

# MEDICARE

A PRIMER

2009

# **Medicare: A Primer**

**January 2009**

## INTRODUCTION

Established in 1965, Medicare is a social insurance program, like Social Security, that provides health and financial security for individuals age 65 and older and for younger people with permanent disabilities. Prior to 1965, roughly half of all seniors lacked medical insurance; today, virtually all seniors have health insurance under Medicare. Medicare provides health insurance coverage to 45 million people – approximately 38 million people age 65 and older and another 7 million people with permanent disabilities who are under age 65. The program helps to pay for many important health care services, including hospitalizations, physician services, and prescription drugs. Individuals contribute payroll taxes to Medicare throughout their working lives and generally become eligible for Medicare when they reach age 65, regardless of their income or health status.

Comprising an estimated 13 percent of the federal budget and 19 percent of total national health expenditures in 2009, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and health care spending in the U.S.<sup>1</sup> With the dual challenges of providing needed and increasingly expensive medical care to an aging population and keeping the program financially secure for the future, discussions about Medicare are likely to remain prominent on the nation's agenda in the years ahead.

---

<sup>1</sup> The Medicare share of the federal budget is from Office of Management and Budget (OMB), FY 2009 Mid-Session Review, Budget of the U.S. Government, July 2008. The Medicare share of national health expenditures is from Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT), National Health Expenditure Projections 2007-2017, February 2008.

# DIC R RI R

---

Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.

Individuals become eligible for Medicare when they reach age 65, if they or their spouse made payroll tax contributions for 10 or more years. People under age 65 qualify for Medicare after 24 months of receiving Social Security Disability payments, or if they have end-stage renal disease or Lou Gehrig's disease.

Medicare covers a diverse population. Most people with Medicare live on modest incomes and many have multiple chronic conditions.

Medicare covers basic health services, including hospital stays, physician visits, and prescription drugs. Most benefits are subject to deductibles and cost-sharing requirements. Medicare does not cover most long-term care services, vision or dental care, or hearing aids.

**D** Medicare helps cover the cost of prescription drugs offered through private drug plans. **D** As of 2008, more than half of all beneficiaries are enrolled in a Part D drug plan.

Medicare Advantage plans are private health plans that receive payments from Medicare to provide Medicare-covered benefits to enrollees. As of 2008, more than 20 percent of all beneficiaries are enrolled in a Medicare Advantage plan.

Many beneficiaries have some type of supplemental insurance to help pay Medicare's cost-sharing requirements and to help fill gaps in Medicare's benefit package. Sources of supplemental insurance include employer-sponsored insurance, state Medicaid programs, Medigap policies, and Medicare Advantage plans.

Spending on Medicare is estimated to account for 13 percent of federal spending in 2009. Inpatient hospital services comprise the largest share of Medicare benefit payments (29 percent), followed by payments to Medicare Advantage plans (24 percent) and physician visits (17 percent), while the drug benefit accounts for 11 percent of payments.

Funding for Medicare comes primarily from payroll tax revenues (41 percent), general revenues (39 percent), and premiums paid by beneficiaries (12 percent). With an aging population, the declining ratio of workers-to-retirees, and rising health care costs, financing care for future beneficiaries remains a challenge.

**I** **C** **R**  
**D** **C**

## T I D I C R

Established in 1965 under title XVIII of the Social Security Act, Medicare was initially established to provide health insurance to individuals age 65 and older, regardless of income or medical history. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities and people suffering from end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). As of 2008, 45 million people rely on Medicare for their health insurance coverage—38 million people age 65 and over and 7 million people under age 65 with disabilities.

Part A, also known as the Hospital Insurance (HI) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is funded by a dedicated tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). In 2008, Part A accounted for approximately 40 percent of Medicare benefit spending.<sup>2</sup> An estimated 44.5 million people were enrolled in Part A in 2008.

Part B, the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, home health, and preventive services. Part B is funded by general revenues and beneficiary premiums (\$96.40 per month in 2009). In 2008, Part B accounted for 27 percent of benefit spending.<sup>3</sup> Medicare beneficiaries who have higher annual incomes (over \$85,000 per individual, \$170,000 per couple in 2009) pay a higher, income-related monthly Part B premium, ranging from \$134.90 to \$308.30 in 2009 depending on income. Part B is voluntary—some beneficiaries (such as the working aged who receive employer-sponsored health care) delay enrollment until they retire. An estimated 41.6 million people were enrolled in Part B in 2008.

Part C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed, and accounted for 21 percent of benefit spending in 2008. As of October 2008, 10.2 million beneficiaries are enrolled in Medicare Advantage plans.

Part D is the outpatient prescription drug benefit, delivered through private plans that contract with Medicare, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. Authorized by the Medicare Modernization Act of 2003 (MMA) and launched in 2006, Part D plans are required to provide a standard benefit (or one that is equivalent) and may provide enhanced benefits. Individuals with modest income and assets are eligible for additional assistance with premiums and cost-sharing amounts. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 11 percent of benefit spending in 2008. As of October 2008, nearly 26 million beneficiaries are enrolled in a Part D plan, the majority of whom (17.4 million) are enrolled in stand-alone PDPs.

---

<sup>2</sup> Congressional Budget Office (CBO), Medicare Baseline, March 2008.

<sup>3</sup> CBO, Medicare Baseline, March 2008.

## O I I I O R D I C R

Individuals age 65 and over qualify for Medicare if they are U.S. citizens or permanent legal residents. Individuals do not need to meet an income or asset test to qualify for Medicare. Adults under age 65 with permanent disabilities who receive Social Security Disability Income (SSDI) payments for 24 months are eligible for Medicare before they turn 65, even if they have not made payroll tax contributions for 40 quarters. People with end-stage renal disease (ESRD) or Lou Gehrig's disease are eligible for Medicare benefits as soon as they begin receiving SSDI payments, without having to wait 24 months. Individuals who are entitled to Part A do not pay premiums for covered services. Individuals age 65 and over who are not entitled to Part A, such as those who did not pay enough Medicare taxes during their working years, can pay a monthly premium to enroll.

I

Part B is voluntary, but about 95 percent of beneficiaries with Part A are also enrolled in Part B. For most individuals who become entitled to Part A, enrollment in Part B is automatic unless the individual declines enrollment. Individuals age 65 and older who are not entitled to Part A may enroll in Part B. With the exception of the working aged who may delay enrollment because they receive employment-based coverage, those who do not sign up for Part B when they are first eligible typically pay a penalty for late enrollment, in addition to the regular monthly premium, for the duration of their enrollment in Part B.

I

C

Beneficiaries may generally elect to enroll in a Medicare Advantage plan on an annual basis between November 15 and March 31 of the following year.

