



## HEALTH CARE FACTS FOR THE FINAL PUSH

The Senate bill and a reported draft compromise are influencing the health reform debate. The House bill has many advantages, including a public option. Here are the facts on:

1. What We Spend Now: Why We Need Health Reform
2. The Government's Role in Health Care: The Market Doesn't Work
3. Controlling Costs: Where the Dollars Go, Limiting Pay to Providers
4. Medicare: How Does it Work Now? How Much Does It Cost?

### **1. What We Spend Now: Why We Need Health Reform**

**Health Care by the Numbers – Center for American Progress** [www.americanprogress.org](http://www.americanprogress.org)

This year on average a family of four spent \$17,000 on health care. That's 19% of the family's total income.

In 2019, that figure is expected to climb to \$39,000 per year, which is 31% of the average family income.

Health insurance companies in some areas charge seniors 11 times more than younger Americans.

17.4% of insurance claims filed by individuals age 50 to 54 were rejected in 2006

22.3% of insurance claims filed by individuals age 55 to 59 were rejected in 2006

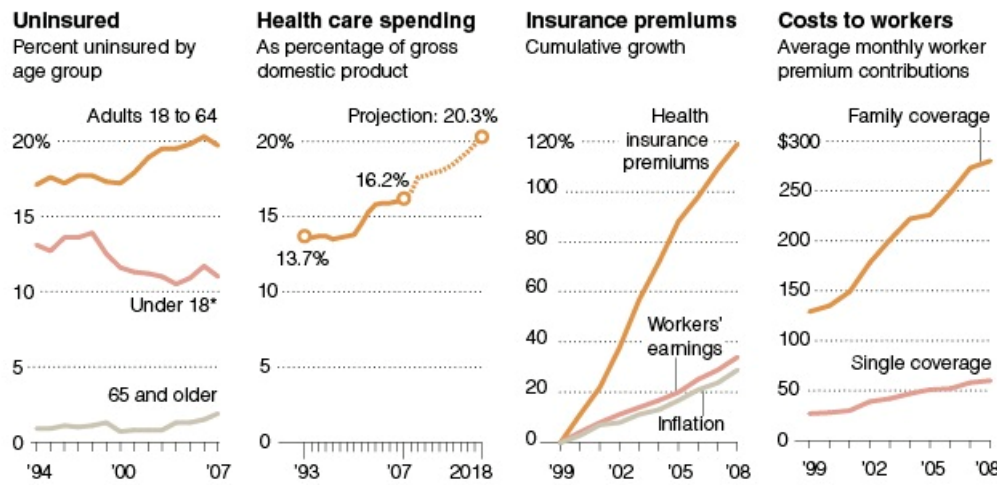
28.7% of insurance claims filed by individuals age 60 to 64 were rejected in 2006

16% of uninsured Americans are children.

Physicians in America waste \$31 billion per year in time lost due to dealing with insurance companies. On average, that's \$68,274 per physician per year.



### Health Care Since the Clinton Era



\*The Children's Health Insurance Program, created in 1997, has significantly reduced the number of low-income children who are uninsured.

Sources: Employee Benefit Research Institute estimates of data from the Current Population Survey. Centers for Medicare & Medicaid Services, Office of the Actuary; Data from the National Health Statistics Group. Kaiser Family Foundation/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008, and Kaiser analysis of data from Bureau of Labor Statistics.

THE NEW YORK TIMES

## 2. The Government's Role in Health Care: The Market Doesn't Work

**Over sixty percent (60.5 percent) of health spending in the U.S. is funded by government.**

Official figures for 2005 peg government's share of total health expenditure at 45.4 percent, but this excludes two items:

1. Tax subsidies for private insurance, which cost the federal treasury \$188.6 billion in 2004. These predominantly benefit wealthy taxpayers.
2. Government purchases of private health insurance for public employees such as police officers and teachers. Government paid private insurers \$120.2 billion for such coverage in 2005: 24.7 percent of the total spending by U.S. employers for private insurance.

