1. Part 2 reviews government health programs in the U.S., such as Medicare and Medicaid, and discusses some implications of health reform.

2. Medicare and Medicaid were both enacted through legislation passed in 1965. Medicare is a federal program that covers health care services for the elderly and disabled. Medicaid is a funding program for low income persons. It is offered by each state and receives federal matching funds.

3. Medicare is a universal entitlement program for the elderly. It provides the same benefits to all eligible persons regardless of their income or wealth. To be eligible one must be 65 years or older and have qualified by paying into the Social Security system. In addition, alternative eligibility provisions exist for non-elderly people. These include persons on kidney dialysis or kidney transplant patients and for persons who are receiving Social Security disability benefits.

4. When created, Medicare had two parts – Part A and Part B. Medicare Part A covers predominantly hospital and institutional care. It does have limits on the maximum number of days covered per year for both hospitals and skilled nursing homes. It is important to note that Medicare does not provide year round funding for nursing home care. In addition, Part-A funds home health care services, as well as hospice care.

5. Part B covers professional and outpatient services. This includes physician visits, emergency room visits, ambulance transportation, outpatient lab tests and treatments, as well as durable medical equipment.

6. Medicare Part A and Part B are funded differently. Part A is funded through payroll taxes. Additional payments are not required for eligibility once a person becomes eligible. In contrast, Part B is funded through a premium and by general revenues, which is a federal subsidy. The monthly premium changes each year. The premium is voluntary such that individuals could choose not to pay the premium and then not be covered for Part B services. However nearly all Medicare eligible persons pay Part B because they need the services. In addition, both Part A and Part B require cost-sharing, which includes a deductible for each part. Consequently, Medicare has a premium for Part B and cost-sharing for both Parts A and B.

7. Medicare Parts A and B do not cover all needed services. Originally, Medicare did not cover outpatient prescription drugs. However, the Medicare Modernization Act of 2003 subsequently added optional benefits for prescription drugs under Part D.

8. Part C was also added, which is the Medicare Advantage Plan. It allows Medicare recipients to choose a private health plan offered by a private company (such as an HMO). Medicare pays a premium to the health plan that contracts to provide a member’s Part A and Part B services. The health plan then pays for the member’s health services, as needed.

9. Medicare Part C allows recipients to participate in a managed care plan, such as an HMO or PPO. Managed care combines the financing and delivery of healthcare services. As such, the health plan is positioned between the patient and clinicians. The health plan can decide which providers deliver services and under what terms patients can receive them. Managed care differs from traditional health insurance plans, including traditional Medicare, which pay for services but do not intervene regarding the choice of providers or utilization of covered services.

10. HMOs or Health Maintenance Organizations have four characteristics. They have a health care provider panel, they negotiate fees with providers, they use primary care physicians as gatekeepers, and they require prior authorization of expensive services.

11. In establishing the provider panel, the HMO recruits providers and then signs a contract with
each, agreeing to specific terms about services, expectations and reimbursement of providers. The use of provider panels can place limits on the providers (physicians and hospitals) that a patient may use. If a patient wants the HMO to fund services provided by a non-panel provider, the patient must get consent from the HMO.

12. Medicare HMOs negotiate the rates they will pay providers, which is typical of other types of health plans. In addition to HMOs, traditional Medicare likewise does not pay charges. However, the rates a Medicare HMO pays a provider does not need to conform with the rates paid by traditional Medicare.

13. HMOs tend to use gatekeeper physicians, who serve as a patient’s primary care physician. The intent is to determine and coordinate needed services, while also attempting to keep care at the lowest level indicated.

14. Authorization for service is typically required for certain services to get approval from the HMO and their agreement that they will fund the service. However, other types of health plans typically have some such requirements as well.

15. Medicare Advantage plans also include PPO plans. PPO stands for Preferred Provider Organization. These plans offer more flexibility than HMOs. There is a provider panel; however, PPO members can also choose a non-panel provider. If choosing a non-panel provider, the cost sharing is typically higher, recognizing the PPO may not achieve the same rates negotiated with panel providers. Gatekeeper physicians are typically not used in PPOs, as PPO members can choose to go to any provider.

16. Part D is also optional and provides Prescription Drug Coverage. Members can select a prescription drug plan offered by private insurance companies. Most plans charge a premium and premiums vary by plan. Plans also require deductibles, co-insurance and/or co-payments. Costs and coverage vary by drug plan, which has been confusing for some Medicare beneficiaries. The benefit has also been controversial since Medicare did not use its large buying power to negotiate discounts with drug companies.

17. Medicare recipients view the program very positively. This is evidenced with health reform efforts whereby Medicare recipients did not want Medicare to be changed. However, the ACA law of 2010 will slow the growth in Medicare spending by more than $400 billion between 2010 and 2019. Medicare accounts for 15 percent of the federal budget, such that it is sizeable.

18. Medicare is Title XVIII of the Social Security Act. For those interested in more information on Medicare, this web link provides the Medicare page from the Social Security Administration.

19. Shifting to a health policy making perspective, Medicare was enacted in 1965 after many years of emotional discussion and after many compromises. As expected, it was a battle of economic interests. One of the major controversies was whether all elderly should be covered or whether it should be restricted to low income elderly. Controversy also existed on the source of funding for the program.

