to $500,000	Above $320,000 up to $750,000	Above $85,000 and less than $415,000	$433.40
$500,000 and above	$750,000 and above	$415,000 and above	$460.50

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. It is important to note that beneficiary premiums and general fund payments for Parts B and D are redetermined annually and separately. Payments to Medicare Advantage plans are financed from both the HI trust fund and the Part B account within the SMI trust fund in proportion to the relative weights of Part A and Part B benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of Parts A and B. These liabilities may be paid

(1) by the Medicare beneficiary;
(2) by a third party, such as an employer-sponsored retiree health plan or private Medigap insurance; or
(3) by Medicaid, if the person is eligible.

Medigap

The term “Medigap” is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by Blue Cross and Blue Shield and various commercial health insurance companies.

Beneficiary Payment Share

For beneficiaries enrolled in Medicare Advantage plans, the beneficiary’s payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such

beneficiaries, in general, pay the monthly Part B premium. However, some Medicare Advantage plans may pay part or all of the Part B premium for their enrollees as an added benefit. Depending on the plan, enrollees may also pay an additional premium for certain extra benefits provided (or, in a small number of cases, for certain Medicare-covered services).

For hospital care covered under Part A, a beneficiary's fee-for-service payment share includes a one-time deductible amount at the beginning of each benefit period ($1,340 in 2018). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($335 per day in 2018) are required through the 90th day of a benefit period. Each Part A beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments ($670 per day in 2018) are required. For skilled nursing care covered under Part A, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21 through 100, a copayment ($167.50 per day in 2018) is required from the beneficiary.

After 100 days per benefit period, Medicare pays nothing for SNF care. Home health care requires no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of nonreplaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced. There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of the beneficiary's spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the Part A monthly premium rate will be $422 in 2018; for those with 30 to 39 quarters of coverage, the rate will be reduced to $232. Penalties for late enrollment may apply. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom coverage has ceased because earnings are in excess of those allowed.

For Part B, the beneficiary's payment share includes the following:

- One annual deductible ($183 in 2018), the monthly premiums,
- The coinsurance payments for Part B services (usually 20 percent of the remaining allowed charges with certain exceptions noted below),
- A deductible for blood,
- Certain charges above the Medicare-allowed charge (for claims not on assignment), and payment for any services not covered by Medicare.

For outpatient mental health services, the beneficiary is liable for 20 percent of the approved charges. For services reimbursed under the outpatient hospital prospective payment system, coinsurance percentages vary by service and currently fall in the range of 20 percent to 50 percent. For certain services, such as clinical lab tests, HHA services, and some preventive care services, there are no deductibles or coinsurance.

Part D Payments

For the standard Part D benefit design, there is an initial deductible ($405 in 2018). After meeting the deductible, the beneficiary pays 25 percent of the remaining costs, up to an initial coverage limit ($3,750 in 2018). The beneficiary is then responsible for all costs until an out-of-pocket threshold is reached. The 2018 out-of-pocket threshold is $5,000.

Once the beneficiary reaches the threshold, he or she is out of the coverage gap. Once out of the coverage gap the beneficiary automatically receives catastrophic coverage. It assures the individual only pays a small coinsurance amount or copayment for covered drugs for the rest of the year. In 2018, an enrollee will pay the higher of either 5% of retail prices or $8.35 for brands or $3.35 for generics in Catastrophic Coverage - and in 2019, plan participants will pay the higher of either 5% of retail prices or $8.50 for brands or $3.40 for generics in Catastrophic Coverage. So, in 2018 (or 2019), if an individual is using a single-source, brand drug with a $500 retail price, he or she would pay 5% of retail or $25 (5% of $500 = $25), since $25 is higher than $8.35 (or $8.50 in 2019).

Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced cost-sharing amounts. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception to this “true out-of-pocket” provision is cost-sharing assistance from the low-income subsidies provided under Part D and from State Pharmacy Assistance programs. Many Part D plans offer alternative coverage that differs from the standard coverage described above. In fact, the majority of beneficiaries are not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, partial coverage in the coverage gap. The monthly premiums required for Part D coverage are described in the previous section.

Payments to Providers

For Part A, before 1983, payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under the PPS for acute inpatient hospitals, each stay is categorized into a diagnosis-related group (DRG). Each DRG has a specific predetermined amount associated with it, which serves as the basis for payment. A number of adjustments are applied to the DRG’s specific predetermined amount to calculate the payment for each stay. In some cases the payment the hospital receives is less than the hospital’s actual cost for providing Part A–covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays and other situations. Payments for skilled nursing care, home health care, inpatient rehabilitation hospital care, long-term care hospitals, inpatient psychiatric hospitals, and hospice are made under separate prospective payment systems.

For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of;
(1) the physician’s actual charge,
(2) the physician’s customary charge, or
(3) the prevailing charge for similar services in that locality.

Beginning January 1992, allowed charges are defined as the lesser of
(1) the submitted charges or
(2) the amount determined by a fee schedule based on a relative value scale (RVS). (In practice, most allowed charges are based on the fee schedule.)

Payments for durable medical equipment and clinical laboratory services are also based on a fee schedule. Most hospital outpatient services are reimbursed on a prospective payment system, and home health care is reimbursed under the same prospective payment system as Part A.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are "participating physicians" if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since beneficiaries in the original Medicare fee-for-service program may select their doctors, they can choose participating physicians.

Medicare Advantage plans and their precursors have generally been paid on a capitation basis, meaning that a fixed, predetermined amount per month per member is paid to the plan, without regard to the actual number and nature of services used by the members. The specific mechanisms to determine the payment amounts have changed over the years. In 2006, Medicare began paying capitated payment rates to plans based on a competitive bidding process. For Part D, each month for each plan member, Medicare pays stand-alone PDPs and the prescription drug portions of Medicare Advantage plans their risk-adjusted bid (net of estimated reinsurance), minus the enrollee premium. Plans also receive payments representing premiums and cost-sharing amounts for certain low-income beneficiaries for whom these items are reduced or waived. Under the reinsurance provision, plans receive payments for 80 percent of costs in the catastrophic coverage category. Under Part D, Medicare provides certain subsidies to employer and union PDPs that continue to offer coverage to Medicare retirees and meet specific criteria in doing so.

Claims Processing

Medicare's Part A and Part B fee-for-service claims are processed by nongovernment organizations or agencies that contract to serve as the fiscal agent between providers and the federal government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims. Medicare intermediaries process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for Part B. Examples of intermediaries are Blue Cross and Blue Shield (which utilize their plans in various states) and other commercial insurance companies. Intermediaries' responsibilities include:

- Determining costs and reimbursement amounts,
- Maintaining records,

- Establishing controls,
- Safeguarding against fraud and abuse or excess use,
- Conducting reviews and audits,
- Making the payments to providers for services, and
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a state and various commercial insurance companies. Carriers' responsibilities include:

- Determining charges allowed by Medicare,
- Maintaining quality-of-performance records,
- Assisting in fraud and abuse investigations,
- Assisting both suppliers and beneficiaries as needed, and
- Making payments to physicians and suppliers for services that are covered under Part B.

Claims for services provided by Medicare Advantage plans (that is, claims under Part C) are processed by the plans themselves. Part D plans are responsible for processing their claims, akin to Part C. However, because of the "true out-of- pocket" provision discussed previously, the Centers for Medicare & Medicaid Services (CMS) has contracted the services of a facilitator, who works with CMS, Part D drug plans (stand-alone PDPs and the prescription drug portions of Medicare Advantage plans), and carriers of supplemental drug coverage to coordinate benefit payments and track the sources of cost-sharing payments. Claims under Part D also have to be submitted by the plans to CMS, so that certain payments based on actual experience (such as payments for low-income cost-sharing and premium subsidies, reinsurance, and risk corridors) can be determined.

Improper payments

Because of its size and complexity, Medicare is vulnerable to improper payments, ranging from inadvertent errors to outright fraud and abuse. Although providers are responsible for submitting accurate claims, and intermediaries and carriers are responsible for ensuring that only such claims are paid, there are additional groups whose duties include the prevention, reduction, and recovery of improper payments. Quality improvement organizations (QIOs, formerly called peer review organizations or PROs) are groups of practicing health care professionals who are paid by the federal government to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. One function of QIOs is to ensure that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

The ongoing effort to address improper payments intensified after enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), which created the Medicare Integrity Program (MIP). The MIP provides CMS with dedicated funds to identify and combat improper payments, including those caused by fraud and abuse, and, for the first time, allows CMS to award contracts competitively with entities other than carriers and intermediaries to conduct these activities. MIP funds are used for;

(1) audits of cost reports, which are financial documents that hospitals and other institutions are required to submit annually to CMS;
(2) medical reviews of claims to determine whether services provided are medically reasonable and necessary;
(3) determinations of whether Medicare or other insurance sources have primary responsibility for payment;
(4) identification and investigation of potential fraud cases; and
(5) education to inform providers about appropriate billing procedures.

In addition to creating the MIP, HIPAA established a fund to provide resources for the Department of Justice- including the Federal Bureau of Investigation- and the Office of Inspector General (OIG) within the Department of Health and Human Services (HHS) to investigate and prosecute health care fraud and abuse. The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) established and funded the Medicare-Medicaid Data Match Program, which is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information. As is the case under the MIP, CMS can contract with third parties. The funds also can be used
(1) to coordinate actions by CMS, the states, the Attorney General, and the HHS OIG to prevent improper Medicaid and Medicare expenditures and
(2) to increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and the recoupment of fraudulent, wasteful, or abusive expenditures.

Administration

HHS has the overall responsibility for administration of the Medicare program. Within HHS, responsibility for administering Medicare rests with CMS. The Social Security Administration (SSA) assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums from the Social Security benefit checks of most beneficiaries, and by maintaining Medicare data on the Master Beneficiary Record, which is SSA's primary record of beneficiaries. The MMA requires SSA to undertake a number of additional Medicare-related responsibilities, including making low-income subsidy determinations under Part D, notifying individuals of the availability of Part D subsidies, withholding Part D premiums from monthly Social Security cash benefits for beneficiaries who request such an arrangement, and, for 2007 and later, determining the individual's Part B premium if the income-related monthly adjustment applies. The Internal Revenue Service (IRS) in the Department of the Treasury collects the Part A payroll taxes from workers and their employers. IRS data, in the form of income tax returns, play a role in determining which Part D enrollees are eligible for low-income subsidies (and to what degree) and, for 2007 and later, which Part B enrollees are subject to the income-related monthly adjustment amount in their premiums (and to what degree).

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the federal government, oversees the financial operations of the HI and SMI trust funds. The Secretary of the Treasury is the managing trustee. Each year, around the first day of April, the Board of Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds. State agencies (usually state health departments under agreements with CMS) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate

in the Medicare program. In consultation with CMS, these agencies then certify the facilities that are qualified.

Data Summary

The Medicare program covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. In 2017, Part A benefit payments totaled $293 billion, Part B payments were $309 billion, and Part D benefit payments equaled $100 billion.

Medicare: History of Provisions

This section is a summary of selected Medicare provisions. It should be used only as a broad overview of the history of the provisions of the Medicare program. This section does not render any legal, accounting, or other professional advice and is not intended to explain fully all the provisions and exclusions of the relevant laws, regulations, and rulings of the Medicare program. Original sources of authority should be researched and utilized.

Insured Status

Entitlement to Medicare Part A

Also known as Hospital Insurance, or HI Benefits

1965. Individual aged 65 or older entitled to monthly benefits under the Social Security or Railroad Retirement program, or aged 65 before 1968, or 3 quarters of coverage (QC) after 1965 and before attainment of age 65.

1967. Three QC for each year after 1966 and before attainment of age 65.

1972. Disabled individual, under age 65, entitled to disability benefits for 24 consecutive months under the Social Security or Railroad Retirement program (excludes spouses and children of disabled individuals). Individual under age 65 who has end-stage renal disease (ESRD) and who is either fully or currently insured, or is entitled to monthly benefits under the Social Security or Railroad Retirement program, or is the spouse or dependent child of such an insured individual or beneficiary. Entitlement begins on the first day of the third month following the initiation of a course of renal dialysis and ends with the 12th month following the month in which either the dialysis terminates or the individual has a renal transplant.

Individual aged 65 or older enrolled in the Part B program that is not otherwise entitled to HI benefits, upon voluntary participation with payment of HI premium.

1980. Individual who would be entitled to monthly benefits under the Social Security or Railroad Retirement program if application were made. Disabled individual under age 65 entitled to disability benefits for at least 24 months, not necessarily consecutive, under the Social Security or Railroad Retirement program.

Coverage extended for up to 36 months for disabled individuals whose disability continues but whose monthly benefit ceased because they engaged in substantial gainful activity. Second waiting period eliminated if a former disabled-worker beneficiary

becomes entitled again within 5 years (7 years for disabled widows and widowers and disabled children aged 18 or older).
1982. Federal employees covered under HI on the basis of QC for earnings as federal employees or on the basis of deemed QC for earnings as federal employees before 1983.
1983. Employees of nonprofit organizations, effective January 1, 1984.
1986. Mandatory coverage for state and local government employees not covered under Social Security and hired after March 31, 1986.
1987. Second waiting period eliminated if a former disabled beneficiary becomes entitled again (no time limit).
1989. Disabled individuals under age 65 who are no longer entitled to Social Security disability benefits because their earnings exceeded the substantial gainful activity level have the option to purchase Medicare coverage by paying the HI and Supplementary Medical Insurance (SMI) Part B premiums.
2000. The 24-month waiting period (otherwise required for an individual to establish Medicare eligibility on the basis of a disability) is waived for persons with amyotrophic lateral sclerosis (AMLS), effective July 1, 2001. The entitlement to Medicare begins with the first month of the Social Security Administration's determination of eligibility for Disability Insurance benefits.

