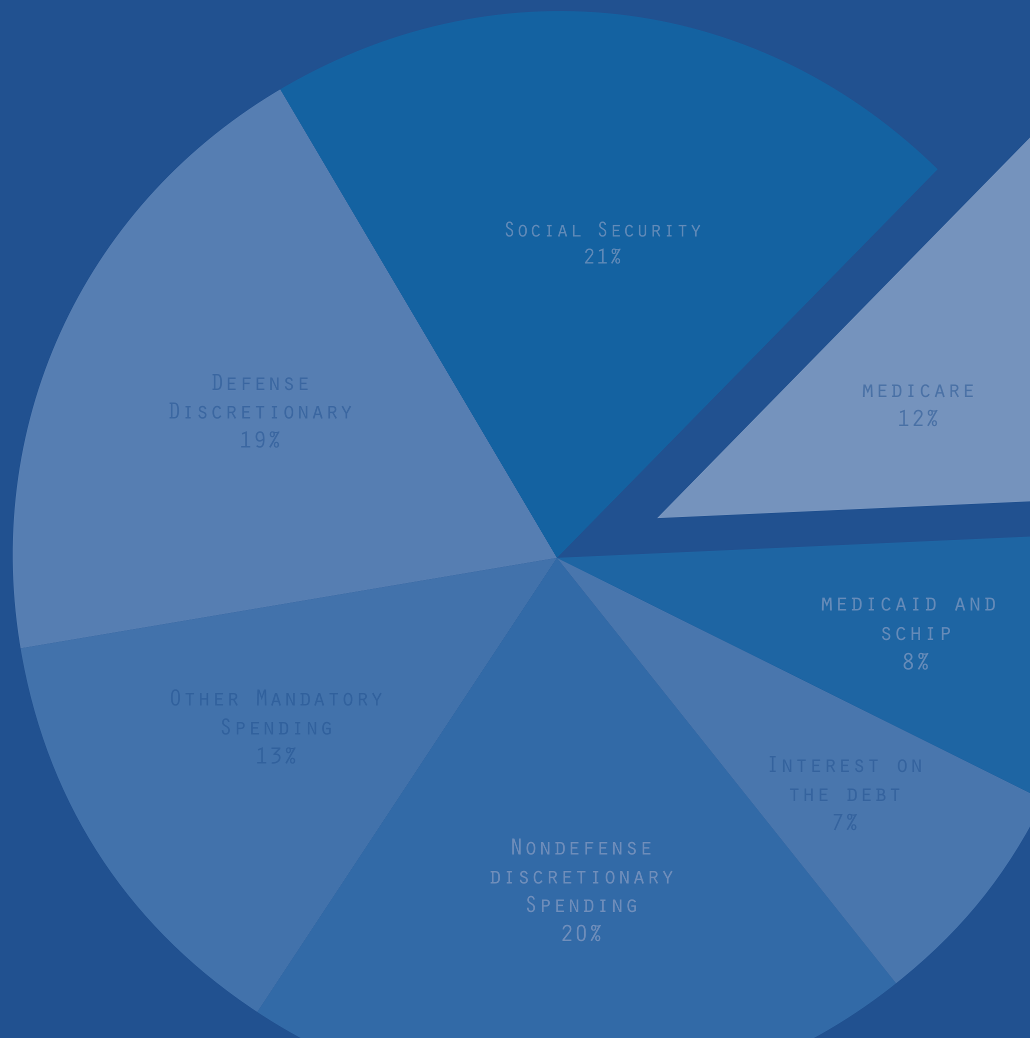
MEDICARE CHARTBOOK

THIRD EDITION • SUMMER 2005

THE HENRY J. KAISER FAMILY FOUNDATION



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THE HENRY J. KAISER FAMILY FOUNDATION

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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.

Section 1

MEDICARE BENEFICIARIES

SECTION 1: MEDICARE BENEFICIARIES

Medicare is a federally-sponsored health insurance program that provides benefits to nearly 42 million people. Most individuals become eligible when they reach age 65 and they or their spouse have made payroll tax contributions to Social Security for at least 40 quarters. Others who are under the age of 65 can become eligible if they are totally and permanently disabled and have received Social Security Disability Insurance (SSDI) payments for 24 months or if they have end-stage renal disease (ESRD).

The Medicare population is demographically diverse and includes significant numbers of individuals who are financially and medically vulnerable. Beneficiaries are predominantly white (79 percent) and female (56 percent). Those over age 85 account for 12 percent of Medicare beneficiaries. The disabled and ESRD populations represent 14 percent of all beneficiaries.

Twenty-eight percent of Medicare beneficiaries report being in fair or poor health. Those who are under age 65 with disabilities, along with African American and Hispanic beneficiaries, are more likely to describe their health status in this way. Medicare beneficiaries with lower incomes generally report poorer self-assessed health than beneficiaries with higher incomes: 43 percent of beneficiaries with incomes below 100 percent of poverty say their health is fair or poor, compared with 17 percent of those with incomes above 300 percent of poverty.

Substantial numbers of Medicare beneficiaries also live with health problems or limitations in their physical or cognitive abilities. Nearly nine in 10 beneficiaries have one or more chronic illnesses; over half report having hypertension (60 percent) or arthritis (58 percent). Roughly a quarter of all Medicare beneficiaries have a cognitive or mental impairment.

