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Medicare in Iowa

Impact of the ACA and Health System Change on the Iowa Safety Net

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Introduction

This is a report that inventories all the information we have collected on Medicare's parts and services, eligibility criteria, funding, expenditures, and population served in Iowa. This information was collected as part of a study funded by The Commonwealth Fund to study the implications of the Affordable Care Act (ACA) on safety net health care providers.

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.[1]

Parts and Services Covered[2,3]

Part A Hospital Insurance - Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care.

Part B Medical Insurance - Most people pay a monthly premium for Part B. Some Medicare beneficiaries are eligible for help with payment of their premium if they meet requirements by the Medicaid program (called dual eligible). Medicare Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part D Prescription Drug Coverage - Most people will pay a monthly premium for this coverage which is a type of insurance provided by private companies. Beneficiaries choose the drug plan and pay a monthly premium.

Part C Medicare Advantage - Under this option, beneficiaries can choose to enroll in and receive care from private health insurance plans that contract with Medicare.

Eligibility Criteria

Generally, eligibility requirements include that a person be entitled to premium-free Part A (age, disability, end stage renal disease) and/or be 65 or more years of age with at least five continuous years of lawful permanent U.S. residency status. Premium-free Part A beneficiaries attain their status due to age or disability and Social Security or Railroad Retirement benefit status. Persons entitled to Part A and/or enrolled in Part B are eligible for Part D prescription coverage which involves a monthly premium as well.[4]

Medicare and the Safety Net

Medicare serves as a safety net payer for the population that is aged 65 and older, many of whom are retired and without employment-related health insurance coverage, and are on a fixed income with limited financial assets as well as disabled populations eligible for Medicare through the Social Security Disability Insurance (SSDI) program. Medicare enrollees also seek health care at safety net providers such as Rural Health Clinics (RHCs) where they constitute about 30% of the patient population and Federally Qualified Health Centers (FQHCs) where they constituted about 6% of the patient population.[5] Medicare contributed about 9.5% of the total patient related revenue for the FQHCs in Iowa in 2011 and 30% of RHCs' revenue nationally according to national survey of RHCs done in year 2000.[6,7] In addition, Medicare also contributed 10% of the revenue of the local public health departments in Iowa in 2010.[8] Thus, Medicare also plays an important role in health care safety net by providing revenue to these safety net providers for services provided to Medicare enrollees.

Medicare utilizes special reimbursement methods for safety net providers like rural health clinics (RHC) and federally qualified health centers (FQHC):

FQHC reimbursement methodology. The FQHCs are reimbursed by Medicare under a methodology referred to as the Medicare FQHC benefit. Reimbursement rates under this methodology are intended to reflect the broad range of services and complexity of care that FQHCs provide to low-income and vulnerable populations. The FQHC Medicare benefit is structured differently for beneficiaries enrolled in traditional fee-for-service (FFS) versus Medicare Advantage (managed care).[9]

Under FFS Medicare, FQHCs receive an all-inclusive amount for each covered visit, regardless of the specific services that were provided. Services covered under this all-inclusive per-visit amount include a range of primary care services, and services incident thereto, including physician, physician assistant, nurse practitioner, and certain other non-physician practitioner services such as clinical social worker and clinical psychologist services. They also include a range of preventive services as well as pneumococcal and influenza vaccines.

Under Medicare Advantage plans, FQHCs receive a wrap-around payment equal to the difference between what the Medicare Advantage plan pays the FQHC, and the all-inclusive per-visit amount the FQHC otherwise would receive under Medicare FFS.

RHC reimbursement methodology. RHCs receive an interim payment throughout the clinic's fiscal year which is reconciled at the end of the fiscal year through cost reporting. The interim payment rate is determined by taking total allowable costs for RHC services divided by allowable visits provided to RHC patients receiving core RHC services otherwise called the all-inclusive payment rate. These rates will be updated annually via Recurring Update Notifications.[10,11]

Social Security Disability Insurance (SSDI) recipients are eligible for Medicare coverage following an additional 24-month waiting period, resulting in a total of 29 months before receipt of health benefits through Medicare for SSDI recipients. SSDI is a federal entitlement program that provides disability payments to individuals (and in certain instances to their surviving spouses and children) who have been

(a) deemed medically disabled due to a physical or mental impairment that prevents them from working for a year or more or that is expected to result in death; and who (b) have earned enough work credits to receive SSDI payments. In 2010, there were 80,325 SSDI beneficiaries aged 18-64 in Iowa.[12,13]