So, government's true share amounted to 9.7 percent of gross domestic product in 2005, 60.5 percent of total health spending, or \$4,048 per capita (out of total expenditure of \$6,697).

By contrast, government health spending in Canada and the U.K. was 6.9 percent and 7.2 percent of gross domestic product respectively (or \$2,337 and \$2,371 per capita). Government health spending per capita

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in the U.S. exceeds total (public plus private) per capita health spending in every country except Norway, Switzerland and Luxembourg.

(Source: Himmelstein and Woolhandler, “Competition in a publicly funded healthcare system” *BMJ* 2007; 335:1126-1129 [1 December] and Woolhandler and Himmelstein, *Health Affairs*, 2002, 21(4), 88, “Paying for National Health Insurance - And Not Getting It.”

## Markets and competition won't fix the problems

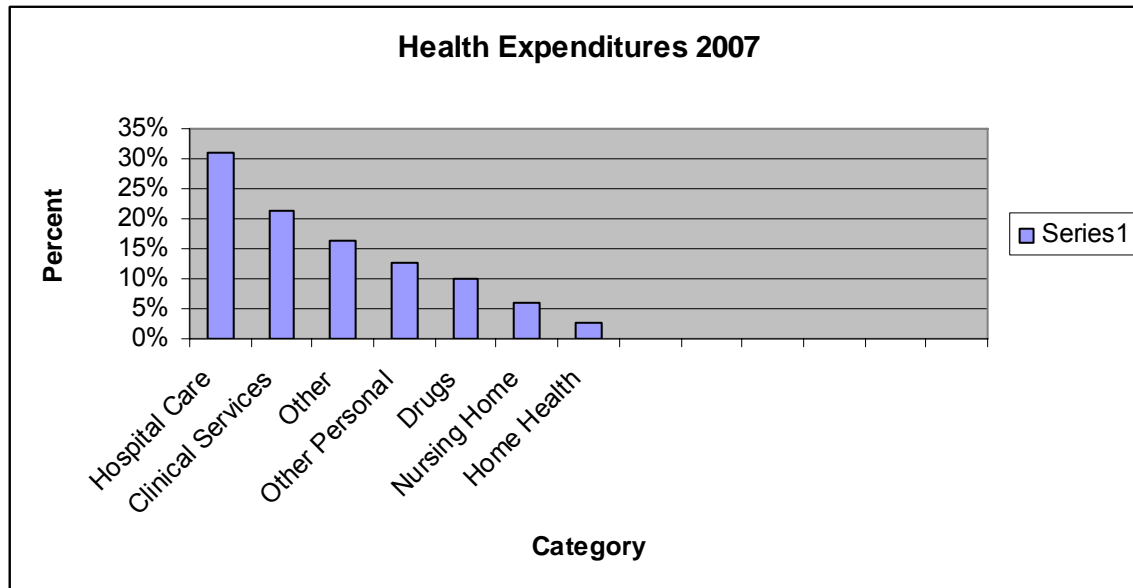
Advocates of the “free market” approach to health care claim that competition will streamline the costs of health care and make it more efficient. What is overlooked is that past competitive activities in health care under a free market system have been wasteful and expensive, and are the major cause of rising costs.

There are two main areas where competition exists in health care: among the providers and among the payers. When, for example, hospitals compete they often duplicate expensive equipment in order to corner more of the market for lucrative procedure-oriented care. This drives up overall medical costs to pay for the equipment and encourages overtreatment. They also waste money on advertising and marketing. The preferred scenario has hospitals coordinating services and cooperating to meet the needs of their communities.

Competition among insurers (the payers) is not effective in containing costs either. Rather, it results in competitive practices such as avoiding the sick, cherry-picking, denial of payment for expensive procedures, etc. An insurance firm that engages in these practices may reduce its own outlays, but at the expense of other payers and patients.



### 3. Controlling Costs: Where the Dollars Go, Limiting Pay to Providers



Source: Kaiser Family Foundation

### Negotiating Hospital Prices: Does Medicare Pay Too Little, or Do Private Plans Pay Too Much?

#### Some notes on hospital consolidation, reducing DSH payments

Hospital Concentration, DSH Payments, and Access for the Uninsured in Los Angeles County and the State of California.