I

D

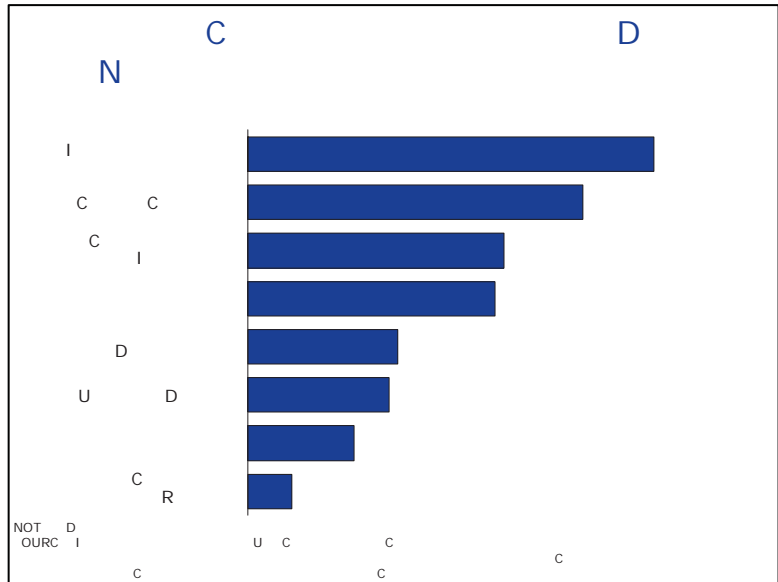
To get Part D benefits, beneficiaries may enroll in a stand-alone prescription drug plan (PDP) or Medicare Advantage prescription drug plan. The enrollment period for stand-alone prescription drug plans runs from November 15 to December 31 of each year. Individuals can enroll in a Medicare Advantage drug plan from November 15 through March 31 of the following year. Similar to Part B, there is a permanent premium penalty for late enrollment for individuals who go for an extended period of time without drug coverage that is at least comparable to the Part D standard benefit (known as creditable coverage).

# T R T C R CT RI TIC O O IT DIC R

Almost half of all Medicare beneficiaries (46 percent) have an income below 200 percent of poverty ( 20,800 individual and 28,000 couple in 2008), and 16 percent have an income below 100 percent of the poverty level.

T

More than one-third (38 percent) of all Medicare beneficiaries lives with three or more chronic conditions. Among the most common conditions are hypertension and arthritis.



More than a quarter (29 percent) of all beneficiaries have a cognitive or mental impairment that limits their ability to function independently.

Approximately one in six (17 percent) beneficiaries have multiple functional limitations, as defined as two or more limitations in activities of daily living, such as eating or bathing.

These individuals tend to have lower incomes than other beneficiaries. About 40 percent are dually eligible for both Medicare and Medicaid. Because of their disabilities, they tend to have relatively high rates of health problems, including functional limitations and cognitive impairments.

Five percent of Medicare beneficiaries (2.2 million) live in a long-term care setting, such as a nursing home or assisted living facility, but a larger share of beneficiaries who are age 85 or older (19 percent).<sup>4</sup> Two-thirds of beneficiaries living in long-term care settings are women.

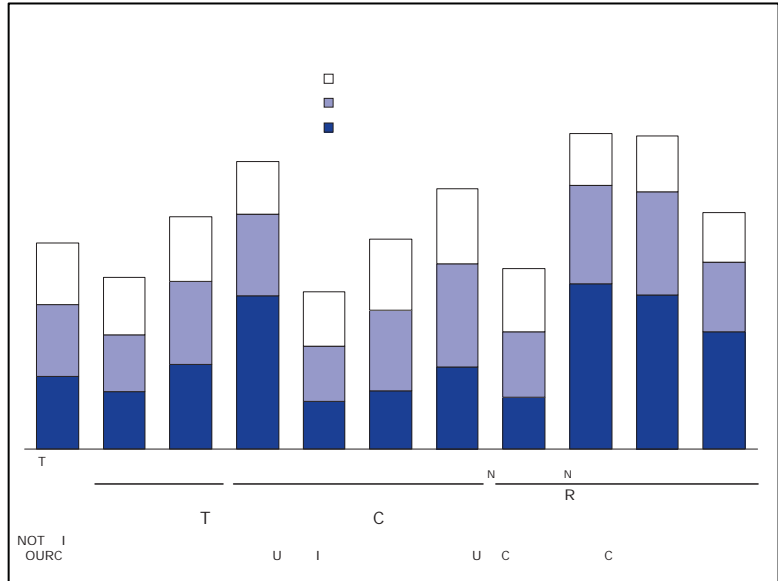
<sup>4</sup> Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services (CMS) Medicare Current Beneficiary Survey, most recent release file, 2005.

N

More than two-thirds of African American and Hispanic beneficiaries live on an income below twice the poverty level, and more than one-third of these beneficiaries have incomes below the poverty level. By contrast, 41 percent of White beneficiaries have an income below twice the poverty level and 12 percent have incomes below poverty.

Early two-thirds of all Medicare beneficiaries with disabilities under the age of 65 live on income below twice the poverty level, and more than a third live in poverty. Among people on Medicare age 65 and older, poverty rates increase with age. Six in ten beneficiaries age 85 and older live on income below twice the poverty level.

Poverty rates are substantially higher among women on Medicare than men. More than half of all female Medicare beneficiaries live on income below twice the poverty level, substantially higher than the rate for men on Medicare.



# T DO      DIC R CO   R ND O   UC DO   N ICI RI OR   N IT

Part A helps pay for inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities, and also covers hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility.

- Most beneficiaries do not pay a monthly premium for Part A services, but pay a deductible before Medicare coverage begins. In 2009, the Part A deductible for each spell of illness is \$1,068 for an inpatient hospital stay.
- Beneficiaries typically pay a coinsurance for benefits covered under Part A, including extended inpatient stays in a hospital (\$267 per day for days 61-90) or skilled nursing facility (\$133.50 per day for days 21-100). There is no copayment for home health visits.

Part B helps pay for outpatient services, such as outpatient hospital care, physician visits, and other medical services, including preventive services such as mammography and colorectal screening. Part B also covers ambulance services, clinical laboratory services, durable medical equipment (such as wheelchairs and oxygen), kidney supplies and services, outpatient mental health care, and diagnostic tests, such as x-rays and magnetic resonance imaging.

- Beneficiaries enrolled in Part B are generally required to pay a monthly premium (\$96.40 in 2009). Some beneficiaries with low incomes and assets are not required to pay the monthly Part B premium (or cost-sharing requirements), because they qualify for additional assistance under the Medicare Savings Programs (MSPs) (*see page 12 for additional information on MSPs*).
- Beneficiaries with a higher annual income greater than \$85,000 for an individual or \$170,000 for a couple in 2009 pay a higher, income-related monthly Part B premium, ranging from \$134.90 to \$308.30 in 2009. The income thresholds are indexed annually to limit the number of beneficiaries who would be subject to the higher premium in subsequent years.
- Part B benefits are subject to an annual deductible (\$135 in 2009).
- Most Part B services are subject to a coinsurance of 20 percent.

Private Medicare (Medicare Advantage) plans generally pay for all benefits covered under Medicare Part A, Part B, and Part D. Private fee-for-service plans are not required to cover prescription drugs. (*See pages 9-10 for additional information about Medicare Advantage.*)

**PART D** helps pay for outpatient prescription drug coverage through private health plans. Plans are required to provide a standard benefit or one that is actuarially equivalent, and may offer more generous benefits. In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. *(See pages 7-8 for additional information about Part D.)*

**Despite the important protections provided by Medicare, there are significant gaps in Medicare's benefit package.**

In addition to the fairly high cost-sharing requirements for covered benefits, Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities.

