

# MEDICARE

## MEDICARE AT A GLANCE

January 2010

### OVERVIEW OF MEDICARE

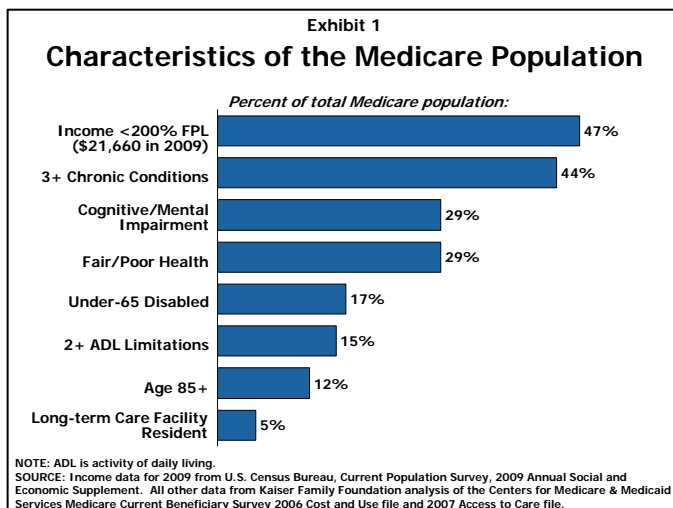
Medicare is the federal health insurance program created in 1965 for all people age 65 and older regardless of their income or medical history, and now covers 46 million Americans. Medicare plays a vital role in helping to provide financial security to beneficiaries.

Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. Medicare was expanded in 1972 to include people under age 65 with permanent disabilities. People under age 65 who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those with End Stage Renal Disease (ESRD) and Lou Gehrig's disease become eligible for Medicare when they begin receiving SSDI payments.

Medicare benefit outlays are expected to total \$504 billion in 2010 — 15% of the federal budget (CBO).

### CHARACTERISTICS OF PEOPLE ON MEDICARE

Medicare covers a diverse population; nearly half of all people on Medicare (47%) have incomes below 200% of poverty (\$21,660 for individuals and \$29,140 for couples in 2009) (Exhibit 1). Almost half (44%) of all beneficiaries has three or more chronic conditions, and more than a quarter (29%) has a cognitive/mental impairment. Seventeen percent — just over 8 million beneficiaries in 2007 — are under age 65 and permanently disabled, and 12 percent of beneficiaries are age 85 or older.

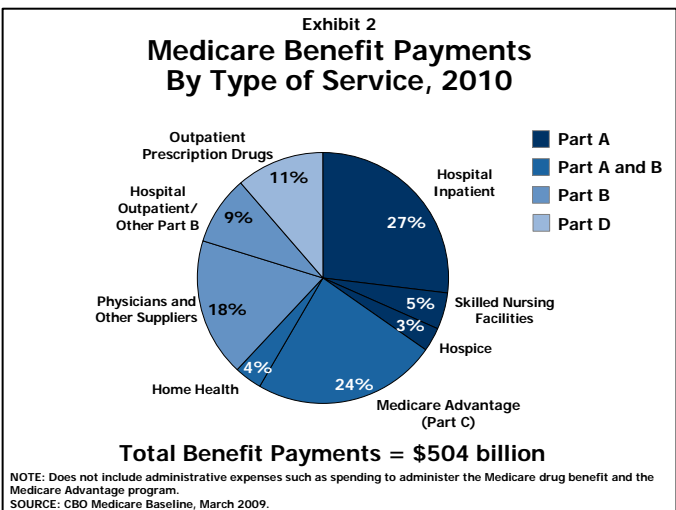


### MEDICARE'S STRUCTURE

Medicare is organized into four parts.

**Part A** pays for inpatient hospital stays, skilled nursing facility stays, home health visits (also under Part B), and hospice care, and, excluding home health, accounts for 35% of benefit spending in 2010 (Exhibit 2).

**Part B** pays for physician visits, outpatient services, preventive services, and home health visits, and, excluding home health, accounts for 27% of benefit spending in 2010.



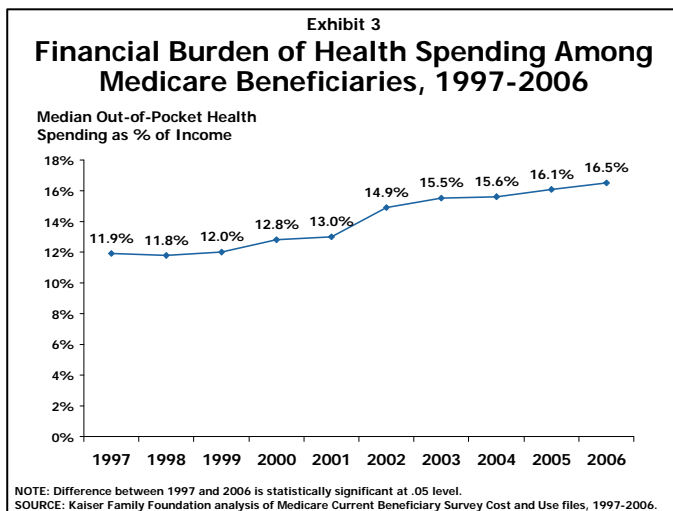
**Part C** refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO), and receive all Medicare-covered benefits, and often extra benefits, such as eyeglasses or hearing exams. In the past, Congress increased payments to Medicare private plans to encourage plan participation throughout the country, including rural areas. As a result, the average Medicare payment to Medicare Advantage plans is 114% of the cost of similar benefits in traditional Medicare (MedPAC, 2009). Medicare Advantage now accounts for 24% of benefit spending, and more than 10 million beneficiaries are enrolled in a Medicare Advantage plan.