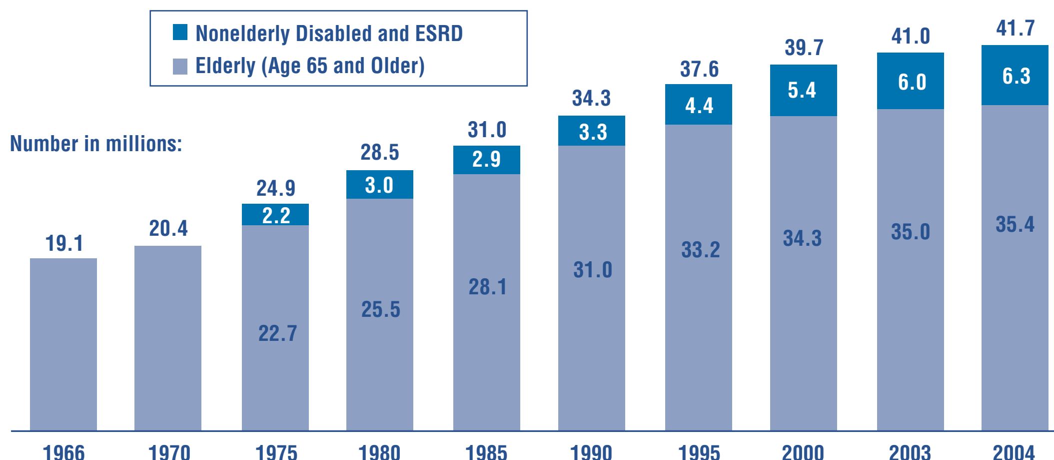
Medicare beneficiaries generally live on modest incomes and depend heavily on Social Security as a primary source of income. Ten percent of elderly people have incomes below 100 percent of the federal poverty level, while 29 percent have incomes between 100 percent and 200 percent of poverty. Poverty rates are higher among elderly women than elderly men, and among elderly African Americans and Hispanics than whites. In addition to having modest incomes, the majority of Medicare beneficiaries have limited assets: more than half had countable assets of $20,000 or less in 2002.[1]

Certain segments of the Medicare population have greater medical needs than other Medicare beneficiaries, including 7 million beneficiaries who are dually eligible for Medicare and Medicaid and approximately 2 million beneficiaries who live in a nursing home or other long-term care facility. Compared to other people with Medicare, a higher share of dually eligible beneficiaries are in fair or poor health (52 percent versus 26 percent), nonelderly and permanently disabled (37 percent versus 10 percent), and living in long-term care facilities (19 percent versus 3 percent). Long-term care facility residents have higher rates of mobility limitations and health problems, and lower incomes than beneficiaries living in the community.

Medicare beneficiaries account for 14 percent of the total U.S. population and a wide ranging share of state populations, from 7 percent in Alaska to 19 percent in West Virginia. Although people with Medicare are generally concentrated in urban communities and areas, 24 percent of beneficiaries live in rural areas. Rural beneficiaries account for more than 70 percent of the Medicare population in South Dakota, Idaho, Mississippi, Vermont, and Montana. Barriers to accessing health care services often encountered in less populous areas can pose particular challenges for Medicare beneficiaries in rural counties.

[1] Countable assets include interest and non-interest earning accounts, bonds/US securities, stocks, mutual funds, IRAs, 401k plans, keoghs, rental property, vacation property, and any other investments; but exclude home value.

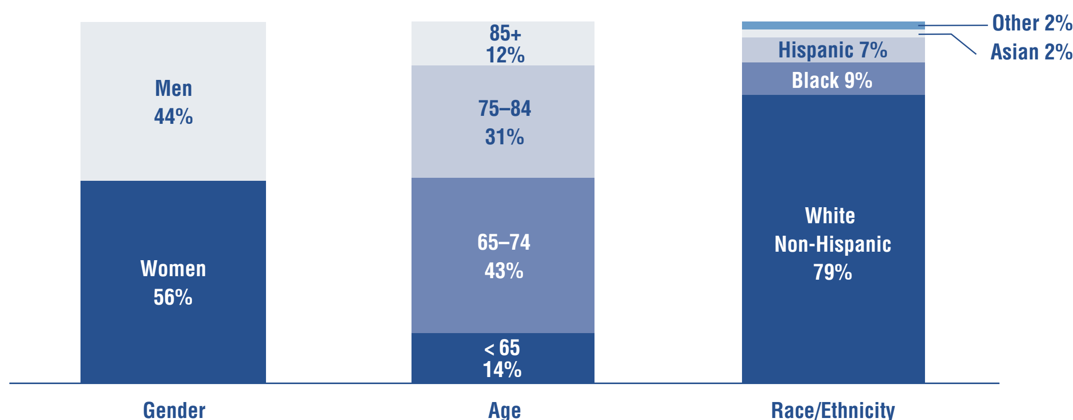
Figure 1.1
Number of Medicare Beneficiaries, 1966–2004



Note: ESRD is end-stage renal disease.
SOURCE: Centers for Medicare and Medicaid Services Data Compendium, 2003 (data through 2000); 2004 and 2005 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (data for 2003 and 2004).

Medicare is a federal health insurance program that covers 35.4 million Americans ages 65 and older and another 6.3 million people with permanent disabilities who are under age 65. With the aging and growth of the U.S. population, the number of Medicare beneficiaries more than doubled between 1966 and 2004, and is projected to double in size again by 2030 to 78 million.