Most notably, Medicare does not pay for custodial long-term care services either at home or in an institution, such as a nursing home or assisted living facility. In addition, Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids. Although many beneficiaries have supplemental insurance to help cover these expenses, they may face significant out-of-pocket costs to meet their medical and long-term care needs. Unlike typical large employer plans, Medicare does not have a stop-loss benefit that limits annual out-of-pocket spending.

# TIT RT D DRU N IT ND O N N ICI RI RT D CO R

D O O D

In 2009, 1,689 stand-alone prescription drug plans (PDPs) are available nationwide, up from 1,429 in 2006 (excluding the territories). Beneficiaries in most states have a choice of at least 50 stand-alone PDPs and multiple MA-PD plans.

D

The standard benefit in 2009 has a \$295 deductible and 25 percent coinsurance up to an initial coverage limit of \$2,700 in total drug costs, followed by a coverage gap (the so-called "doughnut hole").

Enrollees with at least \$2,700 in total costs pay 100 percent of their drug costs until they have spent \$4,350 out of pocket (excluding premiums). At that point, the individual pays 5 percent of the drug cost or a copayment (\$2.40 generic or \$6.00 brand for each prescription) for the rest of the year.

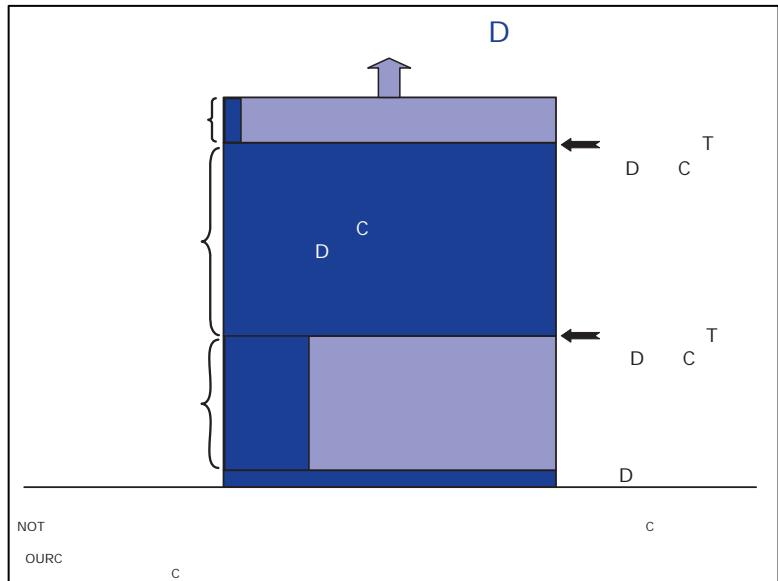
The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

In 2009, only 10 percent of PDPs offer the standard benefit, most charge copayments instead of 25 percent coinsurance, and 55 percent do *not* have a deductible, while 34 percent charge the full \$295 deductible amount.

Plans vary widely in terms of formularies (the list of covered drugs), the placement of drugs on formulary tiers, cost-sharing requirements, and utilization management tools (such as prior authorization requirements).

D

In 2009, 75 percent of PDPs offer no gap coverage, while for the 25 percent of PDPs offering gap coverage, this coverage is limited primarily to generic drugs only. In 2009, less than 1 percent of PDPs (3 plans in Florida, Michigan, and Wisconsin) cover some brand-name drugs in the gap in addition to generic drugs. An estimated 3.4 million Medicare beneficiaries (14 percent of all Part D enrollees) reached the coverage gap in 2007 and faced the full cost of their prescriptions.<sup>5</sup>



<sup>5</sup> Hadley, Grigorenko, Lubinski, and Pechmann, "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008.

D

In 2009, the national average monthly Part D premium is \$30.36 (unweighted by enrollment), but actual premiums vary across plans and regions, ranging from a low of \$10.30 for a standard benefit PDP in New Mexico to a high of \$136.80 for a PDP with enhanced benefits in New York.<sup>6</sup>

I

D

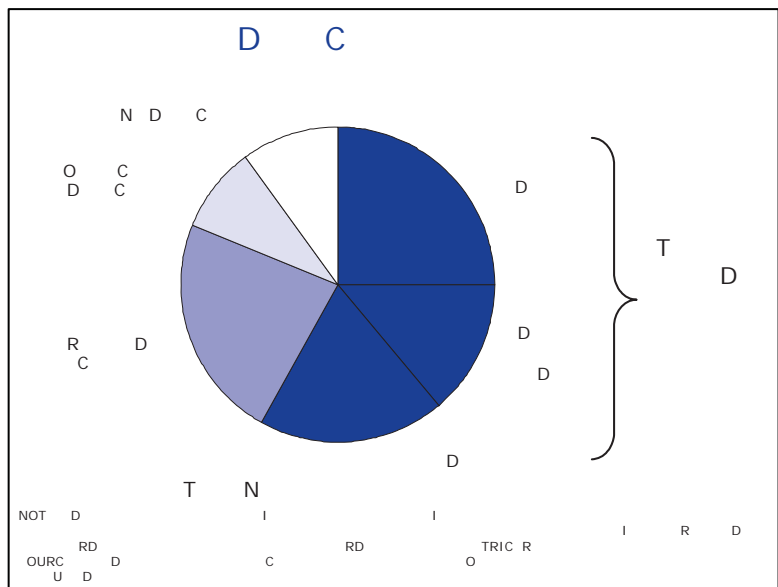
Beneficiaries with income below 150 percent of poverty (\$15,600 for an individual, \$21,000 for a couple in 2008) and limited assets (\$11,990 individual, \$23,970 couple) are eligible for the low-income subsidy (LIS), or extra help, which can increase beneficiaries' cost savings by paying for all or some of the Part D monthly premium, annual deductible, and drug co-payments.

As of January 2008, the Centers for Medicare & Medicaid Services (CMS) estimates that of the 12.5 million beneficiaries potentially eligible for low-income subsidies, 2.6 million beneficiaries were not yet receiving them.<sup>7</sup>

Nearly 26 million Medicare beneficiaries are enrolled in a Part D plan. Of this total, two-thirds (67 percent) are enrolled in stand-alone prescription drug plans. This includes more than 6 million dual eligibles, many of whom were automatically enrolled in stand-alone drug plans.

Almost a quarter of all Medicare beneficiaries (10.2 million) continue to receive prescription drug coverage from a creditable employer or union plan.

As of January 2008, approximately 1 in 10 beneficiaries lack a known source of creditable drug coverage.



<sup>6</sup> The national average monthly premium amount is from CMS, Release of the 2009 Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, the Part D Regional Low-Income Premium Subsidy Amounts, and the Medicare Advantage Regional PPAC Benchmarks, August 14, 2008.