Entitlement to Medicare Part B

Also known as Supplementary Medical Insurance Part B Account, or SMI Part B Benefits

1965. U.S. resident (citizen or lawfully admitted alien with 5 years continuous residence) aged 65 or older or any individual entitled to HI benefits, upon voluntary participation with payment of Part B premium.
1972. Individual under age 65 entitled to HI benefits, upon voluntary participation with payment of Part B premium.

Entitlement to Medicare Part D

Also known as Supplementary Medical Insurance Part D Account, or SMI Part D Benefits

2003. For temporary Medicare-endorsed prescription drug discount card program (as a prelude to the new Part D prescription drug program), individual entitled or enrolled under Part A or enrolled in Part B, except those enrolled in Medicaid and entitled to Medicaid outpatient drug coverage, upon voluntary participation with payment of up to $30 annual enrollment fee. Under a Transitional Assistance provision, a drug card-eligible beneficiary whose income does not exceed 135 percent of the federal poverty level and does not have third-party prescription drug coverage is entitled to further benefits. Enrollment began in May 2004, access to discounts began in June 2004, and the program phased out as drug benefits became available in 2006. Beginning January 1, 2006, individual entitled to benefits under Part A or enrolled under Part B, upon voluntary enrollment (including payment of Part D premium, if applicable) in either a stand-alone PDP or an integrated Medicare Advantage plan that offers Part D coverage in its benefit package.

Medicare Benefits

Under Part A

1965. In each benefit period, inpatient hospital services, 90 days. Includes semiprivate accommodations, operating room, hospital equipment (including renal dialysis), laboratory tests and X-ray, drugs, dressings, general nursing services, and services of interns and residents in medical osteopathic or dentistry training. Inpatient psychiatric hospital care limited to 190-day lifetime maximum. Outpatient hospital diagnostic services, Post-hospital extended-care services, 100 days (including physical, occupational, and speech therapy). Post-hospital home health services, 100 visits.
1967. Lifetime reserve of 60 additional days of inpatient hospital services. Outpatient hospital diagnostic services transferred to SMI.
1972. Services of interns and residents in podiatry training.
1980. Unlimited home health visits in a year. Requirement for prior hospitalization eliminated. Home health services provided for up to 4 days a week and up to 21 consecutive days. Alcohol detoxification facility services.
1981. Part A coinsurance is based on the deductible for the calendar year in which services are received rather than the deductible in effect at the time the beneficiary's spell of illness began, starting in 1982. Alcohol detoxification facility services eliminated.
1982. Beneficiaries expected to live 6 months or less may elect to receive hospice care benefits instead of other Medicare benefits. May elect maximum of two 90-day and one 30-day hospice care periods, effective November 1, 1983, to October 1, 1986.
1984. For durable medical equipment provided by home health agencies, the payment amount is reduced from 100 percent of costs to 80 percent of reasonable charges.
1986. Set the Part A deductible for 1987 at $520 with resulting increases in cost sharing. Increased the Part A deductible annually by the applicable percentage increase in the hospital prospective payment rates. Hospice care benefit (enacted in 1982) made permanent.
1987. Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).
1988. Enrollee pays annual hospital deductible (set at $560 for 1989) and Medicare pays balance of covered charges, regardless of the number of days of hospitalization (except for psychiatric hospital care, which is still limited by 190-day lifetime maximum). The number of days in a skilled nursing facility (SNF) changed to 150 per year. Deletes the requirement for a prior hospital stay of 3 or more consecutive days. Expands home health care to provide care for less than 7 days per week and up to 38 consecutive days. Hospice care extended beyond 210 days when beneficiary is certified as terminally ill. All 1988 provisions became effective January 1, 1989.
1989. The spell of illness and benefit period coverage of laws before 1988 return to the determination of inpatient hospital benefits in 1990 and later. After the deductible is paid in benefit period, Medicare pays 100 percent of covered costs for the first 60 days of inpatient hospital care. Coinsurance applies for the next 30 days in a benefit period. The requirement for a prior hospital stay of 3 or more consecutive days is reinstated for SNF services. Coverage returns to 100 days post-hospital care per spell of illness with a daily coinsurance rate in effect for days 21 through 100. Home health services return to a limit of 21 consecutive days of care. Provision providing for home health care for fewer than 7 days per week continued due to a court decision. Hospice care is returned to a lifetime limit of 210 days.

1990. Hospice care is extended beyond 210 days when beneficiary is certified as terminally ill.
1997. Home health services not associated with a hospital or SNF stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or an SNF stay. The cost to the SMI trust fund of the transferred services will phase in over a 6-year period (that is, the HI trust fund will transfer funds to the SMI trust fund during that period). Limits on the number of hours and days that home health care can be provided have been clarified. *Part-time* now defined as skilled nursing and home health aide services (combined) furnished any number of days per week, for less than 8 hours per day and 28 or fewer hours per week. *Intermittent* now defined as skilled nursing care provided for fewer than 7 days each week, or less than 8 hours each day (combined) for 21 days or less. Hospice benefit periods are restructured to include two 90-day periods, followed by an unlimited number of 60-day periods. Medicare coverage provided for a number of prevention initiatives, most of which are covered under SMI program. HI program affected mainly by two of the initiatives: (1) annual prostate cancer screening for male beneficiaries aged 50 or older, effective January 1, 2000, and (2) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances.
2000. The homebound criterion for home health services is clarified to specify that beneficiaries who require home health services may attend adult day care for therapeutic, psychosocial, or medical treatment and still remain eligible for the home health benefit. Homebound beneficiaries may also attend religious services without being disqualified from receiving home health benefits. Screening colonoscopies are covered for all beneficiaries, not just for those at high risk, beginning July 1, 2001. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous one, or 4 years after a screening flexible sigmoidoscopy. (See 1997.)

Under Part B

1965. Physician and surgeon services. In-hospital services of anesthesiologists, pathologists, radiologists, and psychiatrists. Limited dental services. Home health services, 100 visits in calendar year. Other medical services including various diagnostic tests, limited ambulance services, prosthetic devices, rental of durable medical equipment used at home (including equipment for dialysis), and supplies used for fractures. Beginning in 1966, the beneficiary pays a $50 deductible, with a 3-month carryover provision.
1967. Outpatient hospital diagnostic services transferred from HI. Includes physical therapy services in a facility. Purchase of durable medical equipment.
1972. Physical therapy services furnished by a therapist in his or her office or individual's home (calendar year limit of $100). Chiropractor services (limited to manual manipulation of the spine). Outpatient services include speech pathology services furnished in, or under arrangements with, a facility or agency. Services of a doctor of optometry in furnishing prosthetic lenses. Beginning in 1973, the beneficiary pays a $60 deductible.
1977. Services in rural health clinics.

1980. Home health services. Deductible applicable to home health services is eliminated, effective July 1, 1981. Facility costs of certain surgical procedures performed in freestanding ambulatory surgical centers. Increase in annual limit for outpatient therapy from $100 to $500. Recognizes comprehensive outpatient rehabilitation facilities as Medicare providers.
1981. Beginning in 1982, the beneficiary pays a $75 deductible, with the carryover provision eliminated.
1984. Hepatitis B and pneumococcal vaccines and blood clotting factors and necessary supplies are included as Part B benefits. Debridement of mycotic toenails is limited. For outpatient physical therapy services, includes services of a podiatrist. For outpatient ambulatory surgery, includes services of a dentist and podiatrist furnished in his or her office.
1986. Includes vision care services furnished by an optometrist. For occupational therapy services, includes services furnished in an SNF (when Part A coverage has been exhausted), in a clinic, rehabilitation agency, public health agency, or by an independently practicing therapist. Includes outpatient (in addition to previously covered inpatient) immunosuppressive drugs for 1 year after covered transplant. Includes occupational therapy services provided in certain delivery settings. For ambulatory surgical procedures performed in ambulatory surgical centers, hospital outpatient departments, and certain physician offices, the Part B coinsurance and deductible are no longer waived.
1987. Increases the maximum payment for mental health services and includes outpatient mental health services provided by ambulatory hospital-based or hospital-affiliated programs under the supervision of a physician. Services provided by clinical social workers when furnished by risk-sharing HMOs and competitive medical plans, physician assistants in rural health manpower shortage areas, clinical psychologists in rural health clinics and community mental health centers, and certified nurse midwives. Coverage of outpatient immunosuppressive drugs (see 1986) is broadened and clarified to include prescription drugs used in immunosuppressive therapy. Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).
1988. Beginning January 1, 1990, the beneficiary pays a $75 deductible and 20 percent coinsurance, but once out-of-pocket expenses for the deductible and coinsurance exceed $1,370, Medicare pays 100 percent of allowable charges for remainder of year. Beginning in 1991, Medicare pays 50 percent of the cost of outpatient prescription drugs above $600. When fully implemented in 1993, Medicare will pay 80 percent of prescription drug costs above a deductible that assumes that 16.8 percent of Part B enrollees will exceed the deductible. Certain prescription drugs administered in an outpatient or home setting, including immunosuppressive drugs (previously covered for 1 year after a covered transplant), home intravenous drugs, and certain others, will be covered in 1990 under a new prescription drug provision.
1989. Provisions enacted in 1988 and to begin in 1990 and 1991 are repealed, and benefits are restored to levels in effect before January 1, 1989. Limits on mental health benefits eliminated in 1990. Coverage extended to services of clinical psychologists and social workers. The annual payment limits of $500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to $750 for 1990 and later. (See 1980.)
1990. Beginning in 1991, routine mammography screenings are covered. The Part B deductible is set at $100 in 1991 and subsequent years. Beginning in 1992, physicians' services are reimbursed on a fee-schedule basis.

1993. Includes coverage of oral, self-administered anticancer drugs. Lengthens the coverage period for immunosuppressive drugs after a transplant to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter. (See 1986.)
The annual payment limits of $750 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to $900 for 1994 and later. (See 1989.)
1997. Home health services not associated with a hospital or SNF stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or an SNF stay. The cost to the SMI trust fund of the transferred services will phase in over a 6-year period, while the cost of the home health services will phase into the SMI premium over 7 years.
Coverage provided for a number of prevention initiatives, including (1) annual screening mammograms for female beneficiaries aged 40 or older, with SMI deductible waived; (2) screening pap smear and pelvic exam (including clinical breast exam) every 3 years or annually for beneficiaries at higher risk, with SMI deductible waived; (3) annual prostate cancer screening for male beneficiaries aged 50 or older, effective January 1, 2000; (4) colorectal screening procedures, including fecal occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances; (5) diabetes outpatient self-management training in nonhospital-based programs (previously covered in hospital-based programs only) and blood glucose monitors and testing strips for all diabetics (previously provided for insulin-dependent diabetics only), effective July 1, 1998; (6) procedures to identify bone mass, detect bone loss, or determine bone quality for certain qualified beneficiaries, at frequencies determined by the secretary of Health and Human Services, effective July 1, 1998. Beginning January 1999, an annual beneficiary limit of $1,500 will apply to all outpatient physical therapy services, except for services furnished by a hospital outpatient department. A separate $1,500 limit will also apply to outpatient occupational therapy services, except for services furnished by hospital outpatient departments. Beginning with 2002, the caps increased by the percentage increase in the Medical Economic Index. (See 1993.)
1999. The coverage period for immunosuppressive drugs after a transplant is lengthened to 44 months, for individuals who exhaust their 36 months of coverage in 2000. For those exhausting their 36 months of coverage in 2001, at least 8 more months will be covered. (The secretary of Health and Human Services will specify the increase, if any, beyond 8 months.) For those exhausting their 36 months of coverage in 2002, 2003, or 2004, the number of additional months may have been more or fewer than 8. (The secretary will specify the increase for each of these years.) (See 1993.)
The annual payment limits of $1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services furnished by independent practitioners (that is, not by a hospital outpatient department) are suspended for 2000 and 2001. (See 1997.)
2000. Coverage for screening pap smears and pelvic exams (including a clinical breast exam) is provided every 2 years (increased from every 3 years) beginning July 1, 2001. (Annual coverage continues for beneficiaries at higher risk, and SMI deductible continues to be waived.) (See 1997.) Annual coverage of glaucoma screenings is provided for certain high-risk beneficiaries, effective January 1, 2002.
Screening colonoscopies are covered for all beneficiaries, not just for those at high risk, beginning July 1, 2001. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous one, or 4 years after a screening flexible

sigmoidoscopy. (See 1997.) Coverage is provided for medical nutrition therapy services under certain circumstances for beneficiaries who have diabetes or a renal disease, effective January 1, 2002. The amount of a beneficiary's copayment for a procedure in a hospital outpatient department is limited, beginning April 1, 2001, to the hospital inpatient deductible applicable for that year. Also, the secretary of Health and Human Services must reduce the effective copayment rate for outpatient services to a maximum rate of 57 percent in 2001 (for services received after April 1), 55 percent in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and later. Time and budget limitations are removed on the coverage of immunosuppressive drugs, making coverage of these drugs a permanent benefit for beneficiaries who have received a covered organ transplant. (See 1999.) The annual payment limits of $1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services provided by independent practitioners (that is, not by a hospital outpatient department), which were suspended for 2000 and 2001, were also suspended for 2002. (See 1999.)

