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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administered through a number of private, supposedly competitive, prescription drug plans, although 5 private insurance companies cover 68% of the nearly 36 million beneficiaries who receive benefits under Part D, or under Part C, otherwise known as Medicare Advantage.

Medicare Advantage (MA) is part of an effort to establish a completely private portion of Medicare. While in Parts A and B the benefits are defined by the government's Center for Medicare and Medicaid Services (CMS), Parts C and D benefits are defined and administered by private insurers. MA plan carriers are paid a fixed amount per beneficiary from which they need to pay for benefits to beneficiaries, and return a profit to their shareholders. Originally termed Medicare + Choice in the late 1990s, by 2002 most of the private insurers were leaving most markets outside of California and the Northeast. In order to reverse this exiting of private plans from the Medicare market due to insufficient incentives, Congress increased payments to 12% *more* than comparable fee-for-service patients in order to attract private insurers back into the market. Enrollments in MA plans have grown from 13% of beneficiaries in 2005 to nearly 22% of beneficiaries in 2010. One of the major "reforms" in the Affordable Care Act of 2010 was to scale back the 12% extra payment to MA plans to make payments equivalent to those for comparable FFS patients by 2013. In part, this was motivated by comparative analysis of FFS Medicare and MA plans, showing that 2% of FFS Medicare premiums are consumed by administrative expenses, while 17% of MA plan premiums are spent on administrative costs and profit for shareholders. This was designed to recoup $150 billion in payments over the next decade that would be in excess of FFS payments. In the Escher-like Washington world, this was either "cutting Medicare" or "cutting insurance company profits."

Far from being peripheral to Part C Medicare Advantage plans, foot and ankle surgeons are as essential to the plans' wellbeing as they are to their patients'. Part C MA plans are paid a fixed amount per patient per month, based on characteristics of that particular patient. While some of those characteristics are demographic (age, gender, whether the patient also received Medicaid, whether they reside in a long-term care institution or in the community), most of the payment is based upon the diseases that patient has been diagnosed with and treated for during the prior year. Particular diagnoses, for example peripheral vascular disease, peripheral neuropathy, wounds, and diabetes, which are frequently addressed by foot and ankle surgeons, are especially significant in this payment structure. For example, with current MA payments in a typical mid-Atlantic city, a diabetic patient with PVD, neuropathy, and a pressure-related wound due to poor-fitting footwear, if appropriately diagnostically coded, would generate payments for the MA plan in excess of $24,900 for the following year.

As can be seen, Medicare is a complex program, funded with government revenues, but with many private hands all over it. And the role that physicians and surgeons play in providing complete and accurate diagnostic coding in the Medicare Advantage environment is a key and valuable role that providers need to consider seriously when they negotiate fees with managed care companies.

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Reference

1. Rapaport, Richard. How AMA 'Coffee cup' gave Reagan a boost. San Francisco Chronicle. June 21, 2009.