<sup>7</sup> U.S. Department of Health and Human Services (HHS), Medicare Prescription Drug Benefits' Projected Costs Continue to Drop, Press Release, January 31, 2008.

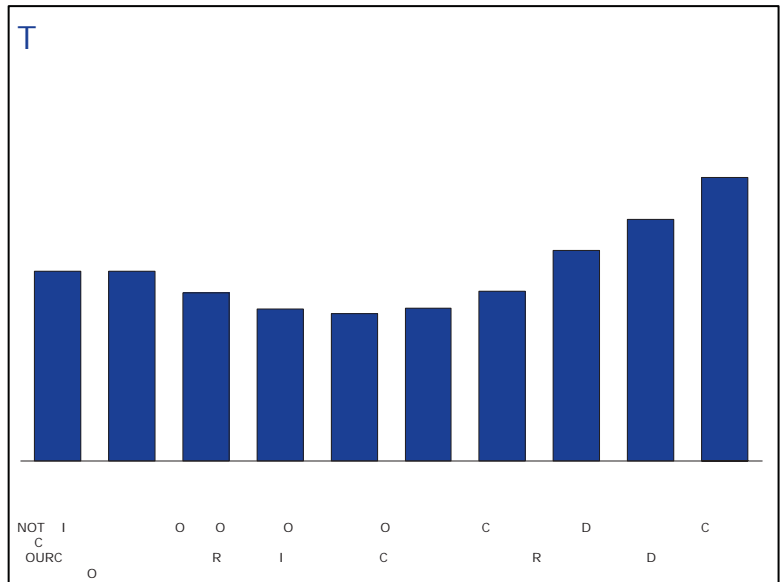
# TI DIC R D NT

C

Private plans, such as health maintenance organizations (HMOs), have been an option under Medicare since the 1970s. In addition to HMOs, Medicare now contracts with a variety of other types of private health plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, or those with certain severe and disabling conditions.

I

Private plans are playing a larger role in Medicare through a revitalization of the Medicare Advantage program attributed to increased payments to plans and new marketing and outreach opportunities associated with the Medicare drug benefit. After a steep decline between 1999 and 2003, the program has recently seen a rapid increase in both the number of plans and enrollees. The number of Medicare enrollees in private health plans increased from 5.3 million in 2003 to 10.2 million as of October 2008. Between 2005 and 2008, the number of enrollees in PFFS plans increased dramatically, from about 209,000 enrollees to 2.3 million enrollees.



In 2008, less than 5 percent of beneficiaries in 3 states (Alaska, Delaware, and Vermont) were enrolled in Medicare Advantage plans while at least 30 percent of beneficiaries in 9 states (Arizona, California, Colorado, Hawaii, Minnesota, Nevada, Oregon, Pennsylvania, and Rhode Island) were in such plans. Nationwide, half of all Medicare Advantage enrollees lived in 6 states (California, Florida, New York, Ohio, Pennsylvania, and Texas) in 2008.

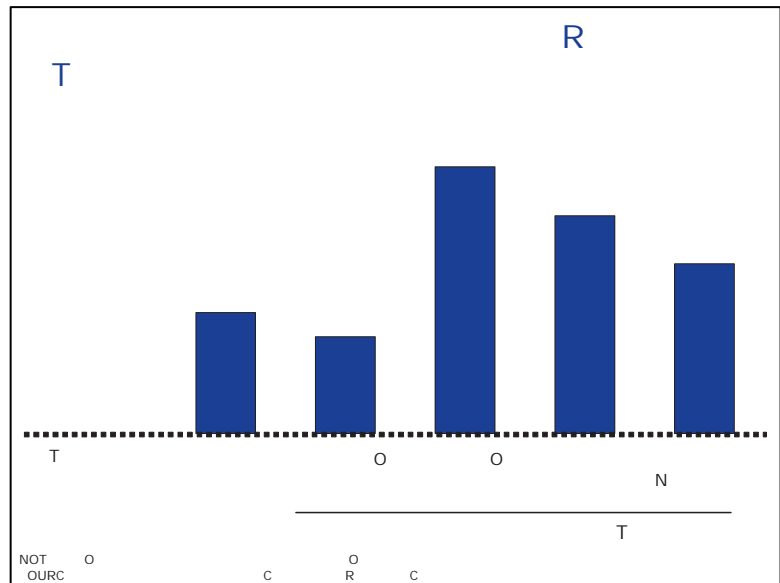
Medicare Advantage plans receive payments from the federal government to provide benefits to enrollees, and plans are required to use any savings between the payments they receive and their costs to reduce enrollee premiums or improve benefits offered. Plans may also offer supplemental benefits, for which they are permitted to charge enrollees a supplemental premium. Examples of these benefits include vision, hearing, preventive dental care, podiatry, and chiropractic services.

T

Medicare Advantage plan sponsors are generally required to offer at least one plan with basic drug coverage, and in 2008 most Medicare Advantage plans offered drug coverage. Private fee-for-service plans are not required to provide drug coverage in 2008, about 60 percent of PFFS plans elected to offer it. The Medicare Medical Savings Account plans are not permitted to offer prescription drug coverage. About half of all Medicare Advantage drug plans offer some coverage in the coverage gap, mainly for generic drugs only just one percent of all Medicare Advantage drug plans cover all brand-name and generic drugs in the coverage gap.

An analysis by the Medicare Payment Advisory Commission (MedPAC) found that Medicare payments to private health plans on behalf of enrollees in 2007 averaged 113 percent of Medicare fee-for-service costs for the counties where MA enrollees reside.<sup>8</sup> PFFS plans were paid 117 percent of traditional Medicare fee-for-service costs, before adjusting for enrollee risk.

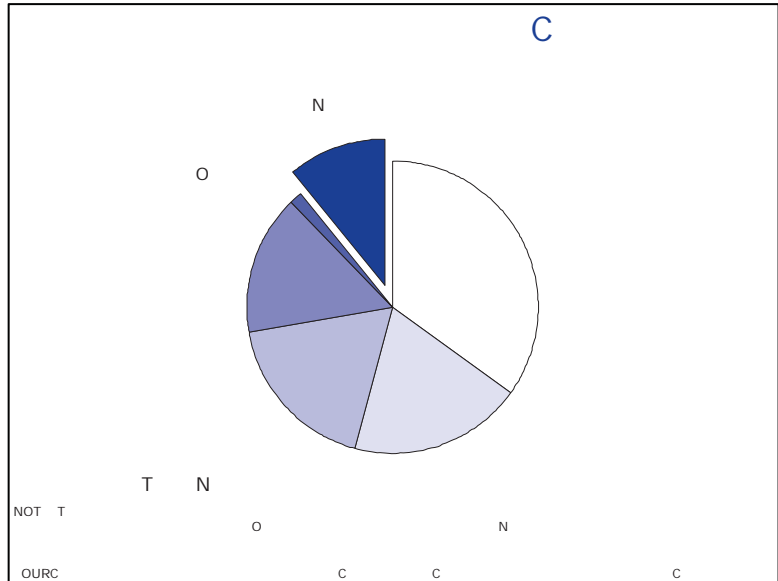
Recently-passed legislation, the Medicare Improvements for Patients and Providers Act of 2008, adjusted future payments to Medicare Advantage plans, but did not fully eliminate the disparity in payment levels between Medicare Advantage and fee-for-service Medicare.