20. So how was consensus achieved regarding eligibility and funding? The process has been described as a three layered cake. First, the Democrats wanted compulsory hospital insurance under Social Security, which emerged as Part A. Second, the Republicans wanted government subsidized voluntary insurance for physician services, which became Part B. Both Democrats and Republicans supported extending medical care to the poor, which emerged as Medicaid. This major legislation occurred due to bi-partisan support and the compromises reached in meeting the goals and expectations of both political parties.

21. As mentioned, Medicaid was also enacted in 1965 and is provided for low income persons and families of all ages. It was developed as a continuation of previous welfare medicine programs that had included voucher programs and other types of special funding arrangements. The Medicaid program is financed through general taxes at both state and
The federal government provides more than 50% of Medicaid funding. Each state administers its Medicaid program, such that programs vary by state. Each state must meet the minimum federal requirements, but can also choose to provide more generous Medicaid benefits. Medicaid eligibility is determined by income.

While in theory, Medicaid is available to all low income persons, it has been restricted to persons in specified categories. The categories emphasize pregnant women, children and teenagers, and low income elderly, blind or disabled persons. However, Medicaid is being expanded under the ACA law.

This reflects the important role of Medicaid in funding births to advance the delivery of healthy babies. In half the states, 40 to 60 percent of births are funded by Medicaid.

For elderly, blind or disabled persons, Medicaid eligibility requires a low income and limited financial resources. These individuals can apply if residing at a nursing home and can be eligible for dual enrollment in Medicare. In such cases, Medicaid pays the Medicare Part B premium and cost sharing amounts.

Medicaid is Title XIX of the Social Security Act. If interested, this web link provides the detailed information about Medicaid from the Social Security Administration.

The Centers for Medicare and Medicaid Services or CMS administers both the Medicare and Medicaid programs. CMS also administers the State Children’s Health Insurance Program.

The State Children’s Health Insurance Program (S-CHIP) was enacted with the Balanced Budget Amendment of 1997. It provides federal matching funds to states that expand coverage of low and middle income children. States can choose to expand their Medicaid program or to create a separate program. Florida did both by expanding Medicaid and creating a separate program.

This depicts the health insurance status of the U.S. population in 2013. Private health insurance covered more than half the population. Medicaid and Medicare have relatively similar enrollments, with 16% and 15% respectively.

With regard to the Affordable Care Act, one major source of contention is the mandate to have health insurance. This means people who do not qualify for a public plan, such as Medicaid or Medicare, and can afford insurance, are expected to purchase health insurance or pay a fine. Thus, it only affects the uninsured who are able to afford health insurance. The fine is $695 or 2.5% of income, whichever is higher. The rationale is that the new law prohibits insurance companies from discriminating or denying coverage based on a person’s pre-existing conditions. Without an individual mandate, uninsured patients could choose to delay purchasing insurance until becoming ill.

Following the ACA’s 2014 Medicaid expansion and insurance coverage from the exchanges, the percent uninsured decreased from 13% in 2013 to 9% in 2016.

In December 2017, Congress and the President repealed the penalty for not purchasing health insurance.

Among public health professionals, one important element of health reform was providing a public option, meaning individuals could purchase insurance from the government rather than a private company. The public option would be a public insurance plan that would function similar to Medicare. It is a means of assuring affordable health care as the administrative costs are much lower and no revenues are allocated to “profit.” A provision for the public option was included in early health reform bills, but not included in the final law, which means people can only purchase health insurance from private companies.

This provides an example of how premium revenue could be allocated by a for-profit health insurance plan. In this example, 80% of premium revenue is spent on medical costs, 15% on administration and 5% on profit. In contrast, Medicare has a much lower administrative cost, which is about 5%. Thus, with a public plan, more of each dollar paid in premiums is spent on medical costs, which means less money is needed in total. One provision of the
new health reform law is that 80% to 85% of a health insurance plan’s premiums must be spent on medical costs.

35. These are the actual medical loss ratios, meaning the percent spent on medical costs, for five different health insurance companies. It becomes evident why some insurance companies are opposed to the requirement to spend 80 to 85% on medical costs.

36. Another point of contention in health reform is the McCarran-Ferguson Act of 1945. It exempts insurance companies from certain federal anti-trust laws and allows states to regulate insurance, instead of the federal government. This federal law allows insurance companies to share their rate making data, which helps small insurance companies to correctly set premiums. It ultimately increases the market power of insurance companies, relative to hospitals and other health providers. Early health reform bills included a repeal of McCarran-Ferguson for health insurance, which means the federal anti-trust laws would apply to health insurance companies.

37. A GAO analysis concluded the McCarran-Ferguson Act essentially allows insurers to engage in price fixing, which ultimately increases premium prices, recognizing for-profit companies strive for revenue growth. In contrast, consumers want premiums to decrease. Ultimately, McCarran-Ferguson was not repealed in the final health reform law.

38. The ACA of 2010 gave private health insurance companies two major victories. First, a public option will not be available to consumers, and, second, the McCarran-Ferguson Act of 1945 was not repealed, which means insurers can continue with their pricing activities.

39. Students should be able to answer the following questions.