Figure 1.2
Selected Characteristics of the Medicare Population, 2002

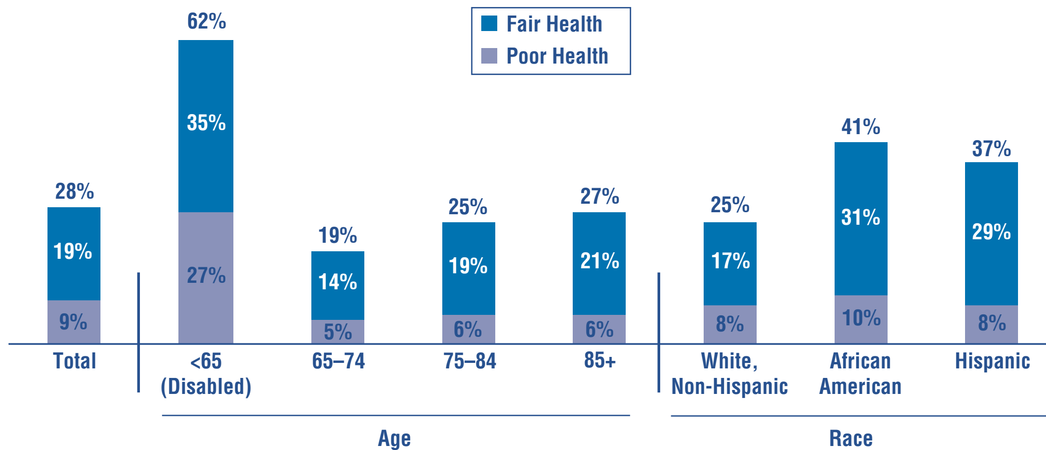


Total = 41.8 Million Medicare Beneficiaries, 2002

Note: Numbers may not sum to 100% due to rounding. Total number of Medicare beneficiaries is based on weighted number of respondents in the Medicare Current Beneficiary Survey 2002 Cost and Use file.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare serves the health needs of a diverse population that is predominantly female, white, and non-Hispanic. By age, the largest segment includes those ages 65 to 74. Beneficiaries over the age of 85, as well as members of racial and ethnic minority groups, represent growing segments of the Medicare population.

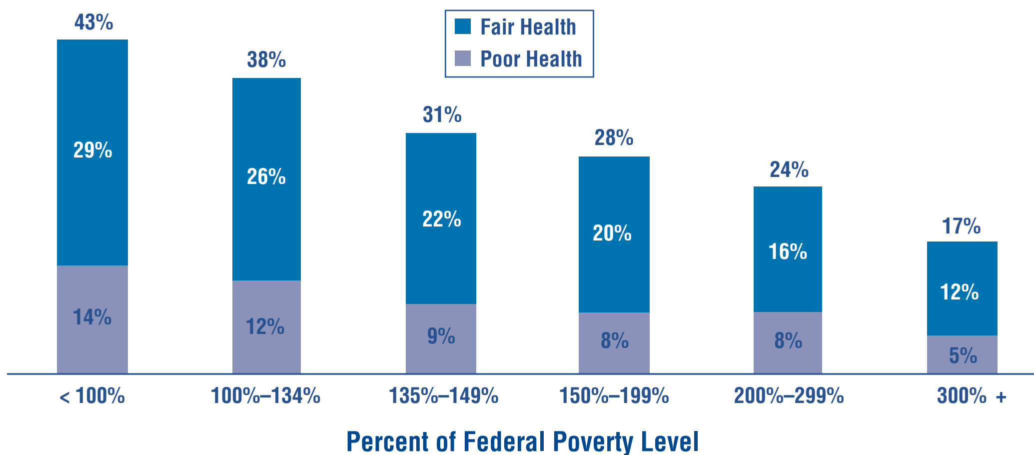
Figure 1.3
Self-Reported Health Status of Non-Institutionalized Medicare Beneficiaries, by Age and Race, 2002



Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

More than a quarter (28 percent) of non-institutionalized Medicare beneficiaries report being in fair or poor health. However, certain subgroups of the Medicare population are far more likely than others to report being in fair or poor health, including nonelderly beneficiaries with disabilities, and African American and Hispanic beneficiaries.

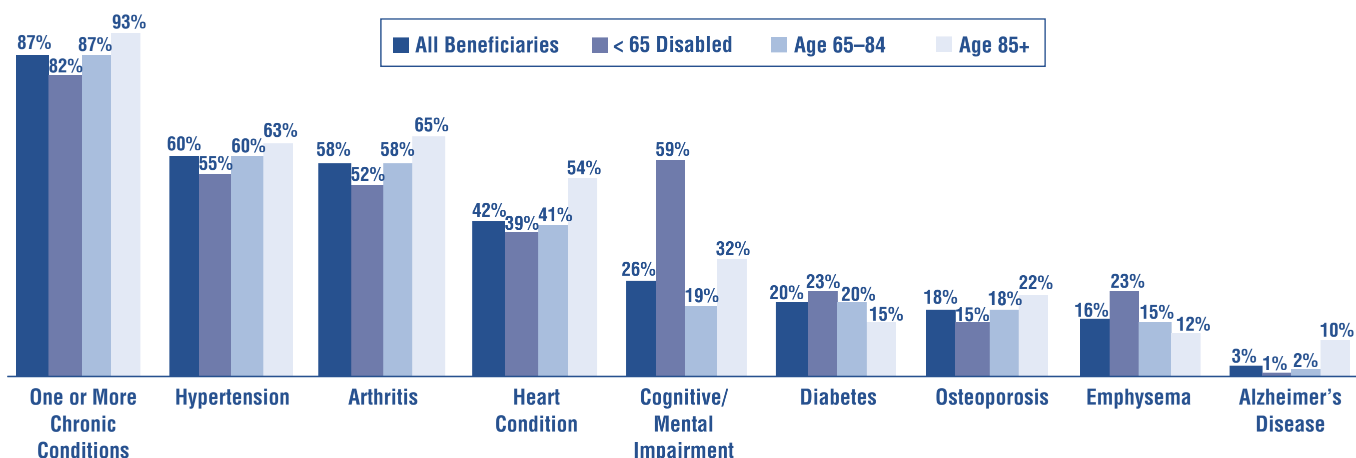
Figure 1.4
Self-Reported Health Status of Non-Institutionalized Medicare Beneficiaries, by Poverty Status, 2002