Home Health Benefits Eligibility

The homebound criterion for home health services is clarified to specify that beneficiaries who require home health services may attend adult day care for therapeutic, psychosocial, or medical treatment and still remain eligible for the home health benefit. Homebound beneficiaries may also attend religious services without being disqualified from receiving home health benefits.

2003. The standard monthly premium for Medicare Part B enrollees will be $135.50 for 2019, an increase of $1.50 from $134 in 2018. The annual deductible for all Medicare Part B beneficiaries is $185 in 2019, an increase of $2 from the annual deductible $183 in 2018. A one-time, initial preventive physical exam is covered within 6 months of a beneficiary's first coverage under Part B, beginning January 1, 2005, for beneficiaries whose Part B coverage begins on or after that date.
Certain screening blood tests are covered for the early detection of cardiovascular disease and abnormalities associated with elevated risk for such disease, including certain tests for cholesterol and other lipid or triglyceride levels, effective January 1, 2005, under frequency standards to be established (but not to exceed once every 2 years). Diabetes screening tests, including a fasting plasma glucose test and other such tests determined appropriate by the secretary of Health and Human Services, are covered for beneficiaries at risk for diabetes, beginning January 1, 2005, under frequency standards to be established (but not to exceed two times per year).
2005. The colorectal screening benefit (see 1997 and 2000) is exempt from the Part B deductible, effective January 2007. Exceptions to the financial limits on therapy services not provided by a hospital outpatient department are allowed for services furnished in 2006, if such services are determined to be medically necessary. (See 1997, 1999, and 2000.)
2006. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through December 31, 2007. (See 2005.)
2007. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate were extended through July 1, 2008. (See 2005 and 2006).
2008. For outpatient mental health services, the percentage of approved charges for which the beneficiary is liable phases down from 50 percent to 20 percent, over the 5-year period 2010-2014. For the one-time, initial preventive examination (see 2003), the Part B deductible is waived, the eligibility period is extended from 6 months to 1 year

after enrollment in Part B, measurement of body mass index is covered, and, upon agreement with the beneficiary, end-of-life planning is covered.

Under Parts A and B

Medicare Secondary Payer

Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "Coordination of Benefits" when assigning responsibility for first and second payment.) The term "Medicare Secondary Payer" is sometimes confused with Medicare supplement. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the *primary payer*. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program.

Coordination of Benefits

Generally, Medicare is the “primary payer”—that is, it pays health claims first, and if a beneficiary has other insurance, that insurance may fill in all or some of Medicare’s gaps. However, §1862(b) of the Social Security Act authorizes the Medicare Secondary Payer program, which identifies specific conditions under which another party pays first and Medicare is only responsible for qualified secondary payments, thereby reducing expenditures under the Medicare program. The law prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer. Medicare is the secondary payer to insurance plans and programs, under certain conditions, for beneficiaries covered through (1) a group health plan based on either their own or a spouse’s current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers’ compensation situations, including the Black Lung program. Additionally, under §1862(a) of the Social Security Act, items and services paid for directly or indirectly by a government entity, subject to certain limitations, are excluded from Medicare coverage. This includes the U.S. Department of Veterans Affairs, among others. As a result, Medicare also coordinates benefits for cases involving the Veterans Health Administration.

1965. Requires that Medicare be secondary payer to benefits provided by liability insurance policies or under no-fault insurance.
1981. Requires that Medicare be secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely on the basis of end-stage renal disease (ESRD) for up to 12 months.
1982. For workers and their spouses aged 65 to 69, Medicare is the secondary payer when benefits are provided under an employer-based group health plan (applicable to employers with 20 or more employees who sponsor or contribute to the group plan). Health maintenance organizations (HMOs) will be authorized as providers of benefits. The secretary of Health and Human Services must certify the prospective payment mechanism for HMOs before implementation.
1984. Medicare secondary-payer provisions are extended to spouses aged 65 to 69 of workers under age 65 whose employer-based group health plan covers such spouses.

For HMOs, includes medical and other health services furnished by clinical psychologists.
1985. Provides payment for liver transplant services.
1986. Extends the working-age, secondary-payer provision to cover workers and their spouses beyond age 69. For HMOs that offered organ transplants as a basic health service on April 15, 1985, such services may be offered from October 1, 1985, through April 1, 1988. For disabled individuals who are covered by employer-based health plans (with at least 100 employees), Medicare is the secondary payer, effective for the period from 1987 to 1991.
1987. Requires HMOs and competitive medical plans that cease to contract with Medicare to provide or arrange supplemental coverage of benefits related to preexisting conditions for the lesser of 6 months or the duration of an exclusion period. Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker). Clarifies that the secondary-payer provision for disabled individuals covered under employer-based health plans for employers with at least 500 employees applies to employers who are government entities.
1990. Requires that Medicare be the secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely on the basis of ESRD for up to 18 months (extended from 12 months), effective February 1, 1991, to January 1, 1996. The secondary-payer provision for disabled beneficiaries covered under large employer plans (see 1986) is effective through September 30, 1995.
1993. The secondary-payer provision for disabled beneficiaries covered under large employer plans is effective through September 30, 1998. The secondary-payer provision for beneficiaries with ESRD applies to all beneficiaries with end-stage renal disease, not only those entitled to Medicare solely on the basis of ESRD. The extension to include the first 18 months of an individual's entitlement on the basis of ESRD is effective through September 30, 1998.
1996. The Medicare Integrity Program (MIP) is created, providing dedicated funds to identify and combat improper payments, including those caused by fraud and abuse, and, for the first time, allowing for contracts to be awarded competitively to entities other than carriers and intermediaries to conduct these activities.
1997. Established an expanded set of options for the delivery of health care under Medicare, referred to as Medicare+Choice (and also known as “Medicare Part C”). All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service program. In addition, most beneficiaries can choose instead to receive their Medicare benefits through one of the following Medicare+Choice plans:
(1) coordinated care plans (such as HMOs, provider sponsored organizations, and PPOs),
(2) Medical Savings Account (MSA)/High Deductible plans (through a demonstration available for up to 390,000 beneficiaries), or
(3) private fee-for-service plans. Except for MSA plans, all Medicare+Choice plans are required to provide the current Medicare benefit package (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. MSA plans provide Medicare benefits after a single high deductible is met, and enrollees receive an annual deposit in their medical savings account. Transition rules for current Medicare HMO program also provided. (See also HMO provision of 1982.)

The provision making Medicare the secondary payer for disabled beneficiaries covered under large employer plans, previously scheduled to expire September 30, 1998, made

permanent. The provision making Medicare the secondary payer for the first 12 months of entitlement because of ESRD, which had been extended on a temporary basis (through September 30, 1998) to include the first 18 months of entitlement, has been extended, permanently, to include the first 30 months of entitlement on the basis of ESRD.
2003. Medicare+Choice is renamed Medicare Advantage. (It is still sometimes referred to as “Medicare Part C.”) As before, beneficiaries enrolled in both Part A and Part B can receive their Medicare benefits through the original fee-for-service program; most can opt instead to use a Medicare Advantage plan in their area. Medicare Advantage plans include
(1) Medicare Managed Care plans (like HMOs),
(2) Medicare Preferred Provider Organization
plans (PPOs),
(3) Private Fee-for-Service plans, and
(4) Medicare Specialty plans (available in some areas to provide Medicare benefits for certain people with special needs, such as beneficiaries in institutions).

Beginning in 2006, Medicare Advantage plan choices expanded to include regional PPOs. Participating regional PPOs were required to serve an entire region (10 to 50 regions were established). Regional PPOs must have a single deductible for benefits under Parts A and B, and they must include catastrophic limits for out-of-pocket expenditures. Beginning in 2006, the adjusted community rate (ACR) process for determining plan payments is replaced by a competitive bidding process. (Historical reference points to this item include the Medicare+Choice provision of 1997 and the HMO provision of 1982, both of which are displayed in this section.)
2007. Group health plans are required to provide information identifying situations in which the plan is, or has been, primary to Medicare, effective January 2009. Effective June 2009, liability insurance, no-fault insurance, and workers' compensation plans must submit specific information to enable appropriate determinations concerning coordination of benefits and any applicable recovery claims.

Under Part D

2003. Under temporary Medicare-endorsed prescription drug discount card program, for eligible beneficiaries voluntarily enrolling and paying up to $30 annually, discounts on certain prescription drugs, as specified by card sponsors. Under Transitional Assistance provision, eligible beneficiaries whose incomes do not exceed 135 percent of the federal poverty level and do not have third-party prescription drug coverage are eligible for
(1) financial assistance of up to $600 per year for purchasing prescription drugs and
(2) a subsidized enrollment fee under the temporary Medicare-endorsed prescription drug discount card program. Enrollment began in May 2004, access to discounts began in June 2004, and program phased out as drug benefit became available in 2006 (see next entry). Beginning January 1, 2006, upon voluntary enrollment in either a stand-alone PDP or an integrated Medicare Advantage plan that offered Part D coverage in its benefit, subsidized prescription drug coverage. Most FDA-approved drugs and biologicals were covered.

Plans may set up formularies for their drug coverage, subject to certain statutory standards. (Drugs currently covered in Parts A and B remain covered there.) Part D coverage can consist of either standard coverage or an alternative design that provides

the same actuarial value. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

Donut Hole- Standard Part D coverage was defined for 2006 as having a $250 deductible, with 25 percent coinsurance (or other actuarially equivalent amounts) for drug costs above the deductible and below the initial coverage limit. This begins the coverage gap or Donut Hole. Most Medicare drug plans have a coverage gap. This means there's a temporary limit on what the drug plan will cover for drugs. Not everyone will enter the coverage gap. The coverage gap begins after the insured and his or her drug plan have spent a certain amount for covered drugs. In 2018, once the insured and his or her plan have spent $3,750 on covered drugs ($3,820 in 2019), they are in the coverage gap. This amount may change each year.

Part D Catastrophic Coverage

For higher costs, there is catastrophic coverage; it requires enrollees to pay the greater of 5 percent coinsurance or a small copay ($2 for generic or preferred multisource brand and $5 for other drugs). After 2006, these benefit parameters were indexed to the growth in per capita Part D spending. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception is cost-sharing assistance from

The catastrophic coverage amount is calculated on a yearly basis, and a beneficiary who reaches catastrophic coverage by December 31 of one year will start his or her deductible anew on January 1. The standard benefit is not the most common benefit offered by Part D plans. Plans vary widely in their formularies and cost-sharing requirements. Most eliminate the deductible and use tiered drug co-payments rather than coinsurance.

Medicare’s low-income subsidies (certain beneficiaries with low incomes and modest assets will be eligible for certain subsidies that eliminate or reduce their Part D premiums, cost-sharing, or both) and from State Pharmacy Assistance Programs. A beneficiary premium, representing 25.5 percent of the cost of basic coverage on average, is required (except for certain low-income beneficiaries, as previously mentioned, who may pay a reduced or no premium). For PDPs and the drug portion of Medicare Advantage plans, the premium will be determined by a bid process; each plan’s premium will be 25.5 percent of the national weighted average plus or minus the difference between the plan’s bid and the average. To help them gain experience with the Medicare population, plans will be protected by a system of risk corridors, which allow Part D to assist with unexpected costs and to share in unexpected savings; after 2007, the risk corridors became less protective. To encourage employer and union plans to continue prescription drug coverage to Medicare retirees, subsidies to these plans are authorized; the plan must meet or exceed the value of standard Part D coverage, and the subsidy pays 28 percent of the allowable costs associated with enrollee prescription drug costs between a specified cost threshold ($250 in 2006, indexed thereafter) and a specified cost limit ($5,000 in 2006, indexed thereafter).
2008. Part D plans are required to include two classes of drugs in their formularies: (1) benzodiazepines and (2) for the treatment of epilepsy, cancer, or chronic mental disorder, barbiturates.

Medicare Financing

Appropriations from General Revenues

1965. For HI costs attributable to transitionally insured beneficiaries. For HI costs attributable to noncontributory wage credits granted for military service prior to 1957 (see Table 2.A2). For the Part B program, an amount equal to participant premiums.
1972. For cost of Part B not met by enrollee premiums.
1982. For HI costs attributable to beneficiaries having transitional entitlement based on Medicare-qualified federal employment.
1983. For HI taxes on noncontributory wage credits granted for military service (a) from the inception of HI program through 1983 and (b) on a current basis, annually, beginning in 1984 (see Table 2.A2).
2002. Eliminated for HI taxes on noncontributory wage credits granted for military service on a current basis, for all years after calendar year 2001 (see Table 2.A2).
2003. For Part D costs not met by enrollee premiums or otherwise, beginning in January 2006. (That is, transfers from general revenues [plus smaller income sources, particularly the payments from states described below] will pay for
(1) the 74.5 percent subsidy to PDPs and the prescription drug portion of Medicare Advantage plans [which remains after enrollee premiums of 25.5 percent, on average], in the form of a direct subsidy and reinsurance, and
(2) for other Part D costs, such as low-income subsidies and subsidies to employers who provide qualifying drug coverage to their Medicare-eligible retirees.) Beginning January 2007,

Table 2.A2—Noncontributory wage credit provisions, by year enacted

Year enacted	Provision
1946	Fully insured status and average monthly wage of $160 for World War II veterans who died within 3 years after discharge.
1950	Wage credits of $160 per month of military service during World War II period (September 16, 1940–July 24, 1947).
1952	Wage credits of $160 per month of military service to December 31, 1953.
1953	Wage credits of $160 per month of military service to June 30, 1955.
1955	Wage credits of $160 per month of military service to March 31, 1956.
1956	Wage credits of $160 per month of military service to December 31, 1956.
1967	For uniformed services, wage credits of $100 for each $100 (or fraction thereof) of basic pay not in excess of $300 per calendar quarter, beginning in1968.
1972	For uniformed services, wage credits of $300 per calendar quarter of service after 1956. (Supersedes 1967 provision.) For U.S. citizens of Japanese ancestry, wage credits for the period they were interned by the U.S. government during World War II period (December 7, 1941–December 31, 1946) and who were aged 18 or older.
1977	For uniformed services, wage credits of $100 for each $300 of basic pay up to maximum credit of $1,200 per calendar year after 1977.
2002	For uniformed services, deemed wage credits are eliminated for all years after calendar year 2001. Deemed wage credits will continue to be given for appropriate earnings for periods prior to calendar year 2002.

