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Overview

Medicare provides health and financial security for almost 42 million elderly and disabled Americans. Medicare is a social insurance program, like Social Security, that offers health coverage to eligible individuals, regardless of income or health status. People pay into Medicare throughout their working lives and are generally eligible for Medicare when they reach age 65. Now comprising 12 percent of the federal budget and 17 percent of total national health spending, Medicare is often a significant part of discussions about how to limit both the growth in federal spending and health care costs. 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 the Medicare program are likely to remain prominent in the years to come.

This chartbook presents a framework, as well as basic data, for understanding the role of Medicare today and the challenges in its future. The book is organized into the following seven sections:

Medicare Beneficiaries. Medicare is a source of health insurance coverage for 35.4 million elderly people and 6.3 million nonelderly people with permanent disabilities. With the aging and growth of the population, the number of beneficiaries more than doubled between 1966 and 2004 and is projected to double yet again to 78 million by 2030. Medicare serves a population with diverse needs and circumstances. Although the median age of Medicare beneficiaries is 73 years, 14 percent are under age 65 and another 12 percent are age 85 or older. While some have high incomes and are in fairly good health, many live on modest incomes and have multiple chronic conditions. More than half of beneficiaries have two or more chronic conditions and more than a quarter say their health status is fair or poor. More than 2 million Medicare beneficiaries live in nursing homes or other long-term care settings, a large share of whom are female and age 85 or older. One-fourth of all Medicare beneficiaries have problems with mental functioning or cognitive impairments, with substantially higher rates reported by nonelderly beneficiaries with disabilities.

Most beneficiaries rely on Social Security for the bulk of their income and are especially vulnerable to the high and rising cost of health care services. Nearly four in 10 elderly people have incomes below 200 percent of poverty—\$18,120 for individuals and \$22,836 for couples in 2004—with higher rates among Hispanic and African American beneficiaries. Compounding these income disparities, Medicare beneficiaries with lower incomes are generally in poorer health than their counterparts with higher incomes. While 43 percent of those living under the poverty level describe their own health as either fair or poor, only 17 percent of those with incomes above 300 percent of poverty do so.

Medicare Benefits and Utilization. Medicare provides coverage of basic health services, such as inpatient hospital care (through Part A, the Hospital Insurance (HI) Program) and physician services, preventive services, and outpatient care (through Part B, the Supplementary Medical Insurance Program). However, the program provides limited long-term care benefits, does not cover eyeglasses, hearing aids, or dental care, and, until 2006, does not pay for outpatient prescription drugs. Medicare-covered benefits are generally subject to deductibles and cost-sharing requirements. Because of beneficiaries' advancing age and significant health needs, most use one or more Medicare-covered services throughout the year. In 2002, 67 percent had one or more physician visits and 19 percent were hospitalized—with higher rates reported among those in relatively poor health. To encourage use of preventive medical care, the Medicare Part B deductible and coinsurance are waived for certain preventive services. In 2002, 65 percent of male Medicare beneficiaries were screened for prostate cancer, 53 percent of female Medicare beneficiaries received a mammogram, and 39 percent of female beneficiaries received a Pap smear.

Supplemental Insurance Coverage and Medicare Advantage. To help pay for benefits not covered by Medicare and to ease the burden of Medicare's relatively high cost-sharing requirements, the majority of Medicare beneficiaries—almost nine in 10—have some form of supplemental health insurance. Employer-sponsored coverage was the most common source of supplemental insurance in 2002 (covering 35 percent of non-institutionalized beneficiaries), followed by individually-purchased Medigap policies (21 percent), Medicaid (17 percent) for those with low incomes (the “dual eligibles”), and Medicare HMOs (15 percent).

In recent years, cost increases have led to the erosion of private coverage—particularly employer-sponsored retiree health benefits—and to increases in Medigap premiums, resulting in higher out-of-pocket spending by beneficiaries. Thirteen percent of beneficiaries were covered by Medicare HMOs and other Medicare Advantage (MA) plans (formerly called Medicare+Choice plans) in 2005. While enrollment in Medicare Advantage plans has been declining since the late 1990s, these plans are expected to play a greater role in Medicare in the future (although enrollment projections vary widely).

Out-of-Pocket Spending. In 2002, Medicare covered less than half (45 percent) of beneficiaries' total medical and long-term care expenses. Beneficiaries paid, on average, 19 percent of total expenses, or \$2,223, out of pocket. About half of all beneficiaries spent less than \$1,000 out of pocket, while almost 10 percent of beneficiaries spent \$5,000 or more. Out-of-pocket spending on health care increases with declining health status and advancing age and is higher for those lacking supplemental coverage.

Because Medicare has not covered prescription drugs used by beneficiaries in an outpatient setting (until the drug benefit begins in 2006), the cost of medications has been a significant concern. Out-of-pocket spending on prescription drugs by Medicare beneficiaries varies by source of supplemental coverage, reflecting differences in the generosity of benefits and variations in the health care needs of those with different sources of coverage. Between 2000 and 2004, average out-of-pocket spending on prescription drugs increased by 39 percent, from \$613 to \$1,005. Average per capita out-of-pocket spending on prescription drugs among Medicare beneficiaries is estimated to be \$1,139 in 2005, but slightly lower (\$970) once coverage under the new drug benefit begins in 2006. Almost 60 percent of beneficiaries are projected to have no or low (\$750 or less) out-of-pocket drug expenses in 2005. At the upper end of spending, 7 percent of beneficiaries are projected to have out-of-pocket drug costs of more than \$3,600.

