Public Policy Statement: Medicare

Medicare, created in 1965, is a program that provides health care for U.S. seniors (people 65 years of age and older) and people under age 65 with certain disabilities. The program covers approximately 44 million people in 2007 and cost the federal government $374 billion in service claim payments in 2006 – 13 percent of all U.S. Federal spending.

The Medicare program comprises four distinct parts – known as Parts A, B, C, and D. Part A covers Hospital Insurance (inpatient care), Part B covers Medical Insurance (doctors' services and outpatient care), and Part D covers prescription drug coverage. Part C, also known as Medicare Advantage, is an amalgam of Parts A and B, with services combined and delivered through competing private health insurance plans. Each of these parts has its own beneficiary enrollment and eligibility rules, distinctly different covered services, as well as different provider participation and payment rules. (additional information about Medicare is provided below).

Merck's Position on Medicare

1. Merck views the Medicare program as a critical source of health care security for American seniors and people with disabilities. Merck supports maintaining adequate and stable funding for the program.

2. While recognizing that the traditional, fee for service Medicare program will continue to be an option many beneficiaries chose, Merck supports the growth of Medicare Part C. We believe that private sector entities competing for enrollees/members can be more innovative and responsive than the public sector.
   - Within Part C, Merck supports increased emphasis on improving health plan ability to integrate and coordinate patient care for optimal efficiency and outcomes. Part C should not just be a network fee-for-service option, but instead should be designed to create real value for patients and the program.
   - Merck also supports increased accountability for health plans to achieve the goal of care coordination. Health plans that coordinate care across service setting and disease states provide real value to the Medicare program and are properly aligned to help ensure that prescription medicines are appropriately leveraged to improve quality and reduce other health care costs.

3. Merck believes the Medicare Part D program – which has exceeded expectations in performance and cost control – should be maintained without significant change at this time.
   - Merck supports the ability of Part D sponsors to use the full variety of formulary management tools to maintain program affordability and foster private sector competition among Part D plans. Secretarial authority to negotiate drug prices is not needed and will lead to restrictions on beneficiary choice and access to medicines.
   - Merck supports incremental changes in the Part D program to improve access to medicines for low income people through modifying current eligibility rules and other initiatives to improve enrollment.

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- Merck supports modifications to Medicare that would improve beneficiary access to preventive vaccines. These improvements could take a number of forms: creating rules to protect access to vaccines among subsidy eligible low income people, federal support for physician real time Part D billing and transaction capability, or specifying that all preventive vaccines are covered under Part B in the same manner as new medically necessary treatments and diagnostics are covered under Part B.

Additional Background on Medicare

Part A of the program covers inpatient (hospital) medical services, including sub-acute nursing home care and some home health services among other inpatient care. Any citizen is eligible to enroll in Part A who meets the minimum work history requirement through which they were required to pay Medicare payroll taxes into the system. Approximately 43.4 million people are entitled to Part A.

Those who enroll in Part A do not pay any premiums once they become eligible for the program upon turning age 65 (or younger after having been disabled and unable to work for two years). While there is no premium, there are required service co-payments which can be substantial for inpatient care. Part A is administered under government-set rules and claims are processed by government claims administration contractors. Services are provided by private sector hospitals and other providers, not by government employees.

Part A consumes 40 percent of Medicare resources.

Part B covers outpatient treatment and diagnostic services (and a number of specific primary preventive screening services). People enrolled in Part A can also elect to enroll in Part B. People enrolling in Part B receive government subsidies toward the monthly premiums – 75 percent of the premium cost is paid by the federal government from general (tax) revenues. For 2007, the remaining 25 percent beneficiary obligation is $93.50 per month for most beneficiaries.

There is an annual deductible ($131 in 2007) that increases annually based on inflation. There are also service co-payments equal to 20 percent of the service cost. As with Part A, private sector claims administration contractors administer Part B according to government rules and regulations (including fee schedules).

Part B consumes 35 percent of Medicare resources.

Together, Part A and B of Medicare are known as the "fee for service" Medicare program or "traditional" Medicare in that the beneficiary obtains care from the provider of their choosing and the provider bills the Medicare program (through a private contractor) for each service provided.

Part C is an amalgam of Parts A and B in that the services are combined and delivered through competing private health insurance plans. Part C is also referred to as the Medicare Advantage program. Beneficiaries may choose to elect this part of the program as an alternative to the traditional program if they are entitled to Part A and enrolled in Part B. Once selected, the beneficiaries' Part B premium payment (and any supplemental payment that their private plan may require) is then directed to the plan selected. As of June 2007, just over 8 million people elected a Part C health plan and Part C spending totaled about 20 percent of program spending. Medicare Advantage plans also provide the Part D prescription drug benefit; beneficiaries selecting a Medicare Advantage plan that offers the drug benefit must accept that drug benefit and cannot chose drug coverage through another option.

Beneficiaries choose these plans because of benefit design – either out-of-pocket costs are less than traditional Medicare or there are extra services/benefits not covered by the traditional (Parts A and B) Medicare program (such as eyeglasses or hearing aides). After suffering a significant enrollment decline in the late 1990s due to plan pull-outs resulting from payment cuts, Part C enrollment has rebounded to past peak levels of the mid-1990s. Under current conditions, enrollment is expected to continue to increase.

There is an array of health plans operating in Part C – from traditional HMOs, to the network insurance model of health plan, to a newer model called the private fee for service.

Part D of the program began in 2006 and covers outpatient prescription drugs. Like Part C, the benefit is delivered through competing private sector plans. Like Part B, enrollment in Part D is voluntary. Currently, 24 million people are enrolled directly in Part D plans offered either through stand-alone drug plans or through a Medicare Advantage health plan.[i]

Enrolled beneficiaries pay premiums and cost sharing. The minimum federal premium subsidy is 75 percent and, unlike any other aspect of Medicare, the federal premium subsidy increases for people with low incomes who, at the lowest incomes, pay no premium. Also, unlike any other component of Medicare, there is federal assistance with out of pocket costs for people with low incomes. Part D has another unique feature relative to the rest of the Medicare program – catastrophic coverage where the government subsidizes 95 percent of out of pocket costs when a beneficiary has incurred catastrophic drug spending levels.

Vaccines Coverage in Medicare

In general, Medicare covers all medically necessary services for the treatment of disease. Services for the prevention of disease are not covered except where the Congress has made an explicit exception in the Part B statute. For example, Congress created specific Medicare coverage for certain cancer screenings and coverage of influenza and pneumonia vaccines. Part D, the newest addition to the Medicare program, covers vaccines that are not covered in Part B.

[1] CMS, 2007. Another 10 million retirees are covered through employer-sponsored retiree drug coverage that meets or exceeds Medicare benefits standards.