What is Medicare / Medicaid?

Medicaid and Medicare are two governmental programs that provide medical and health-related services to specific groups of people in the United States. Although the two programs are very different, they are both managed by the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

Medicare is a social insurance program that serves more than 44 million enrollees (as of 2008). The program costs about $432 billion, or 3.2% of GDP, in 2007. Medicaid is a social welfare (or social protection) program that serves about 40 million people (as of 2007) and costs about $330 billion, or 2.4% of GDP, in 2007. Together, Medicare and Medicaid represent 21% of the FY 2007 U.S. federal government.

Both Medicaid and Medicare were created when President Lyndon B. Johnson signed amendments to the Social Security Act on July 30, 1965.

What is Medicaid?

Medicaid is a means-tested health and medical services program for certain individuals and families with low incomes and few resources. Primary oversight of the program is handled at the federal level, but each state:

- Establishes its own eligibility standards,
- Determines the type, amount, duration, and scope of services,
- Sets the rate of payment for services, and
- Administers its own Medicaid program.

What services are provided with Medicaid?

Although the States are the final deciders of what their Medicaid plans provide, there are some mandatory federal requirements that must be met by the States in order to receive federal matching funds. Required services include:

- Inpatient hospital services
- Outpatient hospital services

Medicare / Medicaid / SCHIP

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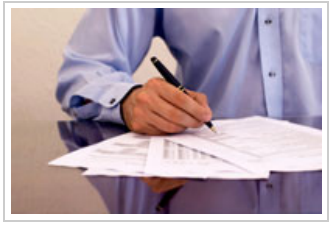
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services and ambulatory services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

States may also provide optional services and still receive Federal matching funds. The most common of the 34 approved optional Medicaid services are:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21
- Transportation services
- Rehabilitation and physical therapy services
- Home and community-based care to certain persons with chronic impairments

Who is eligible for Medicaid?

Each state sets its own Medicaid eligibility guidelines. The program is geared towards people with low incomes, but eligibility also depends on meeting other requirements based on age, pregnancy status, disability status, other assets, and citizenship.



States must provide Medicaid services for individuals who fall under certain categories of need in order for the state to receive federal matching funds. For example, it is required to provide coverage to certain individuals who receive federally assisted income-maintenance payments and similar groups who do not receive cash payments. Other groups that the federal government considers "categorically needy" and who must be eligible for Medicaid include:

- Individuals who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996
- Children under age 6 whose family income is at or below 133% of the Federal poverty level (FPL)
- Pregnant women with family income below 133% of the FPL
- Supplemental Security Income (SSI) recipients
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act

- Special protected groups such as individuals who lose cash assistance due to earnings from work or from increased Social Security benefits
- Children born after September 30, 1983 who are under age 19 and in families with incomes at or below the FPL
- Certain Medicare beneficiaries

States may also choose to provide Medicaid coverage to other similar groups that share some characteristics with the ones stated above but are more broadly defined. These include:

- Infants up to age 1 and pregnant women whose family income is not more than a state-determined percentage of the FPL
- Certain low-income and low-resource children under the age of 21
- Low-income institutionalized individuals
- Certain aged, blind, or disabled adults with incomes below the FPL
- Certain working-and-disabled persons with family income less than 250 percent of the FPL
- Some individuals infected with tuberculosis
- Certain uninsured or low-income women who are screened for breast or cervical cancer
- Certain "medically needy" persons, which allow States to extend Medicaid eligibility to persons who would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State.

Medicaid does not provide medical assistance for all poor persons. In fact, it is estimated that about 60% of America's poor are not covered by the program.

Who pays for services provided by Medicaid?

Medicaid does not pay money to individuals, but operates in a program that sends payments to the health care providers. States make these payments based on a fee-for-service agreement or through prepayment arrangements such as health maintenance organizations (HMOs).

Each State is then reimbursed for a share of their Medicaid expenditures from the Federal Government. This Federal Medical Assistance Percentage (FMAP) is determined each year and depends on the State's average per capita income level. Richer states receive a smaller share than poorer states, but by law the FMAP must be between 50% and 83%.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. However, the following Medicaid beneficiaries must be excluded from cost sharing:

- Pregnant women,
- Children under age 18, and
- Hospital or nursing home patients who are expected to contribute most of their income to institutional care.

All Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services.

