MEDICARE, MEDICAID AND MANAGED CARE

1. Introduction

"The poor are always with us, and the American population without health insurance continues to rise." Studies have shown that the uninsured get less medical care and have more health problems than the general population.\(^2\) In 1999, the number of uninsured persons was 42.6 million.\(^3\) The problem of financing health care coverage is a problem that many Americans, including both the insured, under insured and uninsured, face.

Since the early 1900's the United States as a government has been faced with the problem of health care financing for its citizens.\(^4\) In the early 1930's, there was a general consensus by politicians of the need for "some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs."\(^5\) The main issue at this time, as has been in more recent

\(^1\) Randall R. Bovbjerg and Frank C. Ullman, Health Insurance and Health Access: Reengineering Local Safety Nets, 22 J. Legal Med. 247 (June, 2001).

\(^2\) Id.

\(^3\) Id.

\(^4\) Health Insurance and Health Services at http://www.ssa.gov/statistics/sspus/medicare.pdf

\(^5\) Id.
times was "whether health insurance should be privately or publicly financed." During World War II and the period thereafter, the trend towards privatization of health insurance continued on an upward spiral. This was due to the fact that "fringe benefits were increased to compensate for the government limits on direct wage increases." However, as is the case now, not everyone was able to acquire or afford private health insurance. Thus, calling for governmental attention to this problem - the problem of the uninsured.

It is under this historical background that the systems of Medicare and Medicaid emerged. Since their inception, "the Medicaid and Medicare programs [have become] a crucial part of our health care system, providing health care benefits to approximately seventy-five million Americans, most of whom would otherwise be uninsured."

II. The Government's Health Insurance Programs

The Medicare and Medicaid Programs were created in an attempt to meet the demand for

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6 Health Security: The President's Report to the American People at 21(1993), ("Under our plan, every American would receive a health care security card that will guarantee a comprehensive package of benefits over the course of an entire lifetime, roughly comparable to the benefit package offered by most Fortune 500 companies. This health care security card will offer this package of benefits in a way that can never be taken away.")


8 Id.

9 Id.

10 Id.

11 Jennifer L. Wright, Unconstitutional or Impossible: The Irreconcilable Gap Between Managed Care and Due Process in Medicaid and Medicare, J. Contempt, 17 Health L. & Pol'y 135 (Winter 2000).
health care coverage in America. The appropriations portion of the statutes which comprise the complicated set of laws that govern these programs states that,

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.¹²

Under this premise, the government began one of its many attempts at fixing the problem of being uninsured at least for some of the American population.

A. Medicare

The Medicare program was created in 1965 by amendments to the Social Security Act under Title XVIII.¹³ The program is divided into three parts- Part A, Part B and Part C with each part providing different benefits.¹⁴

1. Medicare Part A

Medicare Part A is a hospital insurance program.” The program is financed through

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revenues from taxes imposed on the earnings of employers and employees.\textsuperscript{16} For this reason, usually the payment of a premium, by those who meet the eligibility criteria, in order to receive this benefit is not necessary.\textsuperscript{17} However, if the person did not pay Medicare taxes while he/she worked, he/she may still be eligible to receive the benefit by paying a monthly premium\textsuperscript{18} as established under guidelines by the Federal Medicare Agency.\textsuperscript{19}

\textbf{a) Eligibility Requirements}

A person may become eligible to receive benefits under Medicare Part A in several ways. The majority of persons covered under Medicare Part A are eligible to receive the benefit because they have reached retirement age; that is, they are sixty-five (65) years of age or older and receive monthly Social Security benefits.\textsuperscript{20} Persons who retire early at age sixty-two (62) are not eligible

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\textsuperscript{16} \textit{Id.}


\textsuperscript{18} Medicare Basics: Medicare Premium Amounts for 2002 at \url{http://www.medicare.gov/Basics/Amounfs2002.asp}. [In 2002, the premium is "$319.00 per month (Note: This premium is paid only by individuals who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare covered employment). The Part A premium is $175.00 for those individuals having 30-39 quarters of Medicare covered employment."]