Note: In 2002, the federal poverty level was $8,860 for an individual and $11,940 for a couple. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare beneficiaries with lower incomes are generally in poorer health than those with higher incomes. While 43 percent of beneficiaries with incomes less than 100 percent of the federal 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.

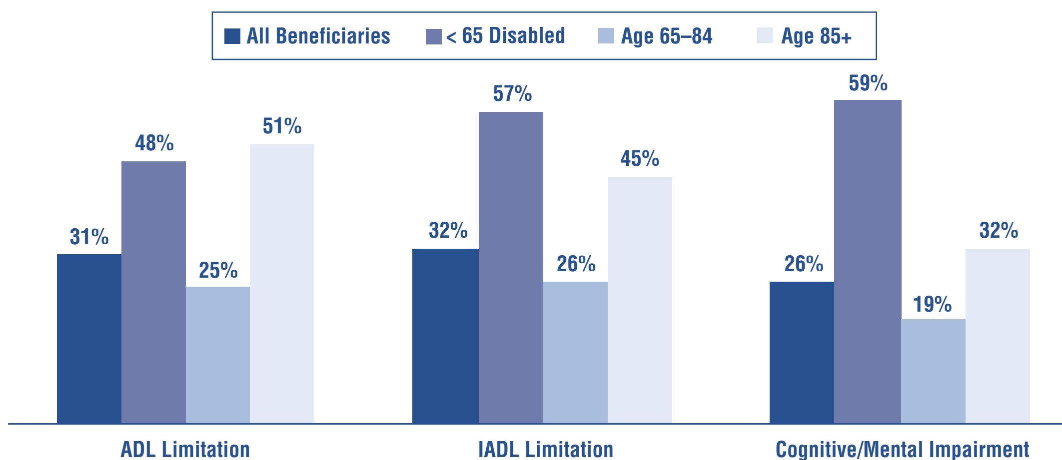
Figure 1.5
Prevalence of Chronic Conditions Among Non-Institutionalized Medicare Beneficiaries, 2002



Note: Heart condition is defined as diagnosis with hardening of arteries, angina, myocardial infarction, congestive heart failure, or problem with heart valves or heart rhythm. Cognitive/mental impairment is defined as diagnosis with mental retardation, mental disorder, or Alzheimer's disease, or having memory loss that interferes with daily activity. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Most Medicare beneficiaries report living with one or more chronic illnesses, most commonly hypertension and arthritis (reported by 60 percent and 58 percent of beneficiaries, respectively). While the prevalence of many conditions increases with age, other conditions, such as emphysema, diabetes, and cognitive/mental impairments, are somewhat more prevalent among nonelderly Medicare beneficiaries with disabilities.

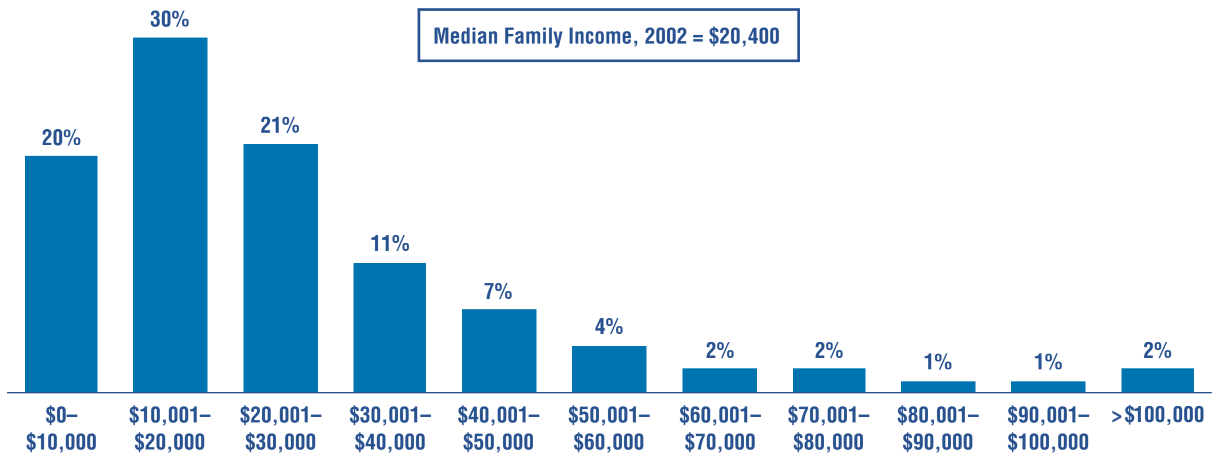
Figure 1.6
Physical and Cognitive Limitations Among the Medicare Population, 2002



Note: ADL is activity of daily living; IADL is instrumental activity of daily living. Cognitive/mental impairment is defined as diagnosis with mental retardation, mental disorder, or Alzheimer's disease, or having memory loss that interferes with daily activity.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

A significant share of people with Medicare, and in particular nonelderly people with disabilities and those age 85 or older, have functional and/or cognitive limitations. One-third of all beneficiaries are limited in their ability to handle basic activities of daily living, such as bathing and eating, and a quarter of all beneficiaries have a cognitive or mental impairment. Nearly six in 10 nonelderly beneficiaries with disabilities have a cognitive or mental impairment.