SOURCES: Social Security Act of 1935 (the Act), as amended through December 31, 2008; regulations issued under the Act; and precedential case decisions (rulings). Specific laws, regulations, rulings, legislation, and a link to the *Federal Register* can be found at the Social Security Program Rules page (http://www.socialsecurity.gov/ regulations/index.htm).

Table 2.A3 Annual Maximum Taxable Earnings and Contribution Rates 1937-2017

Year	Annual maximum taxable earnings (dollars)		Contribution rate (percent)							
			Employer and employee, each				Self-employed person			
	OASDI	HI	Total, OASDI and HI	OASI	DI	HI	Total, OASDI and HI	OASI	DI	HI
1937–1949	3,000	...	1.0	1.0	...	...	...	...	...	...
1950	3,000	...	1.5	1.5	...	...	...	...	...	...
1951–1953	3,600	...	1.5	1.5	...	...	2.25	2.25	...	...
1954	3,600	...	2.0	2.0	...	...	3.0	3.0	...	...
1955–1956	4,200	...	2.0	2.0	...	...	3.0	3.0	...	...
1957–1958	4,200	...	2.25	2.0	0.25	...	3.375	3.0	0.375	...
1959	4,800	...	2.5	2.25	0.25	...	3.75	3.375	0.375	...
1960–1961	4,800	...	3.0	2.75	0.25	...	4.5	4.125	0.375	...
1962	4,800	...	3.125	2.875	0.25	...	4.7	4.325	0.375	...
1963–1965	4,800	...	3.625	3.375	0.25	...	5.4	5.025	0.375	...
1966	6,600	6,600	4.2	3.5	0.35	0.35	6.15	5.275	0.525	0.35
1967	6,600	6,600	4.4	3.55	0.35	0.5	6.4	5.375	0.525	0.5
1968	7,800	7,800	4.4	3.325	0.475	0.6	6.4	5.0875	0.7125	0.6
1969	7,800	7,800	4.8	3.725	0.475	0.6	6.9	5.5875	0.7125	0.6
1970	7,800	7,800	4.8	3.65	0.55	0.6	6.9	5.475	0.825	0.6
1971	7,800	7,800	5.2	4.05	0.55	0.6	7.5	6.075	0.825	0.6
1972	9,000	9,000	5.2	4.05	0.55	0.6	7.5	6.075	0.825	0.6
1973	10,800	10,800	5.85	4.3	0.55	1.0	8.0	6.205	0.795	1.0
1974	13,200	13,200	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1975	[a] 14,100	[a] 14,100	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1976	[a] 15,300	[a] 15,300	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1977	[a] 16,500	[a] 16,500	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1978	[a] 17,700	[a] 17,700	6.05	4.275	0.775	1.0	8.1	6.01	1.09	1.0
1979	22,900	22,900	6.13	4.33	0.75	1.05	8.1	6.01	1.04	1.05
1980	25,900	25,900	6.13	4.52	0.56	1.05	8.1	6.2725	0.7775	1.05
1981	29,700	29,700	6.65	4.7	0.65	1.3	9.3	7.025	0.975	1.3
1982	[a] 32,400	[a] 32,400	6.7	4.575	0.825	1.3	9.35	6.8125	1.2375	1.3
1983	[a] 35,700	[a] 35,700	6.7	4.775	0.625	1.3	9.35	7.1125	0.9375	1.3
1984	[a] 37,800	[a] 37,800	[b] 7.0	5.2	0.5	1.3	[b] 14.0	10.4	1.0	2.6
1985	[a] 39,600	[a] 39,600	7.05	5.2	0.5	1.35	[b] 14.1	10.4	1.0	2.7
1986	[a] 42,000	[a] 42,000	7.15	5.2	0.5	1.45	[b] 14.3	10.4	1.0	2.9
1987	[a] 43,800	[a] 43,800	7.15	5.2	0.5	1.45	[b] 14.3	10.4	1.0	2.9
1988	[a] 45,000	[a] 45,000	7.51	5.53	0.53	1.45	[b] 15.02	11.06	1.06	2.9
1989	[a] 48,000	[a] 48,000	7.51	5.53	0.53	1.45	[b] 15.02	11.06	1.06	2.9
1990	[c] 51,300	[c] 51,300	7.65	5.6	0.6	1.45	15.3	11.2	1.2	2.9
1991	[c] 53,400	[d] 125,000	7.65	5.6	0.6	1.45	15.3	11.2	1.2	2.9
1992	[c] 55,500	130,200	7.65	5.6	0.6	1.45	15.3	11.2	1.2	2.9
1993	[a] 57,600	[a] 135,000	7.65	5.6	0.6	1.45	15.3	11.2	1.2	2.9
1994	[a] 60,600	e	7.65	5.26	0.94	1.45	15.3	10.52	1.88	2.9
1995	[a] 61,200	e	7.65	5.26	0.94	1.45	15.3	10.52	1.88	2.9
1996	[a] 62,700	e	7.65	5.26	0.94	1.45	15.3	10.52	1.88	2.9
1997	[a] 65,400	e	7.65	5.35	0.85	1.45	15.3	10.7	1.7	2.9
1998	[a] 68,400	e	7.65	5.35	0.85	1.45	15.3	10.7	1.7	2.9
1999	[a] 72,600	e	7.65	5.35	0.85	1.45	15.3	10.7	1.7	2.9

Year	Annual maximum taxable earnings (dollars)		Contribution rate (percent)							
			Employer and employee, each				Self-employed person			
	OASDI	HI	Total, OASDI and HI	OASI	DI	HI	Total, OASDI and HI	OASI	DI	HI
2000	[a] 76,200	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2001	[a] 80,400	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2002	[a] 84,900	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2003	[a] 87,000	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2004	[a] 87,900	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2005	[a] 90,000	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2006	[a] 94,200	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2007	[a] 97,500	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2008	[a] 102,000	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2009	[a] 106,800	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2010	[a] 106,800	e	[f] 7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2011	[a] 106,800	e	[g] 7.65	5.3	0.9	1.45	[g] 15.3	10.6	1.8	2.9
2012	[a] 110,100	e	[g] 7.65	5.3	0.9	1.45	[g] 15.3	10.6	1.8	2.9
2013 [h]	[a] 113,700	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2014 [h]	[a] 117,000	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2015 [h]	[a] 118,500	e	7.65	5.3	0.9	1.45	15.3	10.6	1.8	2.9
2016 [h,i]	[a] 118,500	e	7.65	5.015	1.185	1.45	15.3	10.03	2.37	2.9
2017 [h,i]	[a] 127,200	e	7.65	5.015	1.185	1.45	15.3	10.03	2.37	2.9

SOURCES: Social Security Act of 1935 (the Act), as amended through December 31, 2016; regulations issued under the Act; and precedential case decisions (rulings).

Social Security Administration, "Cost-of-Living Increase and Other Determinations for 2017," *Federal Register,* vol. 81, no. 208 (October 27, 2016). See the Social
Security Program Rules page (https://www.ssa.gov/regulations/index.htm) for specific laws, regulations, rulings, legislation, and a link to the *Federal Register.*
NOTES: DI = Disability Insurance; HI = Hospital Insurance; OASI = Old-Age and Survivors Insurance; OASDI = Old-Age, Survivors, and Disability Insurance.
Table shows the contribution (tax) rates used to determine total amounts received by the trust funds. Occasional temporary tax credits and rate reductions affect the rates paid by employers, employees, or self-employed persons, and are summarized in footnotes as applicable.
Based on automatic adjustment, under legislation in 1972 (as modified by legislation in 1973), in proportion to increases in average wage level.
In 1984, the 5.7 percent OASDI tax on taxable wages of employees was offset by a tax credit of 0.3 percent, resulting in an effective employee tax rate of 5.4 percent.
However, the OASDI trust funds received the full 5.7 percent because of a general revenue transfer equivalent to 0.3 percent of taxable wages. Similar credits of 2.7 percent, 2.3 percent, and 2.0 percent were allowed against the combined OASDI and HI taxes on net earnings from self-employment in 1984, 1985, and from 1986 to 1989, respectively.
Based on automatic adjustment, under legislation in 1972 (as modified by legislation in 1973), using a transitional rule, specified by the Omnibus Budget Reconciliation Act (OBRA) of 1989, for computing a "deemed" average annual wage for 1988, 1989, and 1990.
Upper limit on earnings subject to HI taxes was repealed by OBRA 1993.
For 2010, most employers were exempt from paying the employer share of OASDI tax on wages paid to certain qualified individuals hired after February 3. Amounts
equal to the revenue forgone were transferred from the general fund of the Treasury to the OASI and DI trust funds.
For 2011 and 2012, the combined OASDI payroll tax rate was reduced by 2.0 percent for employees and for self-employed workers, resulting in a 4.2 percent effective tax rate for employees and a 10.4 percent effective tax rate for self-employed workers. The authorizing legislation does not specify percentage reductions attributable to the separate OASI and DI trust funds. Amounts equal to the revenue forgone were transferred from the general fund of the Treasury to the trust funds.
Beginning in 2013, an additional HI tax of 0.9 percent is assessed on earned income exceeding $200,000 for individuals and $250,000 for married couples filing jointly. This additional HI tax rate is not reflected in the contribution rates shown in the table.
Public Law 114-74, the Bipartisan Budget Act of 2015, temporarily re-allocated a portion of the OASI tax rate to DI for calendar years 2016 through 2018. Beginning in 2019, the tax rates for each fund revert to the rates in effect from 2000 through 2015.
Based on legislation in 1990.

Participant Premiums

1965. Part B enrollee premium rate (originally $3 per month) to be established annually such that it will pay one-half of program costs.
1972. Part B enrollee premium rate increase limited to rate of increase in OASDI cash benefits. HI premium (originally $33 per month) to be established annually. Only individuals not otherwise entitled to HI but desiring voluntary participation need to pay the HI premium.
1983. Part B enrollee premiums for July 1983 to December 31, 1983, frozen at premium level of June 30, 1983. Premiums for January 1, 1984, to December 31, 1985, set to cover 25 percent of aged program costs.
1984. Part B enrollee premiums for January 1, 1986, to December 31, 1987, will be set to cover 25 percent of aged program costs. Increases in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustment. For calculating the amount of Part B premium surcharge for individuals aged 65–70 not previously enrolled in Part B, the number of years an individual did not enroll because of coverage by employer group health insurance will not be taken into account.
1985. Extends through calendar year 1988 the requirement that Part B premiums be set to cover 25 percent of aged program costs and that increases in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustment. Premium-paying individuals who do not purchase Part A coverage within a specific time after becoming eligible because of age are subject to a 10 percent penalty for each 12 months they are late in enrolling. There is a cutoff on the length of time these individuals will have to pay an enrollment penalty. The 10 percent premium penalty would be limited to twice the number of years enrollment was delayed. Therefore, if enrollment was delayed 1 year, the penalty would be assessed for 2 years. Individuals in this category and already enrolled will have the length of time the higher premium was paid credited to them.
1987. Extends through calendar year 1989 the provisions requiring that the Part B premium be set to cover 25 percent of aged program costs, prohibiting any increase in the premium if there is no Social Security cost-of-living adjustment, and continuing to hold beneficiaries harmless from Social Security check reductions as a result of a premium increase.

1988. Increases in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustments for 1989 and beyond.
1989. Extends through calendar year 1990 the requirement that Part B premiums be set to cover 25 percent of aged program costs.
1990. The Part B premium is set at $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994, and $46.10 in 1995.
1993. Part B enrollee premiums for January 1, 1996, to December 31, 1998, will be set to cover 25 percent of aged program costs.
1997. The Part B premium is permanently set at 25 percent of program costs.
2003. Beginning January 2007, the Part B premium is increased for beneficiaries meeting certain income thresholds. (Beneficiaries with modified adjusted gross incomes under $80,000 will continue to pay premiums that are 25 percent of twice the actuarial rate. *Actuarial rate* is defined as one-half of the Part B expected monthly cost per enrollee. For beneficiaries with incomes greater than $80,000 and less than or equal to $100,000, the applicable percentage is 35 percent; for those with incomes greater than $100,000 and less than or equal to $150,000, the percentage is 50 percent; for incomes greater than $150,000 and less than or equal to $200,000, the percentage is 65 percent; and for incomes greater than $200,000, the percentage is 80 percent. For married couples who file joint tax returns, the income thresholds are doubled. For beneficiaries who are married and lived with their spouses at any time during the taxable year but who file separate tax returns from their spouses, with incomes greater than $80,000 and less than or equal to $120,000, the percentage is 65 percent; with incomes greater than $120,000, the percentage is 80 percent. These thresholds are to be updated each calendar year by the Consumer Price Index (CPI). For Part D, beginning in January 2006, a beneficiary premium, representing 25.5 percent of the cost of basic coverage on average, was required (except for certain low-income beneficiaries who may pay a reduced or no premium). For PDPs and the drug portion of Medicare Advantage plans, the premium will be determined by a bid process; each plan's premium will be 25.5 percent of the national weighted average plus or minus the difference between the plan's bid and the average. A late enrollment penalty will apply for certain beneficiaries who fail to enroll at the first opportunity and who do not maintain creditable coverage elsewhere (external prescription drug coverage, such as through a retiree group health plan that meets or exceeds the actuarial value of standard Part D coverage).