\textsuperscript{20} 42 U.S.C. §426(a)( I ) and (2) (West 2001 ) ["(a) Individuals over 65 years- -Every individual who—(1) has attained age 65, and (2)(A) is entitled to monthly insurance benefits under section 402 of this title, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of subchapter XVIII of this chapter..."]
to receive Medicare benefits until they turn sixty-five (65).  

It is important to note at this point that the definition of both retirement age and early retirement age is changing for future Medicare recipients. Thus, decreasing the number of persons eligible to receive Medicare benefits in the future.

Other persons who qualify to receive Medicare Part A are qualified railroad workers who have reached retirement age. However, not all Medicare recipients need have reached retirement age in order to qualify for benefits under the program. For example, individuals who


22 42 U.S.C. §416(1) ["(1) The term 'retirement age' means-(A) with respect to an individual who attains early retirement age (as defined in paragraph (2) ) before January 1, 2000, 65 years of age; (B) with respect to an individual who attains early retirement age after December 31, 1999, and before January 1, 2005, 65 years of age plus the number of months in the age increase factor (as determined under paragraph (3) ) for the calendar year in which such individual attains early retirement age; (C) with respect to an individual who attains early retirement age after December 31, 2004, and before January 1, 2016, 66 years of age; (D) with respect to an individual who attains early retirement age after December 31, 2016, and before January 1, 2022, 66 years of age plus the number of months in the age increase factor (as determined under paragraph (3) ) for the calendar year in which such individual attains early retirement age; and (E) with respect to an individual who attains early retirement age after December 31, 2021, 67 years of age. (2) The term 'early retirement age' means age 62 in the case of an old-age, wife's, or husband's insurance benefit, and age 60 in the case of a widow’s or widower's insurance benefit. (3) The age increase factor for any individual who attains early retirement age in a calendar year within the period to which subparagraph (B) or (D) of paragraph (1) applies shall be determined as follows: (A) With respect to an individual who attains early retirement age in the 5- year period consisting of the calendar years 2000 through 2004, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2000 and ending with December of the year in which the individual attains early retirement age. (B) With respect to an individual who attains early retirement age in the 5- year period consisting of the calendar years 2017 through 2021, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2017 and ending with December of the year in which the individual attains early retirement age."]

23 42 U.S.C. §416 (1) (B) ["Every individual who-(l) has attained age 65, and... B) is a qualified railroad retirement beneficiary, ..shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2)."]
are under the age of 65 and are disabled are also eligible to receive Medicare benefits. However, these individuals do not immediately qualify for these benefits and must first meet the requirement

24 42 U.S.C. § 416 (b) "(b) Individuals under 65 years. Every individual who--(1) has not attained age 65, and(2)(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 423 of this title or (ii) child's insurance benefits under section 402(d) of this title by reason of a disability (as defined in section 423(d) of this title) or (iii) widow's insurance benefits under section 402(e) of this title or widower's insurance benefits under section 402(f) of this title by reason of a disability (as defined in section 423(d) of this title), or(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 231fT(d) of Title 45, or(C)i has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII of this chapter pursuant to this subparagraph, and (ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this subchapter), including the requirement that he has been entitled to the specified benefits for 24 months, if- (1) medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and (II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A), shall be entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter for each month beginning with the later of (1) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 422(c)(4)(A) of this title, and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under this subchapter or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 78 such months. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 423(a)(l) of this title, in section 402(d)(l)(G)(i) of this title, in the last sentence of section 402(e)(l) of this title, and in the last sentence of section 402(0(1) of this title shall be applied as though it read 15 months."
of waiting a twenty-four month period. Medicare also provides health insurance benefits for those persons who are suffering from End State Renal Disease (ESRD). Unlike other disabled persons, these individuals are not subject to the twenty-four month waiting period that other persons with disabilities are subject to. "Most persons with ESRD are eligible for Medicare

25 42 U.S.C. §426(f) ["(f) Medicare waiting period for recipients of disability benefits for purposes of subsection (b) of this section (and for purposes of section 1395p(g)(1) of this title and section 23 lfd(d)(2)(ii) of Title 45), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1395p(f) of this title), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated- (1) more than 60 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2) of this section, or (2) more than 84 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection, shall not include any month which occurred during such previous period, unless the physical or mental impairment which is the basis for disability is the same as (or directly related to) the physical or mental impairment which served as the basis for disability in such previous period."]