Iowa also offers Medicare Special Needs Plan (SNP) which refers to a new type of Medicare Advantage coordinated care plan focused on individuals with special needs, created under the Medicare Modernization Act of 2003 (Section 231). "Special needs individuals" were identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.[14]

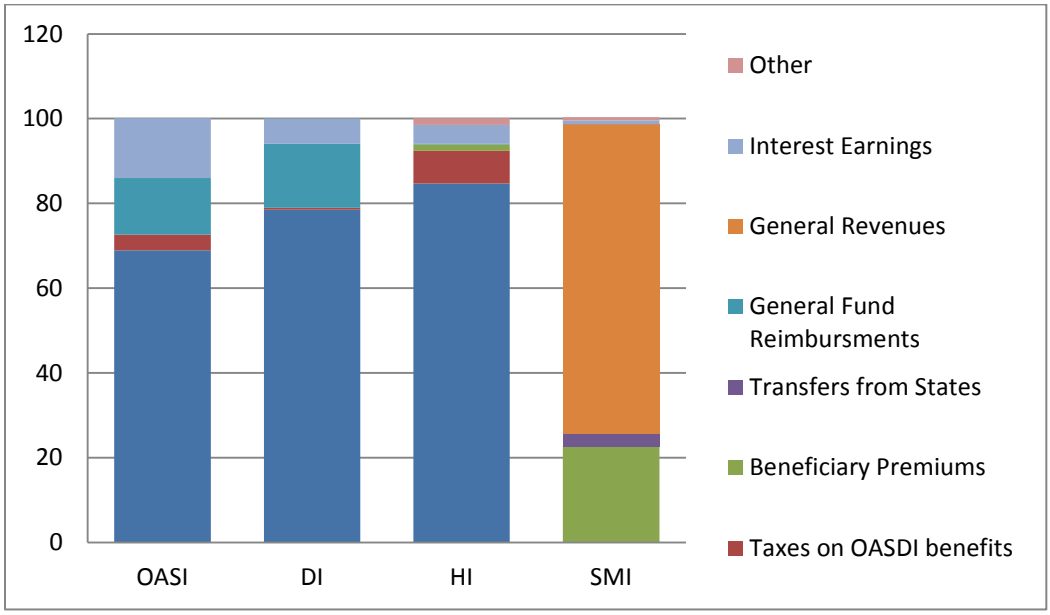
Funding

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 HI trust fund is financed primarily through a mandatory payroll tax. 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.

The SMI trust fund is primarily financed by contributions from the general fund of the U.S. Treasury and (to a much lesser degree) by beneficiary premiums. The standard Part B premium rate was $110.50 per beneficiary per month in 2010 (plus income based adjustment for beneficiaries above an income threshold).[15]

Figure 1. Sources of Medicare Funding, 2012



Source: 2013 Summary of the Annual Reports of the Social Security and Medicare Boards of Trustees

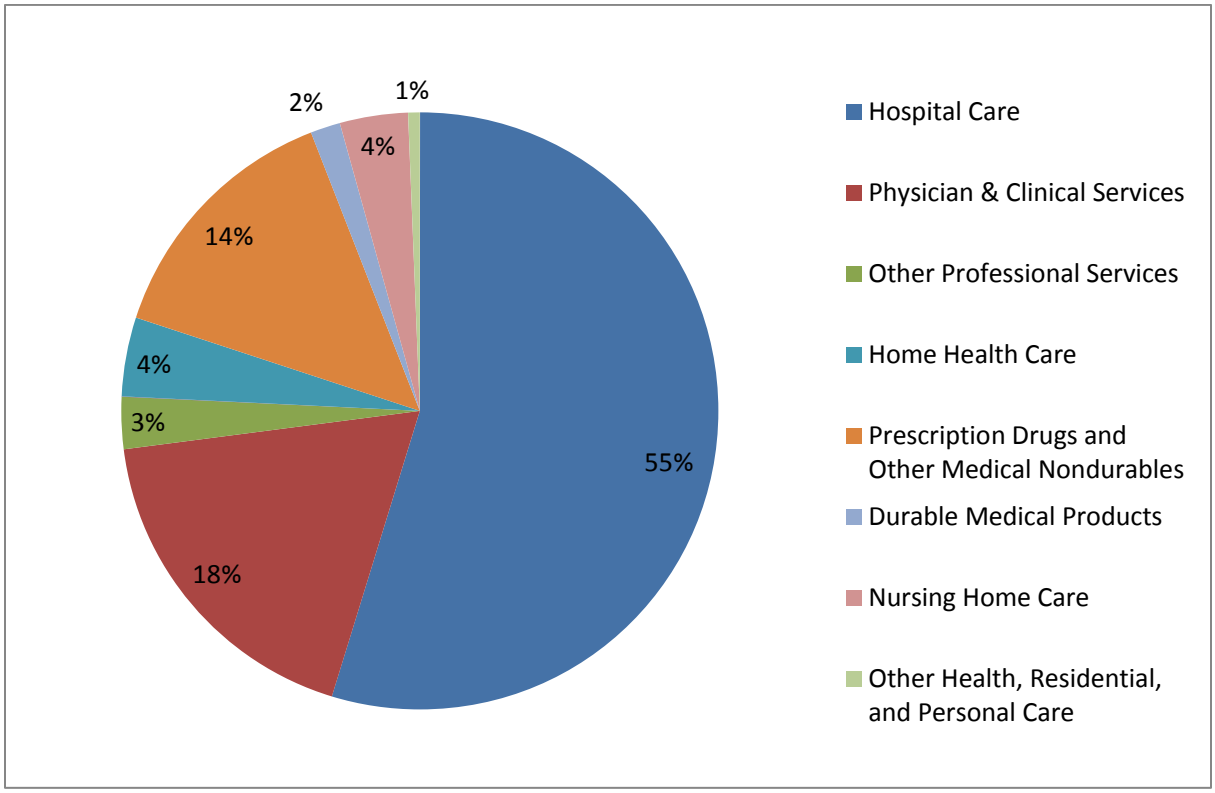
The assets at the end of 2010 for these trust funds were as follows: [16]

