THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE AT A GLANCE

March 2004

What Is Medicare and How is it Structured?

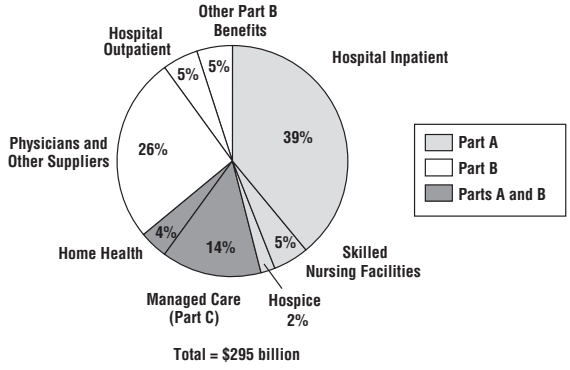
Medicare is a federal health insurance program that covers more than 41 million Americans: 35 million seniors and 6 million non-elderly people with disabilities. Medicare has covered eligible elderly beneficiaries without regard to income or medical history since it was established in 1965 and added coverage for under-65 people with disabilities in 1972. It is a source of coverage for one in seven Americans.

Medicare consists of four parts:

- **Part A**, the Hospital Insurance program, financed 46% of benefits in 2004. It covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part A is financed by a 1.45% payroll tax paid by employees and employers.
- **Part B**, Supplementary Medical Insurance, accounts for over one-third of Medicare benefit spending in 2004. It covers physician and outpatient hospital care, lab tests, medical supplies, and home health. Part B is financed by beneficiary premiums (25%) and general revenues (75%). The monthly Part B premium is $66.60 in 2004.
- **Part C** refers to managed care plans that provide Part A and B benefits to enrollees, accounting for 14% of benefit spending in 2004. Formerly called "Medicare+Choice," Part C has been renamed "Medicare Advantage."
- **Part D** refers to the new outpatient prescription drug benefit that will be implemented in 2006, enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Part D will be financed through beneficiary premiums (25.5%) and general revenues (74.5%). CBO estimates the average monthly Part D premium will be $35 in 2006, although premiums are expected to vary across plans.

Figure 1

Medicare Benefit Payments, by Type of Service, Fiscal Year 2004



Total = $295 billion

Note: Does not include administrative expenses. Excludes Part D low-income subsidy payments.
SOURCE: Congressional Budget Office, Medicare Baseline, March 2004.

Who Is Covered Under Medicare?

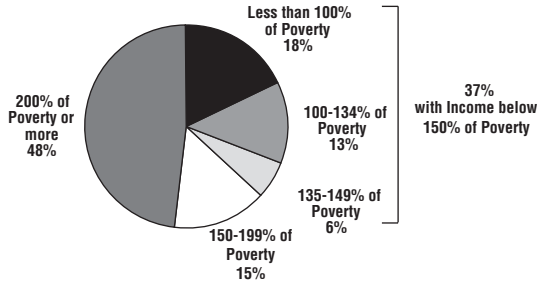
Most individuals ages 65 and over are automatically entitled to Medicare Part A if they or their spouse are eligible for Social Security payments. People under 65 who receive Social Security cash payments due to a disability generally become eligible for Medicare after a two-year waiting period. People with end-stage renal disease (ESRD) are entitled to Part A, regardless of their age. Ninety-five percent of Part A beneficiaries voluntarily enroll in Part B.

Medicare covers a diverse population:

- 37% have incomes below 150% of the federal poverty level ($13,290/single; $17,910/couple in 2002).
- 29% say their health status is fair or poor.
- More than a third (36%) report needing assistance with at least one activity of daily living.
- 23% have cognitive impairments.
- A quarter (24%) live in rural areas.

Figure 2

The Non-Institutionalized Medicare Population by Poverty Level, 2002



Total = 38.4 Million Medicare Beneficiaries

Note: Reflects family income as defined by HHS poverty guidelines. 2002 federal poverty level $8,860/single and $11,940/couple.
Source: Urban Institute estimates based on March 2003 Current Population Survey.

What Do Beneficiaries Pay for Medicare Benefits?

Benefits and cost-sharing requirements include:

- Inpatient hospital services are subject to a deductible ($876/benefit period, 2004) and daily coinsurance beginning after the 60th day of a hospital stay.
- Medicare covers up to 100 days of skilled nursing facility care after three days in the hospital, subject to coinsurance ($109.50/day, 2004) for days 21-100.
- After meeting a $100 Part B deductible ($110 in 2005 and indexed to rise by the annual percentage increase in Part B expenditures thereafter), 20% coinsurance is required for most Part B services.
- Beneficiaries are not required to pay coinsurance for home health visits funded under Parts A or B.

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Medicare Advantage (formerly Medicare+Choice)

Medicare Advantage (MA) plans contract with Medicare to provide both Part A and B services to enrolled beneficiaries. Due to changing payment rates and other factors, the number of participating plans has declined in the last several years, as have the supplemental benefits offered by the remaining plans. Today, 4.6 million Medicare beneficiaries (11%) are enrolled in managed care plans, down from a peak of 6.3 million in 2000.

With the new drug law, Medicare Advantage plans are expected to receive additional payments of $1.3 billion in 2004-2005 and over $14 billion between 2004-2013. CBO estimates that enrollment will rise slightly to 12%.