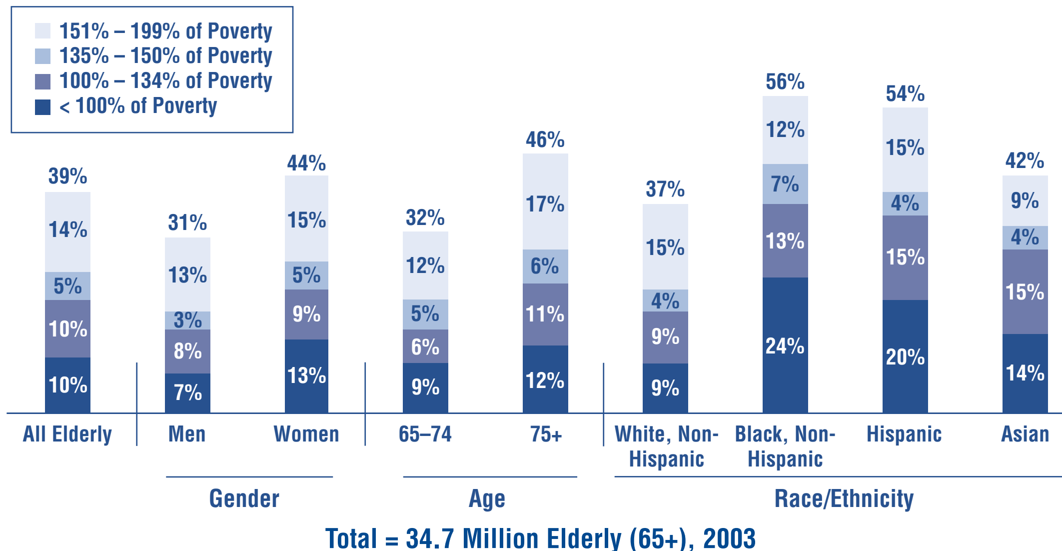
Figure 1.7
Family Income of Non-Institutionalized Medicare Beneficiaries, 2002



Note: Family income is defined as income for individuals and their spouses (if applicable). Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

The majority of Medicare beneficiaries live on modest family incomes. Half of Medicare's non-institutionalized beneficiaries have annual family incomes of $20,000 or less. Twelve percent have annual income greater than $50,000.

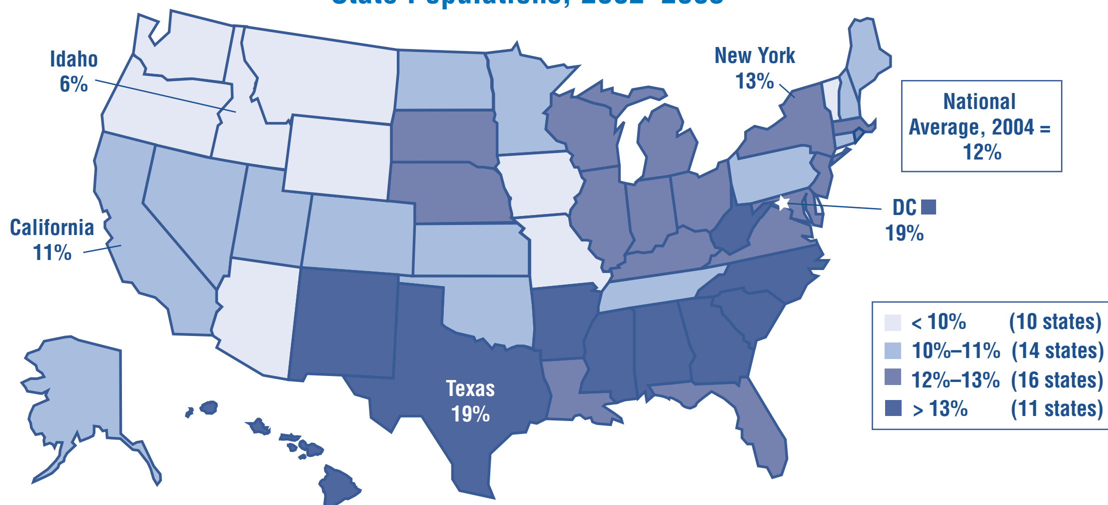
Figure 1.8
Poverty Among the Elderly Population, 2003



Note: In 2003, the federal poverty thresholds for people 65 years and older were $8,825 for an individual and $11,122 for a couple.
SOURCE: U.S. Census Bureau, Current Population Survey, 2004 Annual Social and Economic Supplement.

Four in 10 elderly Americans had income below twice the federal poverty level in 2003 ($17,650 for an individual and $22,244 for a couple that year). Poverty rates vary greatly among different segments of the elderly population. Among the elderly, women, people age 75 or older, and African Americans and Hispanics are more likely than others to have low incomes.