2005. The phase-in of the income-related Part B premium (see 2003) is shortened from 5 years to 3 years, beginning January 1, 2007. (That is, the amount of premium above 25 percent of twice the actuarial rate is phased in at 1/3 for 2007, 2/3 for 2008, and 3/3 for 2009 and later.) For beneficiaries who are volunteering outside the United States through a 12-month or longer program sponsored by a tax-exempt organization and who have other health insurance, the late enrollment penalties imposed on beneficiaries who do not enroll in Part B upon becoming eligible for Medicare are waived, effective January 2007, and a special enrollment period for these beneficiaries is established.
2008. The policy waiving the late enrollment penalty for Part D enrollees who meet certain low-income and limited-resources requirements is codified into statute. (The policy was in effect through 2008 and the law is effective beginning January 1, 2009.)

Income from Taxation of OASDI Benefits

1993. The additional income tax revenues resulting from the increase in the taxable percentage applicable to OASDI benefits (an increase from 50 percent to 85 percent, see Table 2.A31) are transferred to the HI trust fund.

Payment from States

2003. Beginning in January 2006, with the availability of drug coverage and low-income subsidies under Part D, Medicaid was no longer primary payer for full-benefit dual eligibles, and states were required to make payments to defray a portion of the Part D drug expenditures for these beneficiaries. States pay 90 percent of the estimated costs for 2006, phasing down over a 10-year period to 75 percent for 2015 and later.

Medicare dual eligibles

In the Medicare system Medicare Part A and/or B recipients who either [1] qualify for a Medicare Saving Programs (MSP) *or* [2] qualify for Medicaid benefits. Dual eligibles generally qualify for the qualified Medicare beneficiary (QMB) benefits, in which the beneficiary's non-Medicare coverage is covered by Medicaid, effectively providing full health care coverage. With the advent of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, these dual eligibles have automatically been enrolled to a random Medicare Part D plan. As a result of this auto assignment, participants who were already enrolled in a Medicare Advantage HMO, may have been automatically disenrolled from their medical plan to allow for part D enrollment. Medicaid will still cover drugs for dual-eligible patients that are not covered by Medicare Part D, including certain controlled substances. Pharmacies know by automation who these patients are. Individuals that qualify for dual eligibility will be paid first by Medicare and the remainder will be paid by Medicaid.

Table 2.A31 Taxation of Social Security Benefits

Year enacted	Individual's or couples with income exceeding (dollars)-	Benefits included in gross income	Effective for taxable years
		Married filing jointly	
1983	32,000	Lesser of one-half of Social Security and Tier 1 Railroad Retirement benefits or one-half of income over $32,000	Ending after December 31, 1983
1993		32,000 but not 44,000 Lesser of one-half of Social Security and Tier 1 Railroad Retirement benefits or one-half of income over $32,000	Beginning after December 31, 1993
	44,000	Lesser of 85 percent of Social Security and Tier 1 Railroad Retirement benefits or the sum of $6,000 plus 85 percent of income over $44,000	Beginning after December 31, 1993
		Married filing separate returns a	
1983	0	Lesser of one-half of Social Security and Tier 1 Railroad Retirement benefits or one-half of income	Ending after December 31, 1983
1993	0	Lesser of 85 percent of Social Security and Tier 1 Railroad Retirement benefits or 85 percent of income	Beginning after December 31, 1993
		Individuals in all other filing categories	
1983	25,000	Lesser of one-half of Social Security and Tier 1 Railroad Retirement benefits or one-half of income over $25,000	Ending after December 31, 1983
1993	25,000 but not 34,000	Lesser of one-half of Social Security and Tier 1 Railroad Retirement benefits or one-half of income over $25,000	Beginning after December 31, 1993
	34,000	Lesser of 85 percent of Social Security and Tier 1 Railroad Retirement benefits or the sum of $4,500 plus 85 percent of income over $34,000	Beginning after December 31, 1993

a. Includes only married taxpayers filing separately who lived with their spouse at any time during the tax year; married individuals filing separately who did not live with
their spouse are treated the same as unmarried individuals.

SOURCES: Social Security Act of 1935 (the Act), as amended through December 31, 2008; regulations issued under the Act; and precedential case decisions (rulings). Specific laws, regulations, rulings, legislation, and a link to the *Federal Register* can be found at the Social Security Program Rules page (http://www.socialsecurity.gov/ regulations/index.htm). Taxation of Social Security benefits is governed by the Internal Revenue Service Code. IRS describes the rules governing taxation of Social Security benefits in IRS publication 915, available at http://www.irs.gov/pub/irs-pdf/p915.pdf.

NOTES: Income is defined as modified adjusted gross income, plus 50 percent of Social Security and Tier 1 Railroad Retirement benefits. Modified adjusted gross income is adjusted gross income (before Social Security or Railroad Retirement benefits are considered), plus tax-exempt interest income, with further modification of adjusted gross income in some cases involving certain tax provisions of limited applicability among the beneficiary population. Social Security and Tier 1 Railroad Retirement benefits include workers' compensation benefits to the extent they cause a reduction in Social Security or Tier 1 Railroad Retirement disability benefits.

Table 2.A Appropriations from general revenues

And interfund borrowing provisions, by type of transaction and year enacted.

Year Enacted	Provision
	Appropriations form general revenues
1935	Annual appropriations to the old-age reserve account to provide payments; direct appropriation to pay for administrative expenses.
1939	Trust fund created from which benefits and administrative expenses were to be paid.
1944	General authorization to finance benefits and payments.
1947	For cost of gratuitous military service wage credits.
1950	General authorization repealed.
1951	Railroad interchange provisions enacted.
1956	For cost of gratuitous military service wage credits.
1966	For cost of transitional uninsured monthly benefits for those aged 72 and older with fewer than 3 quarters of coverage.
1972	For cost of gratuitous wage credits for Japanese-American internees.
1983	A lump-sum payment to the Old-Age, Survivors, and Disability Insurance (OASDI) trust funds equal to (1) the present value of the estimated additional benefits arising from the gratuitous military service wage credits for service before 1957 and (2) the amount of the combined employer-employee OASDI taxes on the gratuitous wage credits for service after 1956 and before 1984 but less any amounts previously transferred. After 1983, the trust funds will be reimbursed on a current basis for employer-employee taxes on such wage credits for service after 1983. A lump-sum payment to the OASDI trust funds representing the amount of uncashed benefit checks (including interest) issued in the past. In the future, the trust funds will be credited on a regular basis. All transfers made for uncashed benefit checks will be subject to the annual appropriation process. Transfers in each year from the Treasury Department to the OASDI trust funds of amounts equal to income tax receipts attributable to inclusion of Social Security benefits in taxable income. For tax credits for part of the 1984 employment FICA tax and part of the tax on self-employment income under SECA for 1984–1989, see Table 2.A5.
1993	Transfers in each year from the Treasury Department to the Hospital Insurance (HI) trust fund of amounts equal to income tax receipts attributable to the increased portions of Social Security benefits included in taxable income under the 1993 Act.
	Interfund borrowing
1981	Interfund borrowing permitted among Old-Age and Survivors Insurance (OASI), Disability Insurance (DI), and Hospital Insurance (HI) trust funds as needed until December 31, 1982. For all or part of any loan to be repaid, the managing trustee determines if assets of borrowing trust fund(s) are sufficient for that purpose. Interest with respect to any outstanding loan balance at a rate equal to the rate earned by lending trust fund is transferred from time to time.
1983	Interfund borrowing reauthorized among OASI, DI, and HI trust funds for calendar years 1983-1987, with provisions for scheduled repayment, no later than December 31, 1989, of principal and interest (including amounts borrowed in 1982). No borrowing permitted from any fund that has been reduced to specified levels.

SOURCES: Social Security Act of 1935 (the Act), as amended through December 31, 2008; regulations issued under the Act; and precedential case decisions (rulings).
Specific laws, regulations, rulings, legislation, and a link to the *Federal Register* can be found at the Social Security Program Rules page (http://www.socialsecurity.gov/
regulations/index.htm)

Plan Information

- Medicare Advantage Plans
- Medicare Advantage Prescription Drug Plans, and
- Prescription Drug Plans (Medicare plans)

There is no single Medicare drug plan. To get coverage, you must enroll in a Medicare-approved private drug plan. There are at least two ways to get Medicare prescription drug coverage. You can join a **Medicare prescription drug plan** or you can join a Medicare Advantage plan (formerly called Medicare+Choice) with prescription drug coverage. To learn more about Medicare Advantage plans, read the Texas Department of Insurance (TDI) Medicare Advantage Plans publication.

http://www.tdi.state.tx.us/consumer/hicap/medicarepartd.html

http://www.tdi.state.tx.us/pubs/consumer/cb036.html

Medicare Advantage Plans

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as **Medicare+Choice** or **Part C** plans.
Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the compensation and business practices changed for insurers that offer these plans, and "Medicare+Choice" plans became known as **Medicare Advantage** (MA) plans.

Medicare has a standard benefit package that covers medically necessary care that beneficiaries can receive from nearly any hospital or (except in Alaska) doctor in the country. For people who choose to enroll in a Medicare private health plan, Medicare pays the private health plan a set amount every month for each member. Members may have to pay a monthly premium in addition to the Medicare Part B premium and generally pay a fixed amount (a copayment of $20, for example) every time they see a doctor. The copayment can be higher to see a specialist.

The private plans are required to offer a benefit “package” that is at least as good as Medicare’s and cover everything Medicare covers, but they do not have to cover every benefit in the same way. Plans that pay less than Medicare for some benefits, like skilled nursing facility care, can balance their benefits package by offering lower copayments for doctor visits. Private plans use some of the excess payments they receive from the government for each enrollee to offer supplemental benefits. Some plans put a limit on their members’ annual out-of-pocket spending on medical care, providing some insurance against catastrophic costs over $5,000, for example. But

many plans use the excess subsidies to offer dental coverage and other services not covered by Medicare and can leave members exposed to high medical bills if they fall seriously ill. Private plan members can end up with unexpectedly high out-of-pocket costs.

In 2006 enrollees in Medicare Advantage Private Fee-for-Service plans were offered a net extra benefit value (the value of the additional benefits minus any additional premium) of $55.92 a month more than the traditional Medicare benefit package; enrollees in other Medicare Advantage plans were offered a net extra benefit value of $71.22 a month more. Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan (MAPD).

Almost all Medicare beneficiaries have access to at least two Medicare Advantage plans; most have access to three or more. The number of organizations offering Fee-for-Service plans has increased dramatically, from 11 in 2006 to almost 50 in 2008. In 2017, the MA program included almost 3,300 plan options offered by 185 organizations, enrolled about 19 million beneficiaries (32 percent of all Medicare beneficiaries), and paid MA plans about $210 billion (not including Part D drug plan payments). The Kaiser Family Foundation noted that while most Medicare beneficiaries have dozens of private Medicare Advantage plans available in their community, enrollment is highly concentrated among a small number of firms in nearly all states.

Although the Patient Protection and Affordable Care Act of 2010 did not eliminate Medicare Advantage, it did eliminate subsidies which the federal government first used to establish the Medicare Advantage program and which many Medicare Advantage health insurance plans use to offer supplemental benefits. These subsidies (which added an additional $14 billion to the Medicare program last year alone) will gradually be reduced until they are eliminated altogether.

Medicare Advantage Prescription Drug Plan

These private Medicare plans can provide coverage:

- A stand-alone **Prescription Drug Plan** (PDP), which only covers the Medicare Part D prescription drugs, and not other medical costs.
- A **Medicare Advantage Prescription Drug Plan** (MA-PD) that provides all Medicare benefits in one plan, including prescription drugs. MA-PDs cover Medicare Parts A, B, and D. Only people with Medicare Parts A *and* B may enroll in a Medicare Advantage Plan.
- A **Medicare Advantage-Special Needs Plan** (SNP) that serves particular groups (such as people with specific diseases or conditions, people in nursing facilities, or people with Medicaid).

Both MA-PDs and SNPs can be coordinated care plans that offer the Medicaid benefits in coordination with all the client's Medicare benefits. Clients undergoing a continuing treatment of dialysis for End-Stage Renal Disease are not eligible for either of these plans. A client wishing to participate in these plans should choose both the Medicaid Managed Care plan and the Medicare Advantage plan offered by that company. Very few plans will allow an individual to remain in the Medicaid managed care plan if the client does not enroll in the Medicare plan offered by that company.

Unlike most of Medicare, private insurance plans offer prescription drug coverage. Plans choose drugs they will cover, their network pharmacies, and their monthly premiums. The plans must be approved by the Centers for Medicare and Medicaid Services (CMS) but each plan has flexibility in its design.
Each plan has a list of covered drugs called a formulary. The list must include both brand name and generic drugs. People should review the plan materials carefully to make sure their drugs are covered and that their pharmacy is in the plan's pharmacy network.