<sup>8</sup> Medicare Payment Advisory Commission (MedPAC), Report to the Congress Medicare Payment Policy, March 2008.

# T T O U NT IN UR NC DO N ICI RI

In 2006, 35 percent of Medicare beneficiaries had coverage from an employer-sponsored health plan. The vast majority of these beneficiaries received supplemental coverage as part of a retiree health benefits plan. For retirees on Medicare, employer plans remain an important source of health benefits, including prescription drug coverage. Employer plans also often provide additional benefits, including limits on retirees' out-of-pocket health expenses. For an estimated 1.2 million Medicare beneficiaries who are working, employer plans are their primary source of health insurance coverage.<sup>9</sup> For these individuals, Medicare is the secondary payer.



According to the government, in early 2008 an estimated 10.2 million Medicare beneficiaries received prescription drug benefits under an employer or union-sponsored retiree health plan, including 6 million for federal retirees and 4 million for military retirees.<sup>10</sup> However, the availability of retiree health benefits is on the decline. The share of large firms offering retiree health benefits has dropped by more than half over the past two decades, from 66 percent in 1988 to 31 percent in 2008.<sup>11</sup>

Enrollment in private Medicare Advantage health plans has been increasing in recent years. In 2006, 19 percent of Medicare beneficiaries (about 8 million people) were enrolled in a Medicare Advantage plan, but by October 2008, Medicare Advantage enrollment had increased to more than 10 million.<sup>12</sup> Most Medicare Advantage plan enrollees (84 percent) receive prescription drug coverage through their plan. Many receive additional benefits and face lower cost-sharing requirements than they would under traditional Medicare.

<sup>9</sup> D. S., January 2008.

<sup>10</sup> D. S., January 2008.

<sup>11</sup> Kaiser Family Foundation, Survey of Employer-Sponsored Health Benefits, 2008.

<sup>12</sup> CMS Medicare Advantage, Cost, PA, Demo, and Prescription Drug Plan Organizations Monthly Summary Report, October 2008.

Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. In 2006, nearly 20 percent of all Medicare beneficiaries had an individually-purchased Medicare supplemental insurance policy.<sup>13</sup> Prior to implementation of the Medicare drug benefit in 2006, Medigap insurers sold policies that helped pay for outpatient prescription drugs. Beneficiaries may renew Medigap policies offering prescription drug coverage if they were purchased prior to 2006, although that coverage is not comparable to the standard Part D drug benefit and insurers are now prohibited from issuing new Medigap policies with prescription drug coverage.

T

Medicaid helps to make Medicare affordable for low-income beneficiaries, given gaps in the benefit package, premiums, deductibles and other cost-sharing requirements. Most dual eligibles (6.2 million in 2008) qualify for full Medicaid benefits, including long-term care and dental services.<sup>14</sup> Dual eligibles also get help with Medicare's premiums and cost-sharing requirements, and receive subsidies that help pay for drug coverage under Medicare Part D plans.

Some dual eligibles (1.7 million in 2008) do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements through the Medicare Savings Programs (MSP), administered under Medicaid.<sup>15</sup> Eligibility for this assistance is based on a beneficiary's income and resources.

	I		C	C
	I			
	I			
I	I			
I	D			
I	D	I		
NOT		I		D

<sup>13</sup> Kaiser Family Foundation analysis of the MS Medicare Current Beneficiary Survey Access to Care file, 2006.

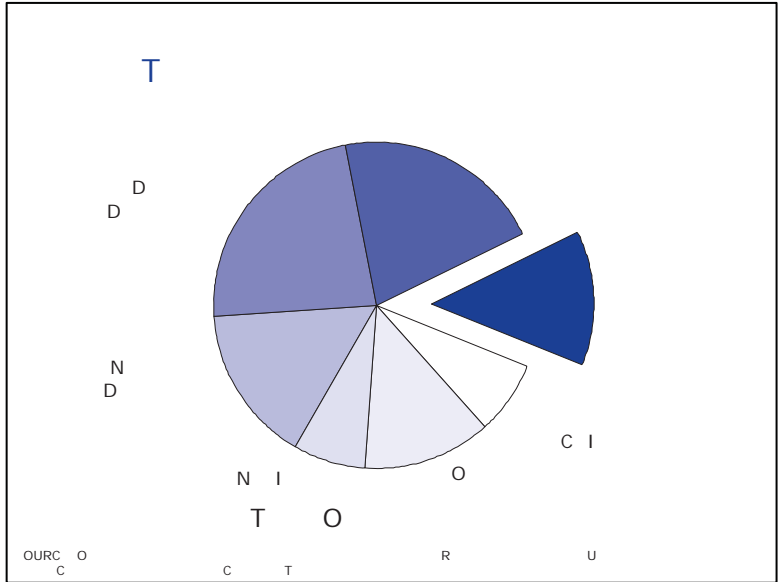
<sup>14</sup> D. S., January 2008.

<sup>15</sup> D. S., January 2008.

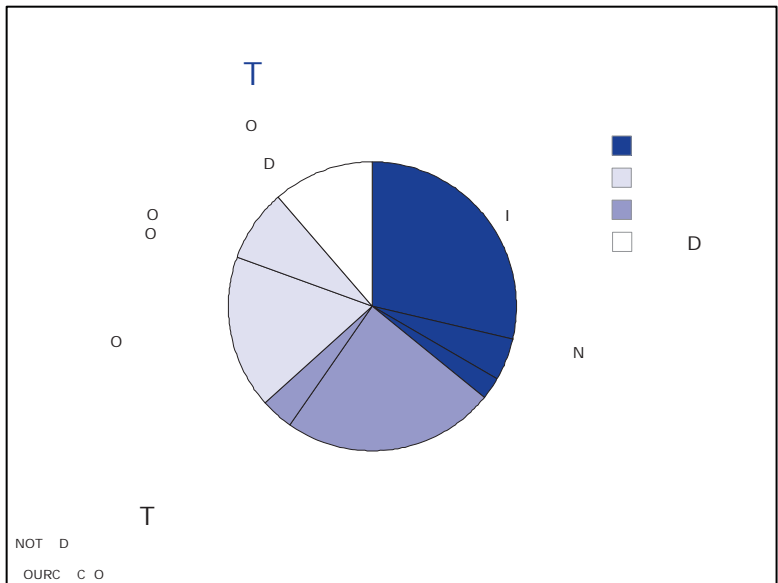
<sup>16</sup> D. S., January 2008.

O U C D O      D I C R C O T N D  
O I T      O N      N T

Medicare represents a large share of the federal budget. Federal spending for fiscal year 2009 is expected to total slightly more than \$3 trillion, with spending on Medicare comprising 13 percent of that amount. Of the three main entitlement programs—Social Security, Medicare, and Medicaid—Medicare is second largest in terms of the share of federal spending on each program. Social Security is largest, at 21 percent of federal spending in 2009. Federal spending on Medicaid and CHIP (State Children's Health Insurance Program) represents 7 percent of total spending.