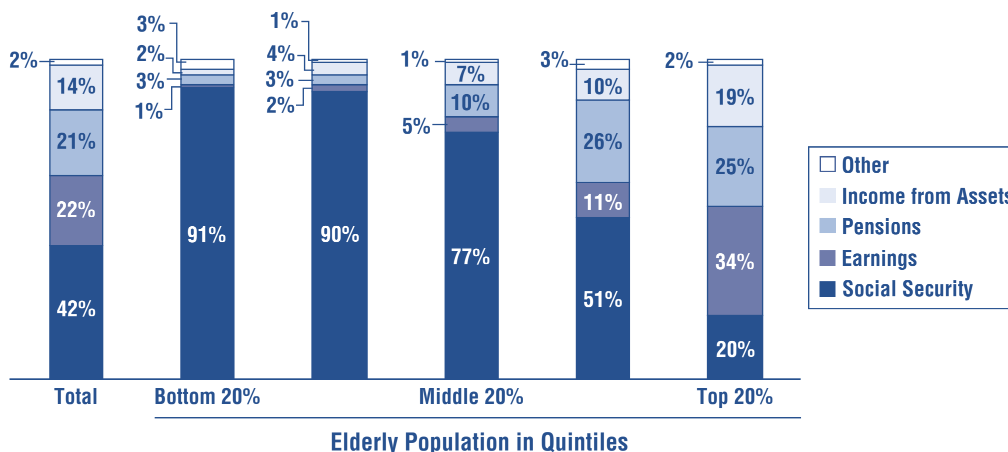
Figure 1.9
Medicare Beneficiaries Under 100% of Poverty as a Percent of State Populations, 2002–2003



Note: In 2003, the federal poverty level was $8,980 for an individual. Various states are identified to show cross-state variation.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002 and 2003 Current Population Surveys.

On average nationwide, 12 percent of Medicare beneficiaries had income less than 100 percent of poverty in 2002–2003, but the share living in poverty within each state varies. Seven of the 11 states with more than 13 percent of Medicare beneficiaries living below the federal poverty level are located in the south. Among all states, Texas and the District of Columbia have the largest proportion of Medicare beneficiaries with annual income below poverty (19 percent), while Idaho has the lowest share (6 percent).

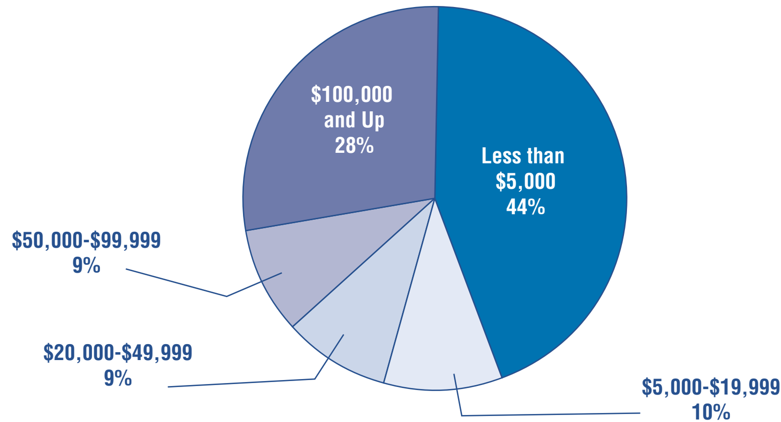
Figure 1.10
Distribution and Sources of Income Among the Elderly Population, 2003



Note: Numbers may not sum to 100% due to rounding.
SOURCE: Employee Benefits Research Institute, Income of the Elderly Population: 2003; January 2005. Based on analysis of data from the 2004 Current Population Survey.

Elderly Americans rely on Social Security, earnings, and pensions for the bulk of their annual income. For 80 percent of the elderly, Social Security comprises at least half of their annual income—an average of 91 percent for those with the lowest incomes. In contrast, earnings and pensions account for more than half of annual income for the 20 percent of elderly people with the highest incomes.

Figure 1.11
Distribution of Non-Institutionalized Medicare Beneficiaries and Asset Levels, 2002

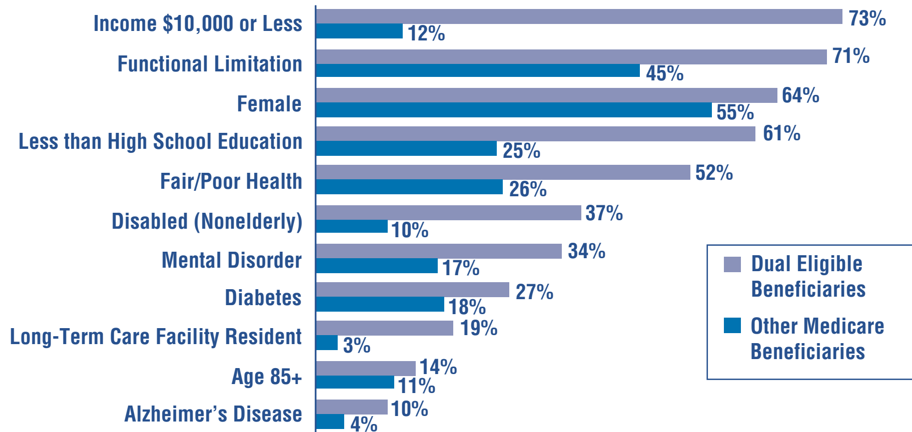


Total = 39.2 Million Non-Institutionalized Medicare Beneficiaries, 2002

Note: Countable assets include interest and non-interest earning accounts, bonds/US securities, stocks, mutual funds, IRAs, 401k plans, keoghs, rental property, vacation property, and any other investments; but exclude home value.
SOURCE: T. Rice and K. Desmond analysis of 2002 Survey of Income and Program Participation data for the Kaiser Family Foundation.