Medicare and Prescription Drugs

Concerns about seniors lacking prescription drug coverage and the rising cost of drugs led to the enactment of the new Part D prescription drug benefit, beginning in 2006. Prior to 2006, most beneficiaries will be able to sign up for a federally-approved drug discount card, with some low-income beneficiaries receiving a $600 subsidy to help pay drug costs. Beginning in January 2006, private insurance plans will offer drug benefits under Part D for a monthly premium. In 2006, under the standard benefit, beneficiaries will pay:

- The first $250 in drug costs (deductible);
- 25% of total drug costs between $250 and $2,250;
- 100% of drug costs between $2,250 and $5,100 in total drug costs (the $2,850 gap or "hole in the doughnut"), equivalent to a $3,600 out-of-pocket limit;
- The greater of $2 for generics, $5 for brand drugs, or 5% coinsurance after reaching the $3,600 out-of-pocket limit ($5,100 catastrophic threshold).

Filling Medicare's Gaps

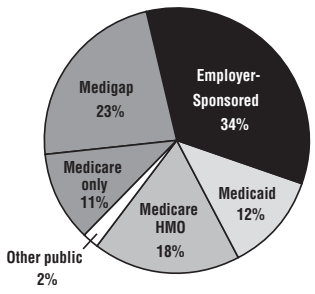
Because of gaps in Medicare's coverage, the elderly spent an estimated 22% of their income, on average, for health care services and premiums in 2002 (Maxwell, et al., 2002). To help with Medicare's gaps, most have some form of supplemental insurance.

In 2001, of non-institutionalized beneficiaries:

- 34% had employer-sponsored benefits (28% as retirees). The share of large employers offering retiree health benefits dropped from 66% in 1998 to 38% in 2003 (KFF/HRET, 2003).
- 23% owned a Medigap policy, but only 7% of all beneficiaries had drug coverage from Medigap.

Figure 3

Sources of Primary Supplemental Insurance Among Noninstitutionalized Medicare Beneficiaries, Fall 2001



Total = 35.5 million non-institutionalized Medicare beneficiaries

Note: Estimates are based on 1996-2001 MCBS "Access to Care" files and represent point-time estimates pertaining to aged and disabled Medicare beneficiaries living in a community setting who were enrolled in Medicare for the entire calendar year. Estimates exclude beneficiaries who were not enrolled in Medicare for the entire calendar year

SOURCES: Bearing Point analysis for Kaiser Family Foundation, 2004.

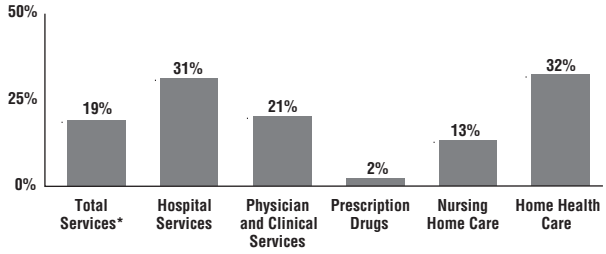
- 12% were covered under Medicaid, the major public insurance program for low-income Americans.
- 18% were enrolled in Medicare+Choice plans.

Medicare Expenditures and Financing

Medicare benefit payments accounted for 19% of total spending for personal health services in the U.S. in 2002. Medicare also financed 31% of the nation's hospital services and 21% of physician and clinical services.

Figure 4

Medicare's Share of National Personal Health Expenditures, by Type of Service, 2002



	(Expenditures in Billions)					
Medicare	$259.1	$149.2	$68.8	$2.6	$12.9	$11.4
Total	$1,340.2	$486.5	$339.5	$162.4	$103.2	$36.1

*Total services also includes dental care, other professional services, durable and non-durable medical equipment, and other personal health care services.

SOURCE: Levit, et al., *Health Affairs*, Jan/Feb 2004.

Medicare benefit spending is projected to grow 8.2% in 2004, totaling $296.7 billion (CBO, 2004). Medicare spending growth has generally been slower than the rise in private health care spending. For the years 1985-2002, spending for benefits commonly covered by Medicare and private health insurance grew at an annual rate of 5.8% in Medicare versus 7.4% for private plans (Levit et al., 2004). Medicare has also had lower administrative costs, accounting for less than 2% of total Medicare spending in 2002 (CBO, 2003), compared to 13% for private health insurers (Levit et al., 2004).

According to the 2004 Trustees' Report, the Part A trust fund is projected to be exhausted in 2019. Looking at the Medicare program as a whole, over half (56%) of spending in 2003 was funded by payroll taxes and interest on the trust funds. General revenues accounted for 30% of the total and premiums represented 10%. The MMA established a new measure requiring Congress to take action when, for two years in a row, general revenues are projected to fund more than 45% of Medicare's program costs within the next seven years. The Administration projects that general revenues will fund more than 45% of Medicare's program costs beginning in 2012.

Medicare's Outlook

Issues related to implementation of the new prescription drug benefit are the most immediate challenges for Medicare. In the future, the aging of the baby-boom generation, the decline in the number of workers per beneficiary, and the continued rise in national health care spending will present additional challenges. Greater resources will be required over time to maintain current benefits and meet the needs of the growing number of beneficiaries.

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