What is Medicare?

Medicare is a Federal health insurance program that pays for hospital and medical care for elderly and certain disabled Americans.

The program consists of two main parts for hospital and medical insurance (Part A and Part B) and two additional parts that provide flexibility and prescription drugs (Part C and Part D).

Medicare Part A, or Hospital Insurance (HI), helps pay for hospital stays, which includes meals, supplies, testing, and a semi-private room. This part also pays for home health care such as physical, occupational, and speech therapy that is provided on a part-time basis and deemed medically necessary. Care in a skilled nursing facility as well as certain medical equipment for the aged and disabled such as walkers and wheelchairs are also covered by Part A. Part A is generally available without having to pay a monthly premium since payroll taxes are used to cover these costs.

Medicare Part B is also called Supplementary Medical Insurance (SMI). It helps pay for medically necessary physician visits, outpatient hospital visits, home health care costs, and other services for the aged and disabled. For example, Part B covers:

- Durable medical equipment (canes, walkers, scooters, wheelchairs, etc.)
- Physician and nursing services
- X-rays, laboratory and diagnostic tests
- Certain vaccinations
- Blood transfusions
- Renal dialysis
- Outpatient hospital procedures
- Some ambulance transportation
- Immunosuppressive drugs after organ transplants
- Chemotherapy
- Certain hormonal treatments
- Prosthetic devices and eyeglasses.

Part B requires a monthly premium ($96.40 per month in 2009), and patients must meet an annual deductible ($135.00 in 2009) before coverage actually begins. Enrollment in Part B is voluntary.

Medicare Advantage Plans (sometimes known as **Medicare Part C**, or Medicare + Choice) allow users to design a custom plan that can be more closely aligned with their medical needs. These plans enlist private insurance companies to provide some of the coverage, but details vary based on the program and eligibility of the patient. Some Advantage Plans team up with health maintenance organizations (HMOs) or preferred provider organizations (PPOs) to provide preventive health care or specialist services. Others focus on patients with special needs such as diabetes.

In 2006, Medicare expanded to include a prescription drug plan known as **Medicare Part D**. Part D is administered by one of several private insurance companies, each offering a plan with different costs and lists of drugs that are covered. Participation in Part D requires payment of a premium and a deductible. Pricing is designed so that 75% of prescription drug costs are covered by Medicare if you spend between $250 and $2,250 in a year. The next $2,850 spent on drugs is not covered, but then Medicare covers 95% of what is spent past $3,600.

What about services that are not provided through Medicare?

Supplemental coverage for medical expenses and services that are not covered by Medicare are offered through MediGap plans. MediGap consists of 12 plans that the Centers for Medicare and Medicaid Services have authorized private companies to sell and administer. Since the availability of Medicare Part D, MediGap plans are no longer able to include drug coverage.

Who is eligible for Medicare?

To be eligible for Medicare, an individual must either be at least 65 years old, under 65 and disabled, or any age with End-Stage Renal Disease (permanent kidney failure that requires dialysis or a transplant.)

In addition, eligibility for Medicare requires that an individual is a U.S. citizen or permanent legal resident for 5 continuous years and is eligible for Social Security benefits with at least ten years of payments contributed into the system.

Who pays for services provided by Medicare?

Payroll taxes collected through FICA (Federal Insurance Contributions Act) and the Self-Employment Contributions Act are a primary component of Medicare funding. The tax is 2.9% of wages, usually half paid by the employee and half paid by the employer. Moneys are set aside in a trust fund that the government uses to reimburse doctors, hospitals, and private insurance companies. Additional funding for Medicare services comes from premiums, deductibles, coinsurance, and copays.

What is Medicare? - Video

A short and simple video tutorial to help you understand about Medicare Part A, B, C and D. Video by Stay Smart / Stay Healthy

Medicare/Medicaid news

Medical News Today is a leading resource for the latest headlines on Medicare and Medicaid. So, check out our medicare/medicaid news section. You can also sign up to daily medical news alerts or our weekly digest medical newsletters to ensure that you stay up-to-date with the latest news.

Sources of information:

- Wikipedia - Medicare (United States)
- Wikipedia - Medicaid
- Centers for Medicare and Medicaid Services - Medicaid
- How Medicare Works
- Medicare.gov

Further information

- Useful Medicare/Medicaid Website Links