Medicare Part D

This is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

Program specifics

Eligibility and enrollment

Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Medicare Part A and/or enrolled in Part B. Beneficiaries can obtain the Part D drug benefit through two types of private plans: they can join a Prescription Drug Plan (PDP) for drug coverage only or they can join a Medicare Advantage plan (MA) that covers both medical services and prescription drugs (MA-PD). The latter type of plan is actually part of Medicare Part C and has several other differences relative to original Medicare. About two-thirds of Part D beneficiaries are enrolled in a PDP option. Not all drugs will be covered at the same level, giving participants incentives to choose certain drugs over others. This is often implemented via a system of tiered formularies in which lower-cost drugs are assigned to lower tiers and thus are easier to prescribe or cheaper.

Dual eligibles (those also eligible for Medicaid benefits) were transferred from Medicaid prescription drug coverage to a Medicare Part D plan on January 1, 2006. They are automatically enrolled in one of the less expensive PDPs in their area, chosen at random. If the dual-eligible person is already enrolled in an MA-PD plan, then they are automatically removed from the MA plan upon enrollment in a PDP.
Most Medicare beneficiaries must affirmatively enroll in a Part D plan to participate. Annual enrollment periods last from November 15 to December 31 of the prior plan year. Starting in 2011 the enrollment period lasts from October 1 to December 7. Medicare beneficiaries who were eligible but did not enroll during the enrollment period must pay a late-enrollment penalty (LEP) to receive Part D benefits. This penalty is equal to 1% the national average premium times the number of years that they were eligible but not enrolled in Part D. The penalty raises the premium of Part D for beneficiaries, when and if they should elect coverage.

In 2018, 43 million of the 60 million people with Medicare have prescription drug coverage under a Medicare Part D plan; most (58%) are covered under a stand-alone prescription drug plan (PDP) but a growing share (42% in 2018) are in Medicare Advantage prescription drug plans (MA-PDs), which also provide other Medicare-covered benefits. More than 12 million Part D enrollees receive premium and cost-

sharing assistance through the Part D Low-Income Subsidy (LIS) program. Plans are required to offer the "standard" benefit or one actuarially equivalent or they may offer more generous benefits. Medicare has made available an interactive online tool called the **Medicare Plan Finder** that allows for comparison of coverage and costs for all plans in a geographic area. The tool allows one to enter a list of medications along with pharmacy preferences. It can show the beneficiary's total annual costs for each plan along with a detailed breakdown of the plans' monthly premiums, deductibles, and prices for each drug during each phase of the benefit design. Plans are required to update this site with current prices and formulary information every other week throughout the year.

Costs to beneficiaries

Beneficiary cost sharing (deductibles, coinsurance, etc.)

The MMA establishes a standard drug benefit that Part D plans must offer. The standard benefit is defined in terms of the benefit structure and not in terms of the drugs that must be covered.
Deductibles: More than 4 in 10 PDP and MA-PD enrollees are in plans that charge no Part D deductible, but a larger share of PDP enrollees than MA-PD enrollees are in plans that charge the standard deductible amount of $405 in 2018.
Cost sharing for generics and brands: Most Part D enrollees face modest cost-sharing amounts for generic drugs but can face much higher cost sharing for brands and non-preferred drugs, and a mix of copayments and coinsurance for different formulary tiers. For example, for PDP enrollees, median cost sharing ranges from $1 for preferred generics to $37 for preferred brands, and a 40% coinsurance rate for non-preferred drugs.

PDP enrollees are in plans with an average monthly premium of $41 in 2018, a modest 2 percent increase over 2017 but up by 11 percent since 2015. The combined average Part D premium for PDP and MA-PD enrollees is $32 in 2018. This is lower than the average for PDPs due in part to the ability of MA-PD sponsors to use rebate dollars from Medicare payments for benefits covered under Parts A and B to lower their Part D premiums. The average MA-PD premium is $34 in 2018, which includes Part D and other benefits.

The standard benefit is not the most common benefit offered by Part D plans. The only out-of-pocket costs that count toward getting out of the coverage gap and into catastrophic coverage are True Out-Of-Pocket (TrOOP) expenditures. TrOOP expenditures accrue only when drugs on plan's formulary are purchased in accordance with the restrictions on those drugs. Monthly premium payments do not count towards TrOOP.

Under The Patient Protection and Affordable Care Act of 2010, the "Donut Hole" coverage gap will be gradually eliminated through a combination of measures including brand-name prescription drug discounts, generic drug discounts, and a gradual decrease in the "catastrophic coverage" threshold. The "Donut Hole" coverage gap will be eliminated in 2019. Beginning in 2019, Part D enrollees will pay 25 percent of the cost of all their prescription drugs from the time they enter the gap until they reach catastrophic coverage. Most plans use specialty drug tiers, and some have a separate

benefit tier for injectable drugs. Beneficiary cost sharing can be higher for drugs in these tiers.

Beneficiary premiums

The average (weighted) monthly premium for PDPs was $35.02 in 2018, compared to $29.89 in 2008. Currently some eight percent of beneficiaries enrolled in a PDP chose one with some gap coverage. Among beneficiaries in MA-PD plans, enrollment in plans offering gap coverage was 33%. Premiums are significantly higher for plans with gap coverage (From Kaiser Family Foundation reports).

Low-Income Subsidies

Medicare offers several Medicare Savings Programs (MSPs) that assist people with low income and assets: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI) and Qualified Disabled Working Individual (QDWI). Certain income and asset limits must be met to qualify for these programs, which are administered by the state Medicaid program.

Qualified Medicare Beneficiaries- A QMB is an aged or disabled Medicare beneficiary who has:
(1) income at or below the Federal poverty line; and
(2) resources below 200 percent of the resources limit set for the Supplemental Security Income (SSI) Program (the QMB resources limits are $4,000 for an individual and $6,000 for a couple). An individual's home and household goods are excluded as resources. To meet the QMB definition, the person must be entitled to Medicare Part A.

Specified low-income Medicare beneficiaries (SLMBs)- Medicaid is also required to pay Medicare Part B premiums for SLMBs. These are persons meeting the QMB criteria except that their income is slightly over the QMB limit. The SLMB income limit is 120 percent of the Federal poverty line. SLMB is limited to payment of the Medicare Part B premiums, unless the beneficiary is otherwise eligible for Medicaid.

Qualifying individuals (QI-s)- The Balanced Budget Act of 1997 required State Medicaid Programs, effective January 1, 1998 through December 31, 2002, to pay Part B premiums for beneficiaries with incomes up to 135 percent of poverty. These persons are referred to as QI-1s. The QI-1 program remained in effect in 2004.

Qualified disabled and working individuals (QDWIs)- Medicaid is authorized to provide partial protection against Medicare Part A premiums for QDWIs. QDWIs are persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have the disabling condition. Medicaid is required to pay the Medicare Part A premium for such persons if their incomes are below 200 percent of the Federal poverty line, their resources are below 200 percent of the SSI limit, and they are not otherwise eligible for Medicaid.

Low-income Drug Subsidies

One option for those struggling with drug costs is the low-income subsidy. Beneficiaries with income below 150% poverty are eligible for the low-income subsidy, which helps

pay for all or part of the monthly premium, annual deductible, and drug co-payments. The subsidy award is given a level with the following effects:

Level	Deductible	Generic Copay	Brand Copay	Catastrophic Coverage
1	$0	$2.50	$6.30	$0 copays on all meds
2	$0	$1.10	$3.30	$0 copays on all meds
3	$0	$0	$0	$0 copays on all meds
4	$63 max	15%	15%	$2.50 Generic & $6.30 Brand copays

Excluded drugs

While CMS does not have an established formulary, Part D drug coverage excludes drugs not approved by the Food and Drug Administration, those prescribed for off-label use, drugs not available by prescription for purchase in the United States, and drugs for which payments would be available under Parts A or B of Medicare. Part D coverage excludes drugs or classes of drugs which may be excluded from Medicaid coverage. These may include:

- Drugs used for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs used for erectile dysfunction
- Drugs used for cosmetic purposes (hair growth, etc.)
- Drugs used for the symptomatic relief of cough and colds
- Barbiturates
- Benzodiazepines
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs where the manufacturer requires as a condition of sale any associated tests or monitoring services to be purchased exclusively from that manufacturer or its designee

While these drugs are excluded from basic Part D coverage, drug plans can include them as a supplemental benefit, provided they otherwise meet the definition of a Part D drug. However plans that cover excluded drugs are not allowed to pass on those costs to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases.

Plan formularies

Part D plans are not required to pay for all covered Part D drugs. They establish their own formularies, or list of covered drugs for which they will make payment, as long as the formulary and benefit structure are not found by CMS to discourage enrollment by certain Medicare beneficiaries. Part D plans that follow the formulary classes and categories established by the United States Pharmacopoeia will pass the first discrimination test. Plans can change the drugs on their formulary during the course of the year with 60 days notice to affected parties.

Typically, each Plan's formulary is organized into tiers, and each tier is associated with a set copay amount. Most formularies have between 3 and 5 tiers. The lower the tier, the lower the copay amount. For example, Tier 1 might include all of the Plan's

preferred generic drugs, and each drug within this tier might have a copay of $5–10 per prescription. Tier 2 might include the Plan's preferred brand drugs with a copay of $20–$30, while Tier 3 may be reserved for non-preferred brand drugs which are covered by the plan at a higher copay level - perhaps $40–$100. Tiers 4 and higher typically contain specialty drugs, which have the highest copays because they are generally quite expensive.

The Plan's tiered copay amounts for each drug only apply during the initial period before the coverage gap. Once in the coverage gap, also known as the Donut Hole, the plan participant must pay for 100% of the prescription costs, based on prices established by the Plan. In 2018, Plans reach catastrophic coverage when the beneficiary reaches $5,000 in total drug costs. The "Donut Hole" coverage gap will be eliminated in 2019. Beginning in 2019, Part D enrollees will pay 25 percent of the cost of all their prescription drugs from the time they enter the gap until they reach catastrophic coverage. The primary differences between the formularies of different Part D plans relate to the coverage of brand-name drugs. Nine out of the ten plans with the highest enrollment increased the number of drugs on their formularies between 2007-2017.

Number of participants

At the start of the program in January 2006, it was expected that eleven million people would be covered by Medicare Part D; of those, six million would be dual eligible. About two million people who were covered by employers would likely lose their employee benefits. In 2018, 43 million of the 60 million people with Medicare have prescription drug coverage under a Medicare Part D plan; most (58%) are covered under a stand-alone prescription drug plan (PDP) but a growing share (42% in 2018) are in Medicare Advantage prescription drug plans (MA-PDs), which also provide other Medicare-covered benefits. More than 12 million Part D enrollees receive premium and cost-sharing assistance through the Part D Low-Income Subsidy (LIS) program. Three firms—UnitedHealth, Humana, and CVS Health—accounted for over half (55%) of all Part D (PDP and MA-PD) enrollees in 2018

Program costs

As of the end of year 2018, the average annual per beneficiary cost spending for Part D, reported by the Department of Health and Human Services, was $1,517, making the total cost for the 2018 Medicare program $583 billion.

Medicare Part D Coverage Gap

The **Medicare Part D coverage gap**- informally known as the **Medicare donut hole-** is the difference of the initial coverage limit and the catastrophic coverage threshold, as described in the Medicare Part D prescription drug program administered by the United States federal government. After a Medicare beneficiary surpasses the prescription drug coverage limit, the Medicare beneficiary is financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold.

The following table shows the Medicare benefit breakdown (including the donut hole) for 2018.

Chart 2 2018 Medicare Part D payments

Coverage Phase	Total Annual Drug Cost	Percentage Paid by Beneficiary	Percentage Paid by Plan
Deductible	$0–$405.00	100%	0%
Initial Coverage	$405–3,750	25%	75%
"Donut Hole"	$2,700–$7,508.75	44% (Generics), 35% (Brands)	56% (Generics), 65% (Brands)
Catastrophic Coverage	over $7,508.75	5%	95%

The costs shown in the table above represent the 2018 defined standard Medicare Part D prescription drug plan parameters released by the Centers for Medicare and Medicaid Services (CMS). Individual Medicare Part D plans may choose to offer more generous benefits but must meet the minimum standards established by the defined standard benefit.

Impact of the donut hole on Medicare beneficiaries

Every Part D plan sponsor must offer at least one basic Part D plan. They may also offer enhanced plans that provide additional benefits. The Affordable Care Act (ACA), which was passed in 2010, ensured that the coverage gap or, so-called "donut hole", would be closing for patients on Medicare Part D. From 2017 to 2019, brand-name drug manufacturers and the federal government will be responsible for providing subsidies to patients in the donut hole.

In an effort to close the coverage cap, in 2010, the Affordable Care Act provided a $250 rebate check for individuals whose drug expenses took them into the donut hole. The Department of Health and Human Services began mailing rebate checks in 2010. Starting in 2011 until 2019, the coinsurance paid for prescriptions while in the coverage gap will decrease at a rate of 7% annually until beneficiaries will pay no more than 25% of the drug cost for their generic and brand name prescription purchases. For instance, a 50% mark down off brand-name medications financed by the manufacturer and a 7% mark down off generic drugs by the government was introduced in 2011 for patients in the donut hole. These reductions on generic drug costs will continue to incrementally rise at a rate of 7% until 2019. The "Donut Hole" coverage gap will be eliminated in 2019. Part D enrollees will pay 25 percent of the cost of all their prescription drugs from the time they enter the gap until they reach catastrophic coverage. Medicare Part D patients will only be responsible for paying 25% of the cost of covered generic and brand name prescription medications following payment of their deductible that year. Moreover, once patients enter the catastrophic threshold, they are only responsible for 5% of the drug cost.

Medicare Prescription Drug Plans (Medicare plans)

A stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through Original Medicare; Medicare Private Fee-for-Service Plans that don’t offer prescription drug coverage; and Medicare Cost Plans offering Medicare prescription drug coverage.

