Commentary

How often is it that a patient tells us that they don't understand how their medical insurance works? When I hear this question, I do my best to explain the facts as I understand them, and then I usually end up instructing my patient to discuss the matter further with our billing manager. Of course, like the tax code, medical insurance can be complicated. In the following editorial commentary, Dr. Kinosian describes some of the intricacies related to the different parts of Medicare coverage. A better understanding of these complexities, I think, could be useful to all of us, patients and providers alike.

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"Take Your Government Hands Off My Medicare"

The above cry heard at Tea Party rallies last August was a source of amusement for many, ignoring as it did the fact that Medicare *was* the government. Paradoxically, however, and certainly unwittingly, it accurately reflects how much more complex the Medicare program is than "single-payer, government-run" health care. This was the case even before the Medicare Modernization Act (MMA) of 2003 privatized much of the infrastructure that made Medicare a government-run health care model.

A look back to the origins of Medicare is telling. During the decade-long legislative struggle for the passage of Medicare, Ronald Reagan famously observed: "[I]f you don't [stop Medicare] and I don't do it, one of these days you and I are going to spend our sunset years telling our children and our children's children what it once was like in America when men were free" (1). What resulted instead was a dramatic expansion of private companies providing health care–related services: institutions (such as hospitals); technologies; pharmaceuticals; and insurance, management, and provider organizations. While ostensibly financed through revenues from payroll taxes, the actual administration and payments were filtered through fiscal intermediaries—private insurance companies that adjudicated claims, denied payment, and conducted audits looking for "waste, fraud and abuse" of government funds. The MMA took things a step further by changing the intermediary structure to phase out all fiscal intermediaries by October 1, 2011, and replace them with Medicare Administrative Contractors (MACs). Fifteen MACs, all of which are private insurers, will cover Part A and B services, while other MACs will cover home health agencies and durable medical equipment.

A quick review of the Medicare structure may be helpful here. The original Medicare benefits, which covered hospital, home health, and other institutional care (e.g., skilled nursing facilities), are covered under Part A, which is provided to all who are eligible. Other medical care such as physician, radiology, or laboratory services are covered under Part B, which an individual must elect, and pay a monthly premium to receive. These Part B benefits are paid on a traditional fee-for-service (FFS) basis, although over the past 2 decades this has evolved into payments from a fee schedule with a prohibition of balance billing for participating providers.

The MMA of 2003 established a pharmaceutical benefit, termed Medicare Part D. The pharmaceutical benefit is

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