The majority of Medicare beneficiaries have limited countable assets (such as savings accounts, stocks, IRAs, and rental properties). More than half (54 percent) of beneficiaries have assets below $20,000; nearly one in five (18 percent) have assets between $20,000 and $99,999; and more than a quarter have assets totaling $100,000 or more.

Figure 1.12
Comparison of Dual Eligible and Other Medicare Beneficiaries, 2002

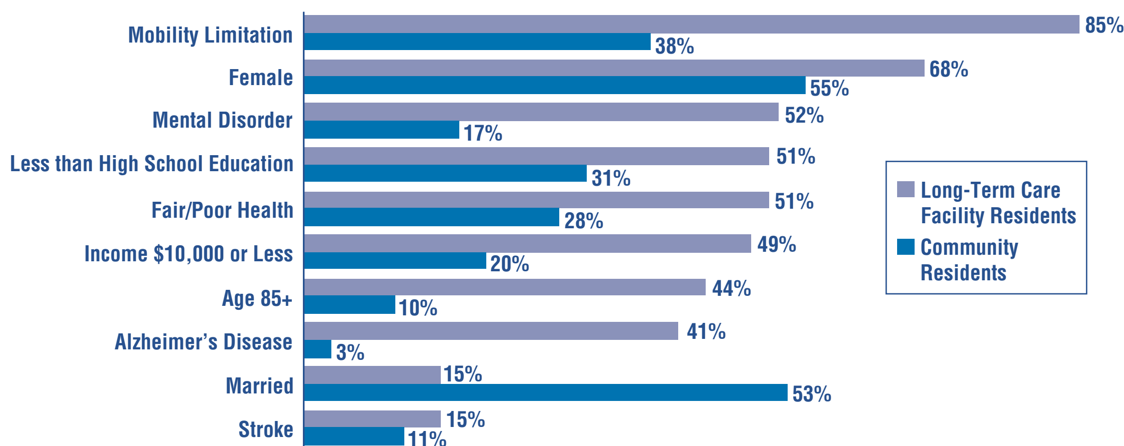


Total = 7.0 Million Dual Eligible Medicare Beneficiaries, 2002

Note: Functional limitation is defined as presence of a limitation in instrumental activities of daily living (IADLs) or one or more limitation in activities of daily living (ADLs).
Total number of dual eligibles includes beneficiaries eligible for full Medicaid benefits, along with other low-income beneficiaries eligible for assistance with Medicare premiums and cost-sharing requirements (the Medicare Savings Programs).
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2002 Access to Care File.

Medicare covers many people with limited incomes and assets or other special circumstances that make them eligible for coverage under their state Medicaid program (the "dual eligibles"). For those with very low incomes, Medicaid pays Medicare's premiums and cost-sharing requirements and covers benefits, such as long-term care and prescription drugs. (See Figure 3.7 for a description of eligibility and benefits.) Compared to other people with Medicare, a higher share of dual eligibles are in fair or poor health (52 percent versus 26 percent), are nonelderly and permanently disabled (37 percent versus 10 percent), and live in long-term care facilities (19 percent versus 3 percent).

Figure 1.13
Comparison of Medicare Beneficiaries Residing in Long-Term Care Facilities and the Community, 2002

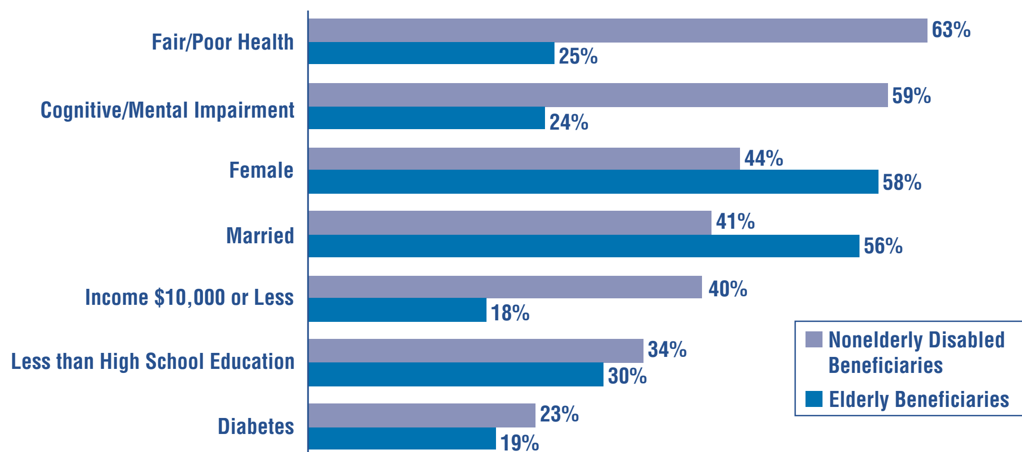


Total = 2.3 Million Long-Term Care Facility Residents, 2002

Note: Mobility limitation is defined as presence of a limitation in activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2002 Access to Care File.