Medigap

Medigap (Medicare Supplement) refers to various private supplemental health insurance plans sold to Medicare beneficiaries in the United States that provide coverage for medical expenses not or only partially covered by Medicare. Medigap's name is derived from the notion that it exists to cover the difference or "gap" between the expenses reimbursed by Medicare and the total amount charged. In 2015 one in four people with traditional Medicare had a Medigap supplemental policy.

Eligibility

A person must be enrolled in part A and B of Medicare before they can enroll in a Medigap plan. During the open enrollment period which begins within 6 months of turning 65 or enrolling in Medicare Part B at 65 or older, a person may obtain a Medigap plan on a guaranteed issue basis (i.e. no medical screening required). Outside of open enrollment, the issuing insurance company may require medical screening and may obtain an attending physician's statement if necessary. Medigap insurance is not compatible with other forms of private Medicare coverage, such as a Medicare Advantage plan.

Products available

Medigap offerings have been standardized by the CMS into twelve different plans, labeled A through L, sold and administered by private companies. Each Medigap plan offers a different combination of benefits. The coverage provided is roughly proportional to the premium paid. However, many older Medigap plans offering minimal benefits will cost more than current plans offering full benefits. The reason behind this is that older plans have an older average age per person enrolled in the plan, causing more claims within the group and raising the premium for all members within the group. Since Medigap is private insurance and not government sponsored, the rules governing the sale and offerings of a Medigap insurance policy can vary from state to state. Some states such as Massachusetts, Minnesota, and Wisconsin require Medigap insurance to provide additional coverage than what is defined in the standardized Medigap plans. Some employers may provide Medigap coverage as a benefit to their retirees. While Medigap offerings have been standardized since 1992, some seniors who had Medigap plans prior to 1992 are still on non-standard plans. Those plans are no longer eligible for new policies.

Drug coverage

Some Medigap policies sold before January 1, 2006 may have included prescription drug coverage, but after that date no new Medigap policies could be sold with drug coverage. This time frame coincides with the introduction of the Medicare Part D benefit. Medicare beneficiaries who enroll in a stand alone Part D plan may not retain the drug coverage portion of their Medigap policy. Beneficiaries choosing to retain a Medigap policy with drug coverage after that date have no such right; in that case the opportunity to switch to a Medigap policy without drug coverage is solely at the discretion of the private insurance company issuing the replacement policy, but the beneficiary may choose to remove drug coverage from their current Medigap policy and retain all other benefits.

Product Suitability

Many companies maintain a requirement to do a suitability explanation to substantiate the sale. The agent's goal is to help provide clients with the best possible outcomes when dealing with insurance carriers and to also help the agent with business submitted. Getting it right the first time without experiencing any delays is in everyone's best interest. The main purpose of **suitability standards** is to make clear that life and health insurers cannot classify individuals without a rational basis for each decision.

In theory it would seem reasonable for beneficiaries to hear about all their Medicare-related choices during a single presentation. The reality of markets is different; Insurers may incentivize producers to push one product over another without regard to suitability Meanwhile, it is not reasonable to believe that consumers will be able to absorb details and nuances about the broad spectrum of Medicare-related products. Limiting a presentation could be seen as desirable under certain circumstances. Beneficiaries are not limited in the information available to them, as they may make a later appointment to discuss other products. In order to learn about their range of choices, beneficiaries may seek information from State Health Insurance and Assistance Programs (SHIP) counselors or other neutral parties to determine the most suitable type(s) of product before requesting sales appointments.

Self-regulatory rulemaking should thoroughly explain the need for new rules, practices, or interpretations supported by quantifiable rationale. Burdens of new regulations must be carefully balanced against the regulatory goals of each proposal. Every self-regulatory initiative should be meaningful to insurers as well as to producers. These essential approaches to rulemaking ensure that new rules and responsive enterprise-wide compliance procedures are appropriate. Suitability rulemaking demands careful scrutiny and compelling justification. The proposal voices concern over increased patterns of unsuitable Medicare-related product sales. The assertion is that "some prospective purchasers continue to be confused by certain features" of Medicare-related products.

Making certain Medicare-related products are suitable for the end user is imperative and this is something that insurance firms might help agents to achieve. Suitability factors are clearly one of the key considerations of the governing bodies that regulate the insurance industry. Making sure that the end user will benefit from a Medicare-related product is an absolute must. Understanding the complexities of the healthcare industry with regards to issues of suitability and product fit is invariably a hardship on agents and that is why most those operating successfully today will realize that they simply could not promote products for seniors efficiently without the help of suitability evaluations.

Compliance System

Each insurer is obligated to operate a system that is reasonably designed to achieve the compliance regulatory goal; that is to supervise recommendations. An insurer may comply by establishing and maintaining the insurer's own compliance system. Each agent and independent agency should adopt an insurer's compliance system or

establish and maintain a functional system of its own. A compliance system should include:

- maintenance of written procedures
- periodic reviews of the insurer’s or agent’s records in a manner reasonably designed to assist in detecting and preventing sales abuses

Agent or insurers need to adopt procedures for conducting compliance reviews that are reasonable under the circumstances. An insurer that contracts with a third party and that complies with the requirements to supervise is deemed to have complied with the insurer’s responsibilities.

Recording Client Needs

Each agent, independent agency, and insurer should maintain, or otherwise be able to account for, records of the information collected from the consumer and other information used in making a recommendation that was the basis for a transaction for a reasonable period of time. An insurer may, but is not required to, maintain documentation on behalf of an agent.

It is also important that agents identify and thoughtfully evaluate the needs of their clients. This can be achieved with a thorough examination of the client's goals, objectives, and expectations. Some of the more common considerations in this investigation are:

- The client's perspective of his or her objectives and whether they are achievable
- The client's time table for achieving his/her objectives
- Current and projected interest rates
- Inflation assumptions

The duty of good faith and fair dealing requires an agent to sell only appropriate products to his clients. For example, he must sell the right amount of insurance for the right reasons. Accurate and reliable recommendations for purchasing a product must be made based upon the appropriateness of the product for meeting the needs of the client and not some personal objectives of the agent.

Suitability requirements also should entail explaining and reviewing a personal worksheet with applicants. Here is an example.

Example 10-Step Medicare Suitability Audit

1. Basic Information

First Name _____ Last _____

Street _____ City _____

Zip Code _____ County _____

Date of Birth: _____

2. Qualifying Information

Do you have Medicare Part A? Yes No
Do you have Medicare Part B? Yes No

If not, have you applied for Medicare? Yes No

3. Medical Information (For Product Suitability Only)

Who is your Primary Care Physician? _____

Which hospital system do you prefer? _____

4. Prescription Drug Information (For Product Suitability Only)

What prescription medications are you currently taking?

_____

_____

_____

What is your current monthly out of pocket expense for your medications?

_____

5. Plan Information

What is your current insurance plan? _____

What do you like most about this plan? _____

What do you dislike most about this plan? _____

6. Plan Preferences

On a scale of 1 –10 please Rate the Following Preferences

Keeping the Same Primary Care Physician I have now 1-2-3-4-5-6-7-8-9-10
Freedom to See Any Doctor or Hospital I Choose 1-2-3-4-5-6-7-8-9-10
Being Able to Predict My Expenses 1-2-3-4-5-6-7-8-9-10

7. Extra Help Qualification

Did you get a letter from Medicare or the Social Security Administration (SSA) that said you are either eligible for or qualified for extra help paying for your Medicare Prescription drug plan costs? Yes No

8. Extra Help Needs

Do you feel like you need extra help paying for your Health Coverage or Prescription Drugs? Yes No

If yes, what is your current total household income? _____

If yes, what is the current value of all of your savings and investments?

9. What is your greatest concern about your health coverage in the future?

_____

10. What is the most important quality you seek in a health insurance agent?

_____

Prohibited Sales Practices

While most insurance agents who sell Medicare Advantage plans match their clients with suitable plans, some agents have used questionable sales tactics to sell products. Such documented cases include:

- Removing beneficiaries from traditional Medicare without their knowledge
- Enrolling beneficiaries in plans they can't afford
- Misleading enrollees to believe their physician or hospital accepts their plan

Complaints about inappropriate or confusing marketing and sales practices leading seniors to enroll in a MA plan without adequately understanding their choice, or even knowing that they had been moved out of traditional Medicare. There are complaints about cross-selling, where insurance agents and brokers use Medicare Part D as a pretext to simply get in the door with a senior, a situation not prohibited by Medicare marketing guidelines. Once inside, agents instead sell the senior an unrelated and sometimes unsuitable insurance product.

What Agents CAN Do

When marketing Medicare products, agents <u>can:</u>

- Distribute information and forms in a retail setting or while participating at a health fair or promotional event.
- Travel to meet Medicare beneficiaries in their home- provided they have been invited.
- Provide consumers information about public assistance programs and help individuals apply for government subsidies.
- Call potential enrollees- as long as they follow federal and state calling hours and the FTC Telemarketing Sales Rules/National Do-Not-Call Registry.

What Agents CANNOT Do

When marketing Medicare products, agents <u>cannot:</u>

- Engage in high-pressure sales tactics.
- Solicit Medicare beneficiaries door-to-door.
- Send unsolicited e-mails.
- Collect names, addresses and enrollment applications or conduct sales presentations at health fairs, educational or promotional events.
- Sell products which are not health-related during a Medicare Advantage or prescription drug plan sales or marketing presentation.
- Provide meals at promotional and sales events.
- Sell products in health care settings (doctor's offices, pharmacies, etc.).
- Make misrepresentations or omit information about a comparative Medicare product to induce a person to buy or change their insurance.
- Use fraudulent or dishonest practices.

The Public Can Avoid Becoming Victims of Predatory Sales Tactics

Agents can disseminate the following common-sense warnings to prospective plan purchasers as a service. The agent who helps clients helps himself

- Be wary of individuals who claim they work for Medicare. Medicare representatives do not make house calls or solicit beneficiaries by telephone.
- Be cautious of individuals selling Medicare products door-to-door. If someone comes to your home without a scheduled appointment, do not let the individual in your home or provide him or her with personal information.
- Beware of insurance agents who tell you it is free to enroll in a Medicare program. Premiums are associated with all Medicare products.
- Be leery of insurance agents who tell you your enrollment in a Medicare Advantage Plan will not affect your Medicare coverage. When you sign up for a Medicare Advantage Plan you will be removed from your traditional Medicare plan and may incur more expenses in terms of deductibles and co-payments.
- Do not be persuaded by an insurance agent who tries to scare you into believing your Medicare rates are going to increase if you do not switch plans immediately.

Complying With the Medicare Marketing Guidelines and Texas Regulations

During the open enrollment period, the Texas Department of Insurance wants to ensure Medicare beneficiaries are not pressured into choosing a Medicare plan. The Department further hopes all agents selling Medicare products provide consumers with a detailed and thorough overview of the products they are marketing so consumers are able to select a plan that best fits their needs.

All agents marketing Prescription Drug (PDP) and Medicare Advantage (MA) plans are to abide by the CMS guidelines established as well as all applicable Texas laws.
In light of the above, all insurers and agents are encouraged to review the CMS Guidelines and the following Texas statutes:

- The Deceptive Trade Practices Act (DTPA) – Section 17.41 of the Business and Commerce Code,
- The use or employment by any person of an act or practice in violation of Article 21.21, Insurance Code- cause of action for unfair or deceptive insurance practices.

Unfair & Deceptive Sales Practices Defined

Unfair Method of Competition, Sanctions and Penalties

Failure of an insurer or agent to comply with the appropriate rules and regulations only invites trouble. Here are some of the activities that are considered unacceptable;

- deceptive or misleading information set forth in any sales material;
- failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;
- intentionally recording an answer incorrectly;
- advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer
- advising a policy or contract owner to contact the insurer directly in such a way as to attempt to obscure the identity of the replacing agent or insurer.

A policy or contract owner has the right to replace an existing life insurance policy or annuity contract after indicating in or as a part of applications for new coverage that replacement is not the intention. However, patterns of that action by policy or contract owners of the same agent is be deemed prima facie evidence of the agent's knowledge that replacement was intended in connection with the identified transactions, and those patterns of action will be deemed prima facie evidence of the agent's intent to violate the rules. If it is determined that the requirements discussed here have not been met, the replacing insurer is to provide the policy owner an in force illustration. If an in force illustration is not available, a policy summary for the replacement policy or an available disclosure document for the replacement contract; and the appropriate notice regarding replacements.

Additional Sanctions

In addition to sanctions and penalties under TIC 541 as provided by 28 TAC Sec. 1114.101, an insurer or agent that violates this chapter is subject to sanctions which may include:

- the revocation or suspension of the agent's license or the insurer's certificate of authority
- administrative penalties
- forfeiture of any commissions or other compensation paid to an agent as a result of the transaction in connection with which the violations occurred.

If it is determined that the violations of this chapter were material to the sale, the insurer may be required to make restitution, restore policy or contract values; and pay interest at the rate set by Sec 84.050 on the amount refunded in cash.

Advertising Prohibitions

The words "savings," "investment," "deposit," "investment plan" and similar terms cannot be used to refer to the premium or to the interest to be credited to the contract in a context or under such circumstances or conditions that have the capacity or tendency to confuse or mislead the proposed purchaser as to the nature and limitations of the product or to any benefits received from it (28 TAC 21.103 & .114).