26 42 U.S.C. §426-1 ["(a) Entitlement to benefits. Notwithstanding any provision to the contrary in section 426 of this title or subchapter IVIII of this chapter, every individual who-- (1)(A) is fully or currently insured (as such terms are defined in section 414 of this title), or would be fully or currently insured if(i) his service as an employee (as defined in the Railroad Retirement Act of 1974 [45 U.S.C.A. §§ 231 et seq.] after December 31, 1936, were included within the meaning of the term "employment" for purposes of this subchapter, and (ii) his medicare qualified government employment (as defined in section 410(p) of this title) were included within the meaning of the term "employment" for purposes of this subchapter; (B) (i) is entitled to monthly insurance benefits under this subchapter, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974 [45 U.S.C.A. §§23 et seq.], or (iii) would be entitled to a monthly insurance benefit under this subchapter if medicare qualified government employment (as defined in section 410(p) of this title) were included within the meaning of the term "employment" for purposes of this subchapter; or (C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B); (2) is medically determined to have end stage renal disease; and (3) has filed an application for benefits under this section; shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of subchapter XVIII of this chapter, subject to the deductible, premium, and coinsurance provisions of that subchapter."]

27 Id.
benefits after a three-month waiting period."

However, exceptions to shorten the waiting period have been created for those persons who are participating in self-care dialysis training programs or are kidney transplant candidates. Unlike Medicaid, with Medicare there are no additional maximum asset or income requirements associated with the above criteria in order for an individual to qualify for Medicare benefits.

b) The Benefits

Under Medicare Part A individuals receive various benefits. These include payment for medical services received in hospitals as an inpatient, care at critical access hospitals, services at

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29 42 U.S.C. §416-1 [(c) Individuals participating in self-care dialysis training programs; kidney transplant failures; resumption of previously terminated regular course of dialysis Notwithstanding the provisions of subsection (b) of this section- (1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1395rr(b) of this title, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter shall begin with the month in which such regular course of renal dialysis is initiated; (2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2) of this section) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter shall begin with the month in which such course is initiated or resumed; and (3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter shall begin with the month in which such regular course of renal dialysis is resumed."


31 Health Care Financing Administration, The Federal Medicare Agency, Medicare & You 2001 (2000). ("Critical access hospitals are small facilities that give limited outpatient and inpatient services to people in rural areas.").
skilled nursing facilities, hospice care and home health services. However, these services are not provided completely free, and the beneficiary may have to pay for certain costs. For example, under the benefits received for hospital care, a Medicare recipient in the year 2001 was responsible for paying a $776 deductible for a hospital stay of one through sixty days. From day sixty-one through day ninety, the recipient was responsible for paying $194 per day. From day ninety-one through one-hundred-fifty, the recipient was responsible for paying $388 per day of a hospital stay. However, should the hospital stay last longer than one-hundred-fifty days, the recipient was responsible for paying all costs for those days over one-hundred-fifty. Those requiring services at a skilled nursing facility had all costs paid by Medicare for the first twenty days of service. However, from days twenty-one through one-hundred the Medicare recipient was responsible for paying up to $97 per day and for paying all costs beyond the one-hundred

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34 *Id.* at p. 6. See also, [http://www.medicare.gov/Basics/Amounts2002.asp](http://www.medicare.gov/Basics/Amounts2002.asp) (This amount will rise to $203.00 a day for the 61st- 90th day each benefit period in 2002).

35 *Id.* See also, [http://www.medicare.gov/Basics/Amounts2002.asp](http://www.medicare.gov/Basics/Amounts2002.asp) [This amount will rise to "$406.00 a day for the 91st- 150th day for each lifetime reserve day (total of 60 lifetime reserve days - non-renewable)]."

36 *Id.*

37 *Id.*

38 See also, [http://www.medicare.gov/Basics/Amounts2002.asp](http://www.medicare.gov/Basics/Amounts2002.asp). (This amount will rise up to $101.50 a day for the 21st- 100th day each benefit period in 2002.)