**Part D** is the voluntary, subsidized outpatient prescription drug benefit, with additional subsidies for beneficiaries with low incomes and modest assets. The Part D drug benefit is offered under private plans that contract with Medicare, both stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs). Part D now accounts for 11% of benefit spending, and more than 27 million beneficiaries are enrolled in a Medicare Part D plan.

## BENEFIT GAPS, OUT-OF-POCKET SPENDING AND SUPPLEMENTAL COVERAGE

Medicare has relatively high cost-sharing requirements, no limit on out-of-pocket spending, and a coverage gap (or “doughnut hole”) in the prescription drug benefit. Further, Medicare does not pay for many services of critical importance to elderly and disabled beneficiaries, such as long-term care, dental or vision.

With health costs rising faster than income for Medicare beneficiaries, median out-of-pocket health spending as a share of income increased from 11.9% in 1997 to 16.5% in 2006 (**Exhibit 3**).



To help with cost-sharing requirements and fill in the benefit gaps, most Medicare beneficiaries have some form of supplemental insurance.

- **Employer-sponsored retiree health plans** provide supplemental coverage for about a third of all beneficiaries, but the share of employers offering retiree health benefits has dropped from 66% in 1988 to 29% in 2009 (KFF/HRET 2009).
- About one in five beneficiaries (17%) purchase Medicare supplemental policies, known as **Medigap**.
- **Medicaid** helps pay for Medicare's premiums and cost-sharing for more than 7 million beneficiaries with low incomes and modest assets (known as “dual eligibles”). Most of these beneficiaries qualify for full Medicaid benefits, which include long-term care.
- Eleven percent of Medicare beneficiaries had **no supplemental coverage** in 2007. The under-65 disabled, the near poor (incomes between \$10,000 and \$20,000), rural residents, and African Americans were disproportionately represented among those without supplemental coverage.

## MEDICARE SPENDING NOW AND IN THE FUTURE

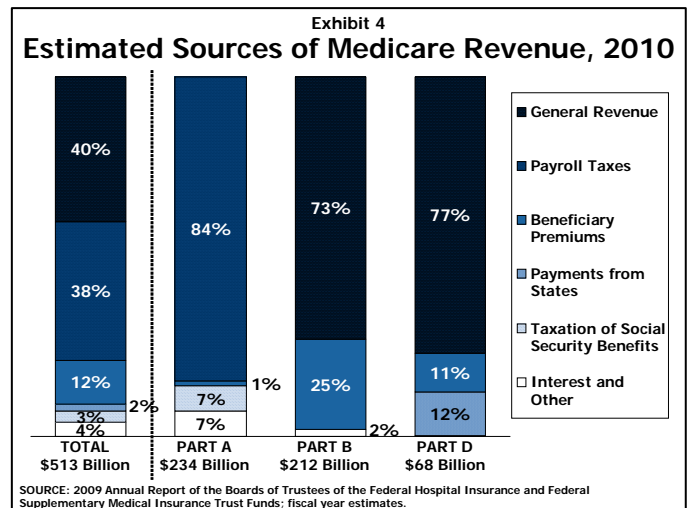
Medicare benefit spending is projected to nearly double from \$504 billion in 2010 to \$916 billion in 2019 (CBO). The annual growth in Medicare spending is influenced by factors that affect health spending generally, including both increasing volume of services and rising prices. CBO estimates that 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. Efforts to control

rising health costs across-the-board would help mitigate Medicare's future funding shortfall.

## HOW MEDICARE IS FINANCED

Medicare is financed by a combination of general revenues (40%), payroll taxes (38%), beneficiary premiums (12%), and other sources (**Exhibit 4**).

- Part A is funded mainly by a dedicated tax of 2.9% of earnings paid by employers and employees (1.45% each) deposited into the Hospital Insurance Trust Fund.
- Part B is funded by general revenues and beneficiary premiums (\$110.50 per month in 2010). However, most continue to pay the lower 2009 monthly premium (\$96.40) due to a provision preventing beneficiaries' Social Security income from declining because of no cost-of-living increase for 2010. Some beneficiaries with higher incomes (\$85,000 for individuals; \$170,000 for couples in 2010) pay a higher, income-related monthly Part B premium.
- Part C (Medicare Advantage) health plans are funded through beneficiary premiums and general revenues. They provide benefits under Parts A, B and D. The average premium for MA-PDs in 2010 is \$48 (weighted by 2009 enrollment).
- Part D is funded by general revenues, beneficiary premiums, and state payments. The average premium for PDPs in 2010 is \$39 (weighted by 2009 enrollment).



## FUTURE CHALLENGES

Looking to the future, Medicare faces a number of critical issues and challenges, but none greater than financing care for an aging population. One critical issue is that the Medicare Part A Trust Fund is projected to have insufficient funds to pay benefits as of 2017. Another critical issue relates to improving the management of care for chronically ill high-cost beneficiaries who account for a disproportionate share of Medicare spending. In addition to these fiscal challenges, Medicare faces other issues including setting fair payments to providers and plans, and providing health and financial security for an aging U.S. population.

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