Medicare and Prescription Drugs. Medicare beneficiaries are highly dependent on prescription drugs to manage their acute and chronic health conditions, with virtually all beneficiaries (91 percent) taking at least one medication in 2002. Despite the relatively heavy use of pharmaceuticals, nearly half of all beneficiaries lacked prescription drug coverage for at least part of the year in 2002: 18 percent of beneficiaries lacked drug coverage for the full year and another 27 percent lacked drug coverage for at least part of that year. Beneficiaries accessed full- or part-year drug coverage through a variety of sources, including employer-sponsored plans (34 percent), Medicaid (14 percent), Medicare HMOs and other managed care plans (12 percent), and individually-purchased Medigap policies (12 percent).

Medicare beneficiaries without prescription drug coverage have higher out-of-pocket drug costs and fill fewer prescriptions than those with some form of drug coverage—one-third fewer prescriptions, on average, in 2002. Average per capita drug spending among the Medicare population is expected to be \$2,864 in 2005; however, drug spending is highly skewed and concentrated among a relatively small share of beneficiaries.

Beginning in 2006, Medicare beneficiaries will have access to prescription drug coverage through private plans (Part D), and drug coverage through state Medicaid programs will end for Medicare's dual eligible beneficiaries. Assistance with premiums and cost-sharing will be available to beneficiaries with limited incomes and resources. The net federal cost of the new Medicare drug benefit is estimated to be \$724 billion between 2006 and 2015. Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, contributions from states (commonly referred to as the “clawback”), and general revenue.

Medicare Spending. In FY2004, Medicare benefit payments totaled \$295 billion, accounting for 17 percent of national health expenditures and 12 percent of the federal budget. Medicare is responsible for almost one-fifth of the \$1.4 trillion in personal health care expenditures in the U.S., but Medicare's share varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2003, Medicare paid for 30 percent of the nation's total hospital spending and 32 percent of home health care spending but less than 2 percent of prescription drug costs.

Currently, inpatient hospital services account for the largest share of Medicare benefit payments (39 percent). The composition of Medicare benefit payments will shift with the addition of prescription drug coverage in 2006. By 2010, prescription drugs are projected to account for 20 percent of Medicare benefit payments. On a per capita basis, Medicare spending has grown at a slightly slower pace, on average, than private health insurance spending. Private health insurance spending grew at an average annual rate of 10.1 percent in the period between 1970 and 2003, while Medicare spending grew at an average rate of 9.0 percent.

Medicare payments for each beneficiary enrolled in the traditional fee-for-service program averaged \$6,110 in 2002. Per capita payments for the elderly (\$6,002) were nearly \$1,500 higher than they were for nonelderly beneficiaries with disabilities that year (\$4,547). Medicare spending is highly concentrated among a minority of beneficiaries. In 2002, 7 percent of beneficiaries incurred expenditures of \$25,000 or more, accounting for just over half of program spending. In total, 12 percent of beneficiaries accounted for more than two-thirds of program spending. At the lower end, 12 percent of beneficiaries in the fee-for-service program incurred no Medicare expenditures in 2002.

Medicare Financing and Future Projections. Medicare Parts A, B, and D (beginning in 2006) are financed differently. Payroll taxes paid by workers and employers finance the majority of Part A (the Hospital Insurance (HI) Trust Fund). The Part B Supplementary Medical Insurance (SMI) Trust Fund is financed by a combination of beneficiary premiums (24 percent) and general tax revenues (most of the remainder). General revenue makes up roughly three-quarters of revenues for Part B and (beginning in 2006) Part D. In total, Medicare revenue in FY2006 will come mostly from general revenue (41 percent), payroll taxes (40 percent), and beneficiary premiums (11 percent). According to the Medicare Boards of Trustees' 2005 intermediate assumptions, total Part A spending is expected to exceed income in 2012, and the HI Trust Fund reserves are projected to be exhausted in 2020. Spending for Part B services, however, are now rising faster than spending for Part A services.

The aging of the Baby Boom generation, a reduction in the ratio of workers to beneficiaries, and other demographic and economic factors will likely play a role in the debate over additional changes in Medicare's financing in the coming years. With the aging of the population and expected increases in overall health care costs, Medicare spending is projected to grow at a rate significantly higher than that of the overall economy. Between 2000 and 2030, Medicare's share of the gross domestic product (GDP) is estimated to triple from 2.3 percent to 6.8 percent. The addition of the prescription drug benefit in 2006 accounts for about one-third of the increase.

About the data. The data presented in this chartbook come from a variety of sources. Data from the Centers for Medicare and Medicaid Services 2002 Medicare Current Beneficiary Survey are used to describe Medicare beneficiary characteristics, service utilization, supplemental coverage, and per capita spending. Prescription drug spending data from 2005 are based on analysis conducted by the Actuarial Research Corporation for the Kaiser Family Foundation. Other sources of data and analysis include the Congressional Budget Office; Kaiser Commission on Medicaid and the Uninsured; Kaiser/Commonwealth/Tufts-New England Medical Center 2003 National Survey of Seniors and Prescription Drugs; Kaiser Family Foundation/Hewitt Survey on Retiree Health Benefits; Mathematica Policy Research; Medicare Boards of Trustees; Medicare Payment Advisory Commission; National Conference of State Legislatures; Office of the Actuary within the Department of Health and Human Services; Urban Institute; and the U.S. Census Bureau.