- HI/ Part A: $271.9 billion
- SMI/ Part B and Part D: $71.4 billion

Expenditures

In 2009, total Medicare expenditures in Iowa equaled $4,329,000,000.[17] These expenditures were distributed as follows, based on the type of services:

Figure 2. Medicare Expenditure based on type of services in Iowa, 2009



Average annual growth in Medicare spending from 1991 to 2009 was about 7.2% and Medicare spending per enrollee in 2009 was $8,461 for Iowa. Medicare spending in Iowa per enrollee by type of service in 2009 was as follows: [18]

Table 1. Medicare Expenditures per enrollee in Iowa by type of service in Iowa, 2009

Hospital care:	**$4,633**
Physician and Clinical Services:	$1,539
Other Professional Services:	$238
Dental Services:	$2
Home Health Care:	$362
Prescription Drugs:	$1,185
Durable Medical Products:	$137
Nursing Home Care:	$313
Other Care:	$53

Population Served

Total number of Medicare beneficiaries in 2004 was 485,000 and it increased to 531,209 in 2012. Those beneficiaries covered by Supplementary Medical Insurance, or Part B, totaled 465,000 in 2004 and 484,000 in 2008. The number of beneficiaries receiving hospital outpatient services was 324,000 in 2004 and 286,000 in 2009.[19] Most recent data for Part D shows that 343,638 Iowans were enrolled in 2010 which represent about 17% of total Iowa population.[20]

In terms of demographics, Iowa's Medicare population in 2004 was composed of 425,715 aged beneficiaries and 59,615 disabled beneficiaries. In 2009, those numbers were 438,349 and 68, 153 respectively.[21] About 16% of total Medicare beneficiaries are duals and Medicare Advantage penetration rate is 12.9% in Iowa. [22]

Data from the Kaiser Family Foundation shown in Tables 2-5 describe age, gender, income and eligibility distribution of the Iowa Medicare population. Kaiser also provides a race/ethnicity breakdown in which 430,400 of 449,300 beneficiaries in 2010-11 were described as white. The remaining beneficiaries are not described due to insufficient data.[23]

Table 2. 2010 Iowa Medicare beneficiaries by Age[24]

Age of Beneficiaries	0-64	65-69	70-74	75-79	80-84	85+	Total
Number of Beneficiaries	89,476	119,847	96,103	79,406	64,270	62,840	**511,942**

Table 3. 2010-2011 Iowa Medicare beneficiaries by Gender[25]

Gender	Number
Female	257,900
Male	191,400
Total	449,300

Table 4. 2010-2011 Iowa Medicare beneficiaries by income (as a percent of the Federal Poverty Level) [26]

Income **(% FPL)**	Number
<100%	59,100
100-149%	76,500
150-199%	67,900
200% +	245,800
Total	449,300

Table 5. 2010 Iowa Medicare beneficiaries by Eligibility Category [27]

Eligibility Category	**Number**
Aged	446,258
Disabled	71,169
Total	517,427

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