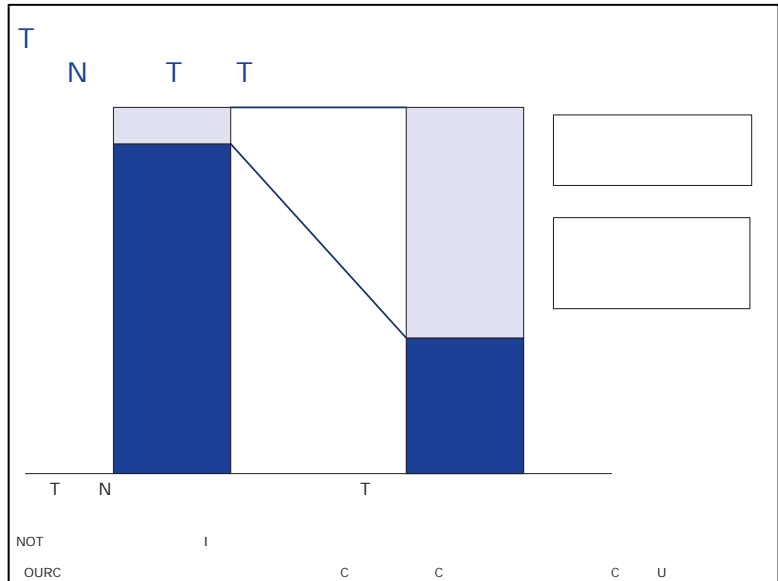
Inpatient hospital services comprise the largest share of Medicare benefit payments (29 percent), followed by payments to Medicare Advantage plans (24 percent), and physician and other outpatient services (17 percent). Spending on the Part D prescription drug benefit accounts for 11 percent of total benefit payments in 2009. Projects that by 2018, Medicare Advantage payments will account for 25 percent of Medicare benefit payments and prescription drugs another 16 percent of Medicare benefit payments.<sup>17</sup>



<sup>17</sup> , Medicare Baseline, March 2008.

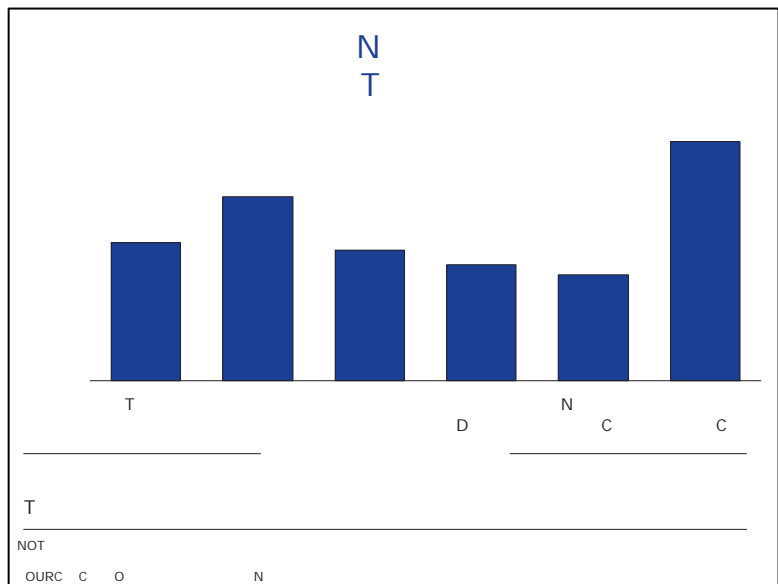
A small share of Medicare beneficiaries accounts for a majority of Medicare spending. Ten percent of beneficiaries in the fee-for-service program accounted for nearly two-thirds of Medicare spending in 2005. At the other end of the spectrum, 28 percent of all fee-for-service beneficiaries had total spending less than \$1,000, accounting for just 2 percent of total expenditures, and 14 percent of beneficiaries incurred no expenditures at all.<sup>18</sup>

In 2005, Medicare spending for each fee-for-service beneficiary averaged \$7,064. Per capita payments were higher for people age 65 or older (\$6,740) than for beneficiaries under age 65 with disabilities (\$5,970). Per capita spending was highest for those beneficiaries with S/D (\$52,379 on average in 2005) who comprise less than one percent of the total Medicare population.<sup>19</sup>



U

Medicare's share of national personal health care expenditures varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2006, Medicare paid for 38 percent of home health care spending, 29 percent of all hospital spending, and 18 percent of prescription drug costs. This represents a significant increase from just 2 percent of national expenditures for prescription drugs in 2005, the year before the Part D drug benefit went into effect.

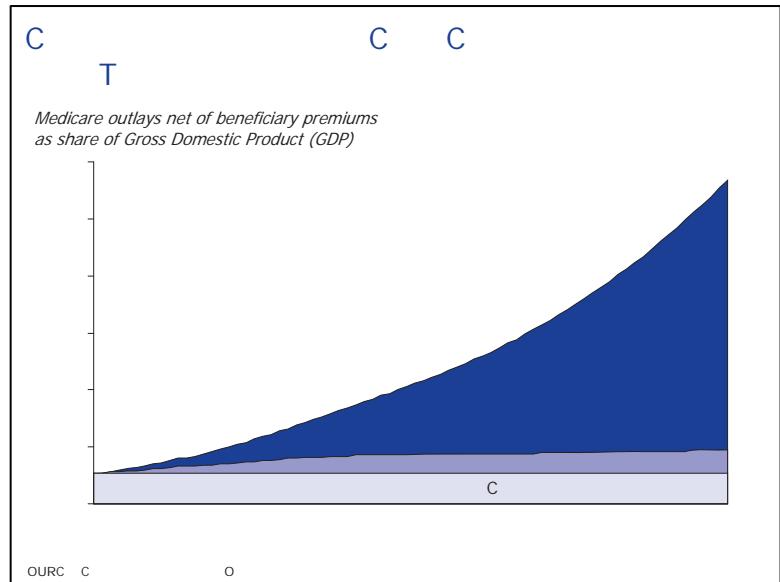


<sup>18</sup> Kaiser Family Foundation analysis of the MS Medicare current beneficiary Survey, 2005.  
<sup>19</sup> Kaiser Family Foundation analysis of the MS Medicare current beneficiary Survey, 2005.

C O

The annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services and higher prices for health care services. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2006 was slightly lower for Medicare (8.7 percent) than for private health insurance (9.7 percent) for common benefits (excluding prescription drugs).<sup>20</sup>

The Congressional Budget Office has estimated that a larger share of future growth in Medicare spending as a share of the Gross Domestic Product will result from growth in health care costs rather than from growth in enrollment.