While most Medicare beneficiaries reside in their own homes or other community-based settings, more than 2 million beneficiaries live in a nursing home or other long-term care facility, two-thirds of whom are women. Facility residents have higher rates of mobility limitations and lower incomes than beneficiaries living in the community.

Figure 1.14
Comparison of Nonelderly Disabled and Elderly Non-Institutionalized Medicare Beneficiaries, 2002

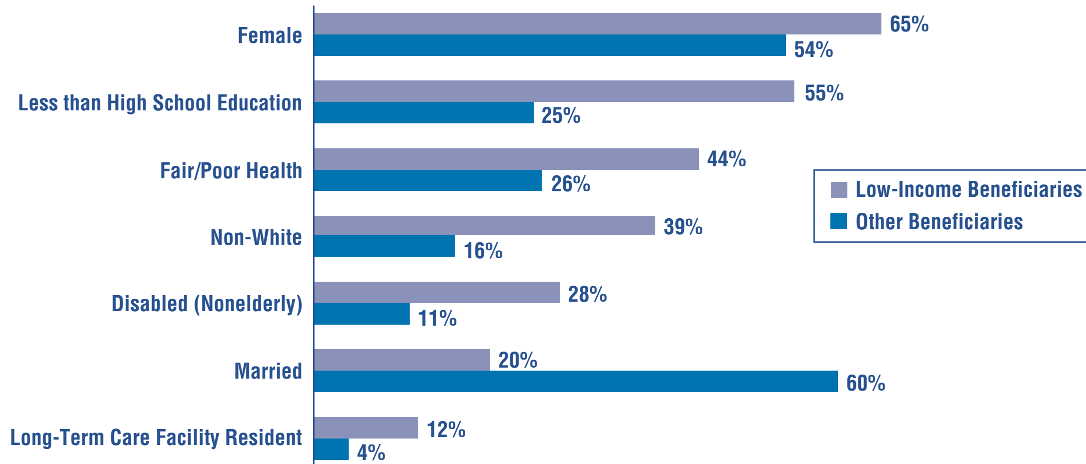


Total = 5.5 Million Non-Institutionalized Nonelderly Disabled Medicare Beneficiaries, 2002

Note: Cognitive/mental impairment is defined as diagnosis with mental retardation, mental disorder, or Alzheimer's disease, or having memory loss that interferes with daily activity. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, there were 5.5 million non-institutionalized Medicare beneficiaries under the age of 65 who were eligible for Medicare because of total and permanent disability or because they had end-stage renal disease (ESRD). Almost two-thirds of nonelderly disabled beneficiaries report their health as fair or poor, four in 10 live on annual income of $10,000 or less, and 59 percent have cognitive or mental impairments.

Figure 1.15
Comparison of Low-Income and Other Medicare Beneficiaries, 2002

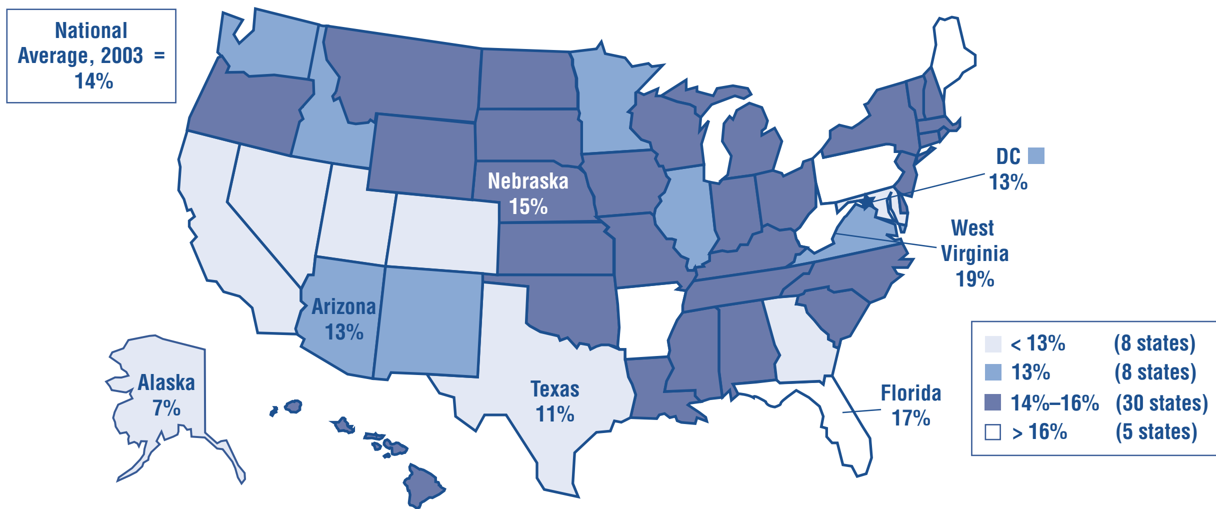


Total = 9.0 Million Low-Income Medicare Beneficiaries, 2002

Note: Low-income is defined as having annual family income of $10,000 or less, including income of individual and spouse (if applicable) only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Almost one-fourth of all elderly and disabled Medicare beneficiaries lived on annual family income of $10,000 or less in 2002—which was in the range of the federal poverty level for that year ($8,860 for individuals, and $11,940 for couples). Compared with beneficiaries at higher income levels, those with low incomes are disproportionately female (65 percent), in fair or poor health (44 percent), and African American or Hispanic (39 percent). Twelve percent of low-income beneficiaries live in long-term care facilities, compared with only 4 percent of those with higher incomes.