Roby D, Kominski G; AcademyHealth. Meeting (2004 : San Diego, Calif.).

*Abstr AcademyHealth Meet.* 2004; 21: abstract no. 946.

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**RESEARCH OBJECTIVE:** This project examines how recent trends toward concentration within the hospital industry among hospital chains and the increase in for-profit ownership (specifically Tenet Healthcare Hospitals) affects access to affordable healthcare in Los Angeles. Specifically, it investigates the impact of hospital concentration on: (1) costs and revenues, which affects the affordability of employer-provided coverage for those that have it, and (2) the competitive position of the public hospitals, which have traditionally provided a safety net to the uninsured and underinsured. The primary focus of this study is Los Angeles County, since for-profit hospital growth has been greatest in this region. For comparison purposes, we also examined data for hospitals in the rest of California, excluding Los Angeles County. We examine how hospitals performed from 1995-2000 in Los Angeles County and in the rest of California in providing care to the uninsured, staying solvent, and taking advantage of funding designed for safety net providers.

**PRINCIPAL FINDINGS:** There was an increase in the number of hospitals in the county owned by hospital systems. For example, Tenet Healthcare Corporation increased their market share from 8% in 1995 to 15% in 2000. In addition, Tenets concentration has greatly increased their payments from the Disproportionate Share Hospital (DSH) program. In California, Tenet owned 8 hospitals in 1995 that received DSH payments; by 2000, they owned 17. In Los Angeles County, Tenet went from owning one DSH hospital in 1995 to owning 6 by the year 2000. Overall, Tenet added 14 hospitals statewide within five years. This growth has occurred while Los Angeles County's government hospitals have been facing financial pressures due to cutbacks and a growing uninsured population. The average total margin for Tenet hospitals grew at a healthy rate in Los Angeles County and the rest of California through 1999. From 1998 to 2000, total margins declined for all hospitals in Los Angeles County and for all hospitals in the rest of California except Tenet hospitals. Operating expenses in Tenet hospitals were fairly stable, while government hospitals in Los Angeles faced a serious problem of rising expenses without sufficient growth in patient revenue. One factor that is largely responsible for Tenets ability to achieve high profits in the current healthcare market is the Disproportionate Share Hospital (DSH) payment system. **CONCLUSIONS:** Tenet engaged in aggressive cost cutting, both in Los Angeles and the rest of California, and this contributed to its relatively high profit margins during 1995-2000. This is clearly one of the potential advantages of hospital chains, namely, that they can achieve greater efficiency than stand-alone facilities. Tenets profit margins grew during the 1995-2000 period because of its rapid increase in DSH payments, while other hospitals in Los Angeles County and the rest of California showed no growth in these payments. Yet during this same period, Tenets share of uninsured patient days declined and remained the lowest of any hospital group. Thus, at a time when the County's health care system has

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faced substantial financial threats, Tenet was successful in rapidly increasing its DSH payments without any increase in uninsured patient days and with a large decline in the average severity of its patient mix. IMPLICATIONS FOR POLICY, DELIVERY OR PRACTICE: Los Angeles County government hospitals continue to struggle financially while a greater portion of DHS payments continue to go to Tenet hospitals. Unless limitations in the formula for distributing DSH payments are addressed by the state legislature, the efficiencies associated with hospital concentration may continue to be offset by the costs imposed on the public sector by aggressive revenue maximization practices. In addition, DSH payments to Tenet hospitals are not being targeted toward hospitals where the poor and uninsured receive most of their care. This shift in the distribution of safety net funding will affect the ability of government and non-profit hospitals to provide care to the underserved.