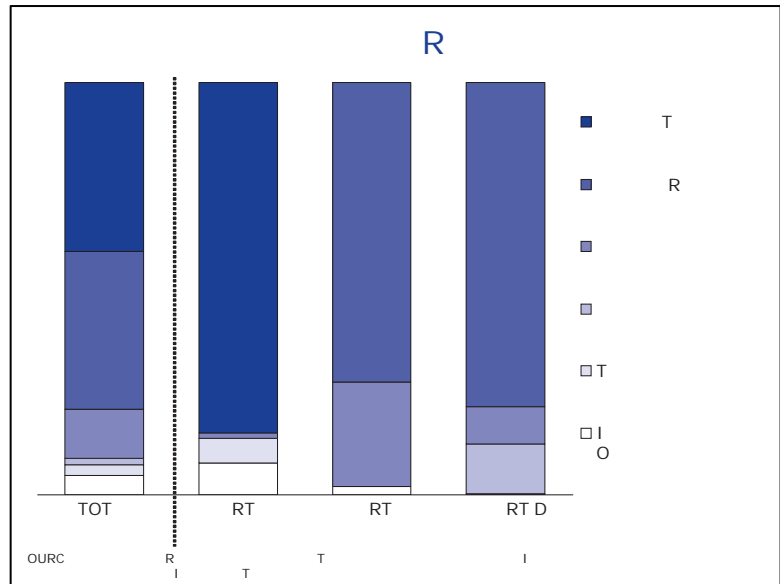


<sup>20</sup> MS, A, National Health Statistics Group, 2007.

# O I DIC R IN NC D ND T R DIC R UTUR IN NCIN C N

Medicare is funded as follows

- the Hospital Insurance (HI) Trust Fund, is financed largely through a dedicated tax of 2.9 percent of earnings paid by employers and their employees (1.45 percent each). In 2009, these taxes are estimated to account for 85 percent of the \$244 billion in revenue to the Part A Trust Fund.
- the Supplementary Medical Insurance (SMI) Trust Fund, is financed through a combination of general revenues and premiums paid by beneficiaries. Premiums are automatically set to cover 25 percent of revenues in the aggregate. In 2009, Part B revenue is estimated to be \$202 billion.
- Part C is not separately financed.
- Part D is financed through general revenues, beneficiary premiums, and state payments for dual eligibles (who received drug coverage under state Medicaid programs prior to 2006). In 2009, Part D revenue is projected to be \$61 billion, 79 percent of which will be from general revenues.



U

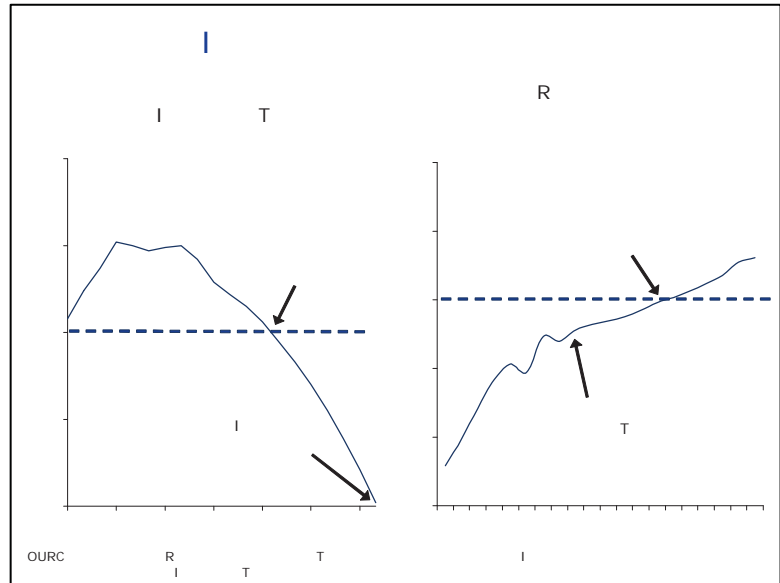
A number of measures are used to assess the long-term financial status of Medicare.

- The Medicare Trustee Report is one of several measures reported by the Medicare trustees in their annual report to the Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. If current trends continue, Medicare expenditures as a share of GDP are projected to rise from 3.3 percent of GDP in 2009 to 6.3 percent of GDP in 2030.<sup>21</sup>

<sup>21</sup> 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

- The **Trust Ratio** is another measure that has been used to present a picture of Medicare's financial health. This indicator looks exclusively at Part A, and does not take into account spending or financing for other parts of the Medicare program. According to the Medicare trustees, Part A spending is expected to exceed income in 2010, and the Trust Fund reserves are projected to be exhausted in 2019.<sup>22</sup>

The projected insolvency of the Medicare Trust Fund has fluctuated from year to year mainly because the projections are highly sensitive to changes in both Medicare policy and the overall economy. For example, in 1997, the trustees projected that the Trust Fund would be insolvent by 2001, yet by 2001, the trustees projected that the trust fund would be solvent through 2029, due in part to economic growth, slower than expected expenditure growth, and decreased payments to Medicare managed care plans over the five-year period.



- The **General Revenue Test** is a relatively new way to measure Medicare's fiscal health. Each year, the Medicare trustees are required to examine general revenues as a share of total Medicare spending, and make a determination as to whether general revenues are projected to exceed 45 percent of total outlays within a seven-year timeframe. If the trustees make this determination two years in row, a Medicare funding warning is issued, indicating that general revenues are becoming a substantial share of total financing for Medicare. In response, the President is required to submit proposed legislation to Congress, which must consider this legislation on an expedited basis.

In 2008, for the third year in a row, the Medicare trustees projected that general revenues will exceed 45 percent of total Medicare spending within seven years (by 2014) and a Medicare funding warning was issued. Also in 2008, the President was required by law to respond to the funding warning that was issued by the Medicare trustees in 2007. The Administration's proposal was to implement a national system of electronic medical records and a provider pay-for-performance system in Medicare provide cost and quality information to Medicare beneficiaries amend the medical malpractice liability system to include a statute of limitations and limits to recovery of non-economic and punitive damages and establish an income-related premium for the Part D drug benefit. In July 2008, the House of Representatives voted to suspend consideration of this legislation for the remainder of the year.

<sup>22</sup> 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, March 2008.

DIC R N IT ND CO T RIN R UIR NT

RT	
Deductible	1,068 per benefit period
Inpatient hospital	
Days 1-60	0 coinsurance
Days 61-90	267 per day
Days 91-150	534 per day (for up to 60 lifetime reserve days)
After 150 Days	not covered
Skilled nursing facility	
Days 1-20	0 coinsurance
Days 21-100	133.50 per day
After 100 Days	not covered
Home health	0 coinsurance no limit on number of visits
Hospice	0 coinsurance for hospice care copayment of up to \$5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	up to 190 days in a lifetime
RT	
Deductible	135
Premium	96.40 month (higher for those with incomes above 85,000 single or 170,000 couple)
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance certain limits may apply
Clinical laboratory services	0 coinsurance
Home health care	0 coinsurance no limit on number of visits
Outpatient mental health services	50% coinsurance (decreasing to 20% by 2014)
One-time Welcome to Medicare physical exam	20% coinsurance covered within first 12 months of Part enrollment Part D deductible does not apply
Preventive services	
Flu shots, Pneumococcal vaccines	0 coinsurance one flu shot per flu season limit
Hepatitis B vaccine colorectal and prostate cancer screenings pap smears mammograms abdominal aortic aneurysm (AAA) screenings	Deductible and coinsurance waived for certain preventive services such as colorectal cancer screenings and AAA screenings
One-time mass measurement, diabetes monitoring glaucoma screening	20% coinsurance
RT D	
Information below applies to the standard Part D benefit. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts. Benefits and cost-sharing requirements typically vary across plans.	
Deductible	295
Premium	30.36 national average monthly premium
Initial coverage (up to 2,700 in total drug costs)	25% coinsurance
Coverage gap (between 2,700 and 6,154 in total drug costs)	100% coinsurance (not covered)
Catastrophic coverage (above 6,154 in out-of-pocket spending)	Minimum 2.40 generic, 6.00 brand or 5% coinsurance

This table does not include all Medicare-covered benefits. For a complete listing, see <http://www.medicare.gov/coverage/home.asp>.