- An advertisement must not use the phrase "low cost" or "low cost plan" without providing a demonstration that a composite of lower production, administrative, and claim cost resulting in a low premium rate to the public.
- An advertisement may not imply that there are advantages that usually apply to group coverage, and/or uses words such as certificate or enrollment, when the policy offered is actually an individual policy. (There are some individual policies that have discounted rates for minimum levels of participation; ads for such policies may describe those discounts.) Neither may an advertisement imply that prospective policyholders would become part of a group or other relationship that does not, in fact, exist.
- An advertisement for life, accident and health, or annuities may not use the existence of the Guaranty Association (fund) as an inducement to purchase coverage.

Not Considered Advertising

The following materials are not considered to be advertising provided they are not used to urge the purchase, increase, modification, or retention of a policy of insurance (28 TAC Sec 21.102):

- Materials used by an insurance company within its own organization and not for public distribution;
- Communications with policyholders;
- A general announcement sent by a group policyholder to members of the eligible group that a policy has been written or arranged; or
- Correspondence between a prospective group policyholder and an insurer in the course of negotiating a group contract.
- Agent recruitment/training materials, i.e., materials used solely for the training, recruitment, and education of an insurer's personnel, and agents. Statements in such materials that are intended to be used, or that *may* be used, in consumer sales presentations are *not* exempt. We do not assume that *all* agent training material is exempt.

Note: The company may not misrepresent products to its own agents (TIC Sec 543).

Marketing Misconduct

The following is adapted from Congressional testimony
U.S. House of Representatives
Committee on Energy & Commerce
Hearing by the Subcommittee on Oversight & Investigations
June 26, 2007
Written Testimony of California Health Advocates

> ….But the wisdom and authority of the legislator are seldom victorious in a contest with the vigilant dexterity of private interest
>
> *History of the Decline and Fall of the Roman Empire*, E Gibbon, 1782

The introduction of the Part D prescription drug benefit coupled with the dramatic growth in the types and numbers of Medicare Advantage plans being sold across the country have increased both the complexity of and confusion surrounding the Medicare program, leading to an environment that is ripe for abuse. The current landscape and choices facing Medicare beneficiaries, examples of how agents have exploited these choices, and the difficulty of undoing the damage of bad choices due to marketing misconduct are discussed below.

Medicare Landscape

The Medicare Modernization Act injected new incentives for private companies to offer a range of new products to Medicare beneficiaries, greatly increasing the number and types of plans available, all of which have significant flexibility to design their benefits and cost-sharing structures. When choosing how to obtain coverage through Medicare, an individual has a range of variables s/he must consider, based upon any current coverage s/he might have. As consumers struggle to find the best combination of prescription drug and medical benefits for their individual needs, they must navigate a dizzying array of configurations and cost-sharing arrangements available through

Original Medicare, Medicare supplemental insurance plans (Medigaps), Medicare Advantage (MA) plans, and retiree or other coverage. There are multiple variations between and among these different options. Some individuals are eligible for both Medicare and Medicaid, or some other program that can help pay for some or all of their costs.

Within the Medicare Advantage program there are multiple plan designs, including: Health Maintenance Organizations (HMOs); Preferred Provider Organizations (PPOs); Special Needs Plans (SNPs); Private Fee-for-Service (PFFS) plans; and Medical Savings Accounts (MSAs). Some MA plans offer Medicare Part D prescription drug coverage, others don't. Depending upon what type of MA plan an individual is enrolled in, s/he may have a right to obtain separate prescription drug coverage outside of their MA plan. Depending upon where an individual Medicare beneficiary lives, there may be an overwhelming number of private plan options available to him or her. (E.g., by the count of the organization giving testimony, there were 106 plan options available in Los Angeles County in 2007: 55 stand-alone prescription drug plans (PDPs), available statewide; 36 "health plans" (including 2 regional PPOs, 1 local PPO, 26 local HMOs [2 of which are only available in parts of the county], 6 PFFS plans and 1 MSA); and 15 Special Needs Plans (SNPs). See www.medicare.gov.

Some of these combinations of Medicare, private and employer plans are compatible with one another while other combinations do not coordinate, and enrollment into a new plan might terminate or jeopardize eligibility for existing coverage. Further, although there are multiple options for beneficiaries, most individuals are limited in their ability to change plans during the course of the calendar year.

Behind these private plan options, of course, are companies and their contracted agents trying to sell them to Medicare beneficiaries. Some agents and plans are able to exploit the complex choices facing Medicare beneficiaries by steering them towards certain products, regardless of whether it is the best option for an individual. As a result, consumer advocates have found that many people with Medicare have been enrolled in Part D or Medicare Advantage plans they do not understand, did not want, or are inappropriate for their needs. Some have faced greater cost-sharing requirements than their previous coverage, and some have been cut off from doctors who refuse to accept the plan they enrolled in. Some have lost or jeopardized their eligibility for coverage they already had, such as retiree or Medicare supplemental (Medigap) insurance.

Examples of Misconduct

Marketing misconduct surrounding the sale of Medicare Advantage plans ranges from outright fraudulent sales practices to the misrepresentation of plans that appears to be the result of either an agent not understanding the product s/he is selling, and/or the applicant not understanding the way the plan works (but the agent makes the sale anyway).

Medicare Advantage Private Fee-for-Service (PFFS) plans have been at the center of many of the incidents of marketing misconduct and abuse reported by Medicare counselors in California and across the country. Despite their meteoric rise in enrollment over the last couple of years, they are perhaps the least understood type of MA plan due, in part, to their departure from the coordinated (or managed) care model of most

other MA plans. Often these plans are pitched as allowing individuals to see any provider that they want, without an adequate explanation that a provider must agree to accept the terms and conditions of a given plan, and that providers are free to refuse to do so. Despite CMS efforts to make this clearer to prospective enrollees and providers (discussed below), many providers appear to remain unwilling to treat PFFS plan enrollees. In addition, CMS has done nothing to restrict the targeting of individuals dually eligible for Medicare and Medicaid (dual eligibles) for these plans, despite the apparent lack of suitability of many such plans for dual eligibles (For a discussion of PFFS access to care concerns, the targeting of dual eligibles, and other issues relating to PFFS plans, see California Health Advocates' 5/22/07written testimony before the House Ways & Means Health Subcommittee available at: http://waysandmeans.house.gov/…).

While the majority of marketing abuse cases we are aware of involves PFFS plans, the following types of abuses have occurred surrounding the sale of other types of MA plans as well.

- Medicare beneficiaries are being signed up for plans without their consent or knowledge.

Example PFFS Plan

Mrs. N., a 78-year old dual eligible living in Sacramento on less than $800 a month, was approached outside her housing complex by an agent selling a PFFS plan and asking many questions. Mrs. N. answered the agent's questions, but says she did not sign up for the plan, yet later received the PFFS plan's enrollment materials. As she began to rack up hundreds of dollars in bills for medical expenses, her daughter asked the company for a copy of the enrollment application, and found that her mother's signature was forged. Prospective enrollees are told outright lies in order to scare them into joining plans, such as "Medicare is going private" or that they will lose their Medicare or Medicaid unless they sign up for a particular plan.

- Individuals who sought out one product end up in another they did not want, primarily impacting Medicare beneficiaries who were sold MA products thinking they were enrolling in either a Medigap plan or a stand-alone PDP offered by the same company. (Beneficiaries switching from Original Medicare to managed care often must change providers and face different and sometimes greater cost-sharing structures often not adequately explained by an agent selling them one of these plans.)
- Individuals dually eligible for Medicare and Medicaid (dual eligibles) are being targeted by some sponsors of MA plans, even though certain plans (notably many PFFS plans) may not suitable for them. In part, dual eligibles are targeted because they are one of the few groups of individuals who can change plans on a monthly basis. While many PFFS plans appear to target dual eligibles, sponsors of other plans pursue them as well.

Example Out-of Pocket

Ms. T, a dual eligible living in the Central Valley of California, was visited by an agent at her home who told her that the HMO the agent was selling would pay "all of her medical costs" and pressured her to enroll in the plan. Ms. T. subsequently found that neither her primary care physician nor her specialists accept her plan, and she has had to pay out of pocket for co-payments and diabetic supplies she could not obtain through her

plan. Medicare Advantage plans, in competition with one another, try to “poach” members of other plans offering comparable coverage.

Example A Change of Plans

Ms. O, a Ventura Co. resident who was enrolled in HMO “A” in 2018, decided to change plans for 2019 and enrolled in HMO “B” in November 2018 (effective 1/1/19). In December 2018, HMO “A” called her numerous times and sent her letters trying to convince her to remain in their plan, but she repeatedly informed them that she no longer wanted the plan, and had enrolled in a new plan. Nonetheless, Ms. O found herself in her old plan, HMO “A” as of January 2019. With the help of her local HICAP program, she was able to fix the problem and re-enroll in her desired HMO “B.” In March 2019, Ms. O received a phone call from an agent asking her to re-enroll in HMO “A”; she again said no and asked not to be contacted anymore. She soon found, however, that she had been disenrolled from HMO “B” -- her desired plan – and was back in HMO “A.” She called 1-800-MEDICARE but was told there was nothing they could do. When she called HMO “A” to tell them she did not want to be in their plan, and did not authorize enrollment, she was told that she would have to call 1-800-MEDICARE again. With the help of HICAP and a subsequent call to 1-800 MEDICARE, she was able to get back into her desired plan.

- Despite CMS’s prohibition of unsolicited door-to-door sales by agents selling MA and PDP products, this practice continues unchecked.
- Agents will cold call an individual but not appropriately identify themselves and/or the purpose of their call, and will later show up at the person’s house.
- Agents misrepresent themselves as being from Medicare, Social Security, or even the local State Health Insurance Program (SHIP). Others do not identify themselves as agents selling plans, but instead as a “Certified Medicare Advisor” or “Senior Advisor” who would like to pay a friendly visit to educate you about changes to Medicare.
- Some agents take advantage of individuals with limited English proficiency by making sales when neither the agent nor the applicant can adequately communicate with one another.

Example Unsolicited Visit

Ms. G., a 72 year old dual eligible living in California’s Central Valley who is limited English proficient and relies on family members to assist her with her medical and financial needs, received an unsolicited visit from an agent while she was home alone. Ms. G. subsequently found herself enrolled in a PFFS plan, and learned that her primary physician does not take the plan.

- Agents sell plans at senior or disabled subsidized housing complexes or senior centers either without invitation or under false pretenses such as giving a presentation about “Medicare changes.” After a minimal (or no) presentation about a particular plan, the agents enroll a large number of beneficiaries all at once, without taking the time to explain the plan and the consequences of enrollment to each individual.

Example Presentation & Disclosure

Mr. & Mrs. S, who live in a senior housing complex in Butte County, CA, attended a presentation at their complex by a sales agent who had set up the presentation with the resident manager under the guise of presenting on “changes to Medicare”, but did not disclose that he was an insurance agent. After the presentation on “Medicare Plan C,” the agent sold several PFFS plans, but had not disclosed the way PFFS plans work, and had indicated that most providers take the plan. Along with several residents, Mr. & Mrs. S. signed up for the PFFS plan, and dropped their Medigap insurance. They subsequently found that their providers refused to accept their plan.

- Some agents have been outright abusive to prospective enrollees either in an attempt to make a sale at any cost, or in response to complaints made about an agent’s previous conduct.

Example Cold Call

Mrs. B, who lives in a mobile home in rural Northern California, was cold called four times by an agent seeking to enroll her in a PFFS plan. When Mrs. B expressed hesitancy, the agent became verbally abusive towards her, cursed and asked for the phone numbers of her doctors. After giving the agent her address, the agent told her that he would come and stand on her doorstep if she refused to sign up for the plan.

Undoing the Damage of Marketing Misconduct

Many victims of marketing abuse who are enrolled in plans that they did not want do not know where to turn. Many Medicare beneficiaries are unaware of both their rights and their ability to get help from SHIP programs and other types of assistance. Plan sponsors – who are charged with policing the activity of their agents – often prove less than helpful when beneficiaries complain to them about marketing abuse; plans are often unable to fix enrollment/disenrollment problems, discourage disenrollment from their plan, or simply inform the individual that “nothing can be done.”

Consumers and consumer advocates report problems both seeking resolution through and lodging complaints with 1-800-MEDICARE and CMS. Processing Special Enrollment Periods (SEPs) and retroactive disenrollments can be problematic as there are no standard timelines for CMS to render decisions, follow up is inconsistent, and often decision-making about whether to grant such requests is passed back to the plans themselves or CMS contractors. Advocates report very mixed results when trying to use CMS processes to resolve enrollment and disenrollment disputes, with timeliness and level of feedback often dependent upon which CMS personnel ends up with a particular case. Sometimes disenrollment due to marketing misconduct – or other reasons – can take many weeks (or months), and, in some instances in which beneficiaries are retroactively disenrolled from a Medicare Advantage plan with Part D prescription drug coverage, can leave a beneficiary with no Part D coverage at all. Undoing the damage of marketing misconduct often requires the extensive involvement of advocates, a type of assistance many people do not know how to access.

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Conclusion

[of California Health Advocates testimony]
Although CMS and the insurance industry would like to blame Medicare Advantage marketing problems on a handful of insurance agents engaged in fraudulent activity – a "few bad apples" – the entire Medicare Advantage orchard is subject to rot as long as underlying structural problems continue to remain. Marketing abuses will continue unchecked unless: 1) plans are truly held accountable for the actions of those who sell their products; and 2) beneficiary protections outlined above are put into place. Congress and CMS must act to ensure that Medicare beneficiaries are able to access timely and quality health care as well as make informed decisions – without undue influence – about how they wish to access their benefits through the Medicare program. Thank you for the opportunity to provide these comments.