## **A Bargain at Twice the Price? California Hospital Prices in the New Millennium**

**[Yaa Akosa Antwi](#), [Martin Gaynor](#), [William B. Vogt](#)**

**NBER Working Paper No. 15134\***

**Issued in July 2009**

**NBER Program(s): [HC](#)**

**The NBER [Bulletin on Aging and Health](#) provides summaries of publications like this. .**

We use data from California to document and offer possible explanations for the sharp increase in hospital prices charged to private payers after 1999. We find a downward trend in price for private pay patients in the 1990s and a rapid upward trend beginning in 1999, amounting to an annual average increase of 10.6% per year over 1999-2005. Prices in 2006 were almost double prices in 1999. By contrast, there was little discernable trend in prices for Medicare and Medicaid patients, although these prices varied from year-to-year. Surprisingly, the increase in prices is not correlated, geographically, with the change in hospital market concentration. For example, the greatest price rises came from hospitals in monopoly and highly concentrated counties which experienced little or no change over our sample period. Two recent California state hospital regulations, the seismic retrofit mandate and the mandatory nurse staffing ratio affected hospital costs. However, the cost increases due to the nursing staffing regulations are not large enough to account for the price increase, and the price increase is not substantially correlated with the costs of compliance with the seismic retrofit mandate. Therefore, the source of the near-doubling of California hospital prices remains something of a mystery.



## MarketWatch

# Hospital Consolidation And Negotiated PPO Prices

Most consolidations among competing hospitals lead to higher, not lower, prices. by Cory Capps and David Dranove

ABSTRACT: We examine the effects of hospital consolidation on the actual prices paid by preferred provider organizations. We find that price increases following consolidations among nearby hospitals invariably equaled or exceeded median price increases among other hospitals in the same market. Using multivariate regression analysis, we find that consolidation enables hospitals to increase prices in three of the four markets studied; these increases are generally statistically significant. In the remaining market, the measured effect was zero. Our results suggest that some, but not all, consolidations of competing hospitals facilitate price increases. We conclude that antitrust scrutiny of hospital consolidation is warranted.

HEALTH AFFAIRS ~ Volume 23, Number 2

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## Hospital Consolidation Outlook: Surviving in a Tough Economy

Chris Myers Jason Lineen

**Consolidation activity is expected to increase as hospitals position themselves for survival in the current economic environment.**

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### At a Glance

- **The rapid hospital consolidation activity of the late 1990s has tapered off, but it's expected to pick up again.**
- **The reasons for hospital consolidation have shifted from gaining leverage with payers to achieving cost savings and operating efficiencies to survive in the market.**
- **The hospital industry can expect to undergo more profound structural and organizational changes in the decade ahead than it did in the past decade.**

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Most major service industries in the United States have experienced considerable transformation, consolidation, and reorganization over the past 25 years. Unlike the banking, airline, hotel, telecommunications, media, and other industries, however, hospitals remain predominantly local businesses.

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Consider how many times the name of your bank and telephone company have changed since the 1980s. During the same period, the name of your local hospital likely has not changed. In fact, many tax-exempt hospitals continue to behave more like school districts than traditional businesses and have not expanded much beyond their original and contiguous boundaries.

Relatively few truly national health systems exist, and some of the best known “brand name” organizations are available in a limited number of markets (e.g., the Mayo Clinic, headquartered in Rochester, Minn., operates in four states; Johns Hopkins Health System, Baltimore, in one). In fact, the largest U.S. operator of hospitals—HCA, based in Nashville, Tenn.—has only 3 percent market share nationally (about 160 hospitals out of roughly 4,900 nonfederal, short-term general community hospitals). The top 10 systems in the United States together have less than 15 percent market share. On the other hand, payers are highly concentrated, with the government insuring approximately 26 percent of the total population (through Medicare, Medicaid, and other public programs) and the 10 largest managed care companies collectively accounting for more than 70 percent of the estimated 170 million privately insured lives in the nation.

### **A Look Back**

The era of most rapid consolidation activity occurred between 1995 and 2000, when 550 hospitals

Much of the system formation activity occurred in response to the rapid consolidation of commercial payers. To further study this relationship, we analyzed commercial payer and health system concentration in the 85 largest U.S. Metropolitan Statistical Areas (MSAs) as measured by the Herfindahl-Hirschman Index (HHI). Our analysis found that commercial payers are concentrated in a remarkable 91 percent of the 85 largest markets, whereas health systems are concentrated in only 66 percent of the largest markets.