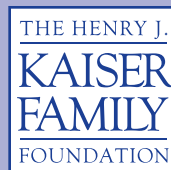
S MS, Medicare 2009.



R ESCRIPTION DRUG COVERAGE ON DISINTEGRATION

Territory	Total	Medicare	Medicaid	Private	Other	Uninsured	Total
U.S. Total	44,417,991	8,010,244	17,392,378	6,180,053	9,385,166	12,112,837	6,902,532
Alabama	806,827	116,564	329,711	88,887	223,873	244,952	115,600
Alaska	60,052	254	22,914	12,115	14,123	24,161	12,723
Arizona	866,014	290,550	217,315	104,190	151,059	220,309	137,840
Arkansas	507,544	43,026	255,092	63,857	132,230	128,234	81,192
California	4,490,521	1,420,472	1,585,286	1,045,340	1,151,602	839,132	645,631
Colorado	579,032	161,290	165,071	52,714	91,305	159,402	93,269
Connecticut	548,114	63,980	225,473	67,189	99,823	169,974	88,687
Delaware	140,383	2,717	64,772	10,109	24,132	50,260	22,634
District of Columbia	74,970	5,927	27,858	15,664	20,548	25,458	15,727
Florida	3,198,093	796,646	1,022,527	298,101	588,556	892,922	485,998
Georgia	1,152,697	102,623	554,151	138,611	290,386	292,805	203,118
Hawaii	194,064	60,579	62,693	25,738	35,081	39,148	31,644
Idaho	213,790	31,700	85,041	19,510	34,904	55,861	41,188
Illinois	1,773,245	110,729	853,431	242,841	337,857	512,825	296,260
Indiana	961,382	49,484	444,989	86,108	169,801	299,725	167,184
Iowa	571,113	37,513	291,116	57,227	82,429	103,218	139,266
Kansas	462,268	27,639	220,467	38,704	67,468	96,733	117,429
Kentucky	726,720	52,482	343,395	146,711	192,758	210,069	120,774
Louisiana	655,237	109,435	277,145	95,327	187,217	160,038	108,619
Maine	253,269	6,972	135,976	47,817	81,512	56,282	54,039
Maryland	743,572	43,944	270,136	61,931	121,704	289,031	140,461
Massachusetts	1,017,722	168,292	391,598	207,019	243,275	288,540	169,292
Michigan	1,577,470	252,875	505,869	195,288	268,807	553,784	264,942
Minnesota	749,569	188,510	299,812	97,753	125,648	157,393	103,854
Mississippi	477,558	18,408	283,253	74,379	159,999	100,435	75,462
Missouri	964,441	150,867	423,524	134,988	194,923	240,750	149,300
Montana	160,373	14,013	74,953	13,200	25,210	41,093	30,314
Nebraska	271,198	20,601	151,994	32,528	43,748	64,161	34,442
Nevada	329,856	95,315	82,341	20,407	46,858	92,884	59,316
New Hampshire	205,148	4,279	84,879	18,463	31,501	66,437	49,553
New Jersey	1,281,391	105,541	542,470	152,026	222,898	411,567	221,813
New Mexico	293,712	60,113	115,172	34,821	67,122	68,781	49,646
New York	2,892,567	620,818	988,173	558,058	721,725	794,213	489,363
North Carolina	1,399,982	161,955	635,716	219,955	339,266	379,170	223,141
North Dakota	106,113	4,142	69,800	9,901	17,495	20,126	12,045
Ohio	1,835,141	300,878	589,569	184,301	314,205	676,665	268,029
Oklahoma	577,305	59,212	271,304	80,796	122,182	145,209	101,580
Oregon	582,843	173,284	185,639	54,126	95,307	121,802	102,118
Pennsylvania	2,218,620	618,352	701,874	277,684	394,456	553,441	344,953
Rhode Island	177,597	57,165	58,471	30,036	41,081	36,089	25,872
South Carolina	719,408	64,168	309,484	114,149	169,978	227,680	118,076
South Dakota	131,800	9,904	75,633	11,926	21,935	29,786	16,477
Tennessee	999,647	164,442	449,574	186,085	284,669	233,341	152,290
Texas	2,799,542	386,680	1,136,370	340,961	680,572	813,173	463,319
Utah	263,623	46,262	90,721	23,722	33,672	77,517	49,123
Vermont	104,950	678	55,151	17,403	25,710	31,659	17,462
Virginia	1,078,060	78,413	453,431	104,805	199,720	341,712	204,504
Washington	901,495	114,449	339,831	101,462	149,135	250,870	196,345
West Virginia	372,340	54,021	165,538	42,372	87,104	99,817	52,964
Wisconsin	873,511	114,550	315,760	111,919	138,303	228,550	214,651
Wyoming	76,102	2,370	38,090	5,825	10,881	21,335	14,307

<sup>1</sup> Includes beneficiaries living in the territories and beneficiaries who were pending assignment to a particular state of residence.  
<sup>2</sup> Includes 1.3 million beneficiaries who were auto-enrolled and 0.15 million additional beneficiaries receiving the low-income subsidy.  
<sup>3</sup> Includes 5.3 million beneficiaries who were auto-enrolled and 2.6 million additional beneficiaries receiving the low-income subsidy.  
<sup>4</sup> Includes beneficiaries with retiree Drug Subsidy, Family Planning, and Active Workers.  
<sup>5</sup> Estimates of unknown no drug coverage are the residual difference between the total column and the combined total of Medicare Advantage, PDP, and other creditable sources of drug coverage for each state.  
Source: Total number of beneficiaries from MSMA State County Penetration File, October 2008. State-level prescription drug coverage estimates from Centers for Medicare and Medicaid Services (CMS) Management Information Integrated Repository (MII), as of January 18, 2008.



## The Henry J. Kaiser Family Foundation

### Headquarters

2400 Sand Hill Road

Menlo Park, CA 94025

Phone 650-854-9400 Fax 650-854-4800

### Washington Offices and

Barbara Jordan Conference Center

1330 G Street, NW

Washington, DC 20005

Phone 202-347-5270 Fax 202-347-5274

[www.kff.org](http://www.kff.org)

This report (#7615-02) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org)

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.