The analysis disclosed that hospitals located in highly concentrated commercial payer markets (e.g., Austin, Texas, and Charlotte, N.C.) have more aggressively pursued consolidation activities than hospitals in moderately concentrated commercial payer markets (e.g., Miami and New York). Also, hospital sectors in smaller markets (1 million in population) tend to have higher concentration levels than larger markets, and none of the top largest markets are concentrated with regard to health systems. Only a handful of markets have a greater concentration among health systems than among commercial payers (e.g., Albuquerque, N.M.; Buffalo, N.Y.; Cape Coral, Fla.; Charlotte, N.C.; Colorado Springs, Colo.; Fresno, Calif.; Jacksonville, Fla.; Norfolk, Va.; Orlando, Fla.; Portland, Ore.; Salt Lake City; Springfield, Mass.; West Palm Beach, Fla.; Wilmington, N.C.; and Worcester, Mass.).

### **Lessons Learned**

Excluding activity by the for-profit chains, the key exception among tax-exempt hospitals has been the formation and growth activity of the faith-based national systems, driven primarily by the reconfiguration of Catholic congregations. Between 1990 and 2003, the growth of cosponsored Catholic systems proliferated from two to 17 systems with multiple sponsors.

Although much of this consolidation activity has enabled these systems to achieve significant economies of scale through the integration of administrative functions such as finance, supply chain, IT, and others, it has done little to drive greater penetration in local markets. One notable exception is Ascension Health’s expansion in Michigan over the past 10 years, which now includes 14 affiliated general acute care hospitals across the state.

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There has been only one notable example of a tax-exempt health system that has significantly migrated markets. Since its formation about 15 years ago, Banner Health has shed assets in slow-growth markets (such as North Dakota) to generate capital to invest heavily in the high-growth Phoenix market.

More recently, there has been an increase in the number of partnership conversations and transactions between “full” academic medical center hospitals and community hospitals with available capacity to provide a more efficient venue of care for lower acuity patients (e.g., Loyola University Medical Center purchased Gottlieb Memorial Hospital in 2007, with plans to relocate its low-risk obstetrics and orthopedics programs).

## A Look Forward

In the coming decade, the hospital industry will undergo more profound structural and organizational changes than it did in the last. Although the last big wave of hospital consolidation was largely driven by accelerating managed care consolidation, the next wave is being jolted into action by the current economic and political tsunami. Facing the perfect storm of decreasing demand, tightening payment, rising bad debt, escalating fixed costs, and investment income losses, U.S. hospitals are once again turning to mergers, affiliations, and partnership strategies to remain viable.

- In the new economy, the case for hospital consolidation has shifted from the revenue side of the equation to improved efficiency and expense reduction. Employers can no longer afford double-digit premium increases that allow providers to subsidize rising shortfalls from government payers. Further, the recent era of historically low interest rates and cheap capital has not produced the most efficient infrastructure for care delivery in many communities. For example, do MSAs the size of Kalamazoo, Mich., and Rockford, Ill., really need multiple Level I trauma centers?

Despite the rise of a handful of health systems with a presence in several parts of the country, health care remains a highly fragmented cottage industry. History tells us that external shocks (e.g., managed care consolidation, Balanced Budget Act of 1997) are required to stimulate hospital M&A activity. As one would expect, there will be winners and losers in the next round of consolidation. Hospitals and health systems evaluating their partnership options *before* a declining financial position pins them in a corner will be best positioned for success.

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## 4. Medicare: How Does it Work Now? How Much Does It Cost?

# Medicare Basics

## What Is Medicare?

Medicare is health insurance for the following:

People age 65 or older ■■

People under age 65 with certain disabilities ■

People of any age with End-Stage Renal Disease (ESRD) (permanent kidney ■ failure requiring dialysis or a kidney transplant)

<http://www.cms.hhs.gov/MedicareGenInfo/>

### Overview

**Medicare is a health insurance program for:**

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

**Medicare has:**

**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. Beneficiaries must meet certain conditions to get these benefits.

**Part B Medical Insurance** - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) 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

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services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

**Prescription Drug Coverage** - Most people will pay a monthly premium for this coverage. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

<http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3534&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

### **CMS ANNOUNCES MEDICARE PREMIUMS, DEDUCTIBLES FOR 2010**

Most Medicare beneficiaries will not see a Part B monthly premium increase as a result of a “hold harmless” provision in the current law. This allows for 73 percent of beneficiaries to be protected from an increase raising the 2010 Part B monthly premiums from \$96.40 to \$110.50. The Administration continues to urge Congressional action that would protect all beneficiaries from higher Part B premiums and eliminate the inequity of a high premium for the remaining 27 percent of beneficiaries.

By law, the Centers for Medicare & Medicaid Services (CMS) is required to announce the Part A deductibles and Part B premium amount – a notice that is published annually in the Federal Register.

Under the Medicare law, the standard premium is set to cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. This monthly premium paid by beneficiaries enrolled in Medicare Part B covers a portion of the cost of physicians’ services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

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In calculating the monthly Part B premium each year, the CMS Office of the Actuary includes a contingency margin to provide for possible variation between actual and projected costs. The size of the contingency margin estimated to be needed for 2010 is affected by two main factors.

First, the current law formula for physician fees, which will result in a reduction in physician fees of approximately 21 percent in 2010 and is projected to cause additional reductions in subsequent years, is one factor affecting the 2010 contingency margin. For each year from 2003 through 2009, Congress has acted to prevent physician fee reductions from occurring.

In recognition of the strong possibility of increases in Part B expenditures that would result from similar legislation to override the decreases in physician fees in 2010 or later years, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of 2009 is not adequate to accommodate this contingency.

Second, the Social Security Administration announced there would be no increase in Social Security benefits for 2010. As a result of the hold-harmless provision, the increase in the Part B premium for 2010 will be paid by only a small percentage of Part B enrollees. Most Part B enrollees will pay the same monthly premium that they paid in 2009 (\$96.40 was the 2009 standard monthly premium).

Approximately 27 percent of beneficiaries are not subject to the hold-harmless provision because they are new enrollees during the year (3 percent), they are subject to the income-related additional premium amount (5 percent), they do not have their Part B premiums withheld from social security benefit payments (19 percent), including those who qualify for both Medicare and Medicaid and have their Part B premiums paid on their behalf by Medicaid (17 percent).

As required in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), beginning in 2007 the Part B premium a beneficiary pays each month is based on his or her annual income. Specifically, if a beneficiary's "modified adjusted gross income" is greater than the legislated threshold amounts (\$85,000 in 2010 for a beneficiary filing an individual income tax return or married and filing a separate return, and \$170,000 for a beneficiary filing a joint tax return) the beneficiary is responsible for a larger portion of the estimated total cost of Part B benefit coverage. In addition to the standard 25 percent premium, such beneficiaries now pay an income-related

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monthly adjustment amount. These income-related Part B premiums were phased-in over three years, beginning in 2007. About 5 percent of current Part B enrollees are expected to be subject to the higher premium amounts

The 2010 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or who file a joint tax return are:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$110.50
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$44.20	\$154.70
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$110.50	\$221.00
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$176.80	\$287.30
Greater than \$214,000	Greater than \$428,000	\$243.10	\$353.60

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at any time during the taxable year are:

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Beneficiaries who are married but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$110.50
Greater than \$85,000 and less than or equal to \$129,000	\$176.80	\$287.30
Greater than \$129,000	\$243.10	\$353.60

### Part B Deductible

The Part B deductible was increased to \$110 in 2005 and, as a result of the Medicare Modernization Act, is currently indexed to the annual percentage increase in the Part B actuarial rate for aged beneficiaries. In 2010, the Part B deductible will be \$155.

### Part A Premium and Deductible

Today, CMS is also announcing the Part A deductible and premium for 2010. Medicare Part A pays for inpatient hospital, skilled nursing facility, hospice, and certain home health care services. The \$1,100 deductible for 2010, paid by the beneficiary when admitted as a hospital inpatient, is an increase of \$32 from \$1,068 in 2009. Beneficiaries must pay an additional \$275 per day for days 61 through 90 in 2010, and \$550 for lifetime reserve days. The corresponding amounts in 2009 are \$267 and \$534, respectively. Daily coinsurance for the 21st through 100th day in a skilled nursing facility will be \$137.50 in 2010, up from \$133.50 in 2009.

Approximately 99 percent of Medicare beneficiaries do not have to pay a premium for Part A services because they have at least 40 quarters of Medicare-covered employment (or are the spouse or widow(er) of such a person). However, other seniors and certain people under age 65 with disabilities who have fewer than 30 quarters of Medicare-covered employment must pay a premium. The EQUAL Coalition includes public health, women's groups, and advocates for Equitable, Quality, Universal, Affordable health care. \* The Center for Policy Analysis [www.centerforpolicyanalysis.org](http://www.centerforpolicyanalysis.org) \* The California Public Health Association-North an affiliate of the American Public Health Association [www.cphan.org](http://www.cphan.org) \* Rekindling Reform [www.rekindlingreform.org](http://www.rekindlingreform.org) \* Older Women's League San Francisco \* California Women's Agenda



quarters of coverage may obtain Part A coverage by paying a monthly premium set according to a statutory formula. This premium will be \$461 per month for 2010, an increase of \$18 from 2009. A reduced premium applies in the case of individuals with 30 to 39 quarters of coverage, who will pay a premium of \$254 in 2010, compared to \$244 in 2009.

### **Online Resources**

Information about the 2010 regional low-income premium subsidy amounts, including a link to the actual amounts, can be found at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmark2010.pdf>

The 2010 Part D plan landscape can be found at:

<http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/>

## **Your Medicare Choices There are Two Main Choices for How You Get Your Medicare Use These Steps to Help You Decide**

In addition to Original Medicare or a Medicare Advantage Plan, you may be able to join other types of **Medicare health plans**. See pages 60–61. You may be able to save money or have other choices if you have limited income and resources. See pages 77–84. You may also have other coverage, like employer or union, military, or Veterans’ benefits. See pages 71–72.

**Note:** If you join a Medicare Advantage Plan, you don’t need a Medigap policy. If you already have a Medigap policy, you can’t use it to pay for out-of-pocket costs you have under the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you can’t be sold a Medigap policy. See pages 74–76.

### **Original**

**Medicare Part A (Hospital Insurance) and Part B (Medical Insurance)** Medicare provides this coverage. ■■ You have your choice of doctors, hospitals, ■ and other providers. Generally, you or your supplemental ■ coverage pay **deductibles** and **coinsurance**. You usually pay a monthly ■ **premium** for Part B. See pages 45–49.

### **Medicare Advantage Plan (like an HMO or PPO) Part C—Includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)**

Private insurance companies approved by ■ Medicare provide this coverage. In most plans, you need to use

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plan doctors, ■ hospitals, and other providers or you pay more or all of the costs. You usually pay a monthly premium (in ■ addition to your Part B premium) and a **copayment** or coinsurance for covered services. Costs, extra coverage, and rules vary by plan. ■ See pages 50–59. If you want this coverage, you must choose ■ and join a Medicare Prescription Drug Plan. These plans are run by private companies ■ approved by Medicare. See pages 62–70. If you want prescription drug coverage, and ■ it’s offered by your plan, in most cases you must get it through your plan. If your plan doesn’t offer drug coverage, you ■ can choose and join a Medicare Prescription Drug Plan. See pages 55–57. You may want to get coverage that fills ■ gaps in Original Medicare coverage. You can choose to buy a Medigap (Medicare Supplement Insurance) policy from a private company. Costs vary by policy and company. ■ Employers/unions may offer similar coverage. ■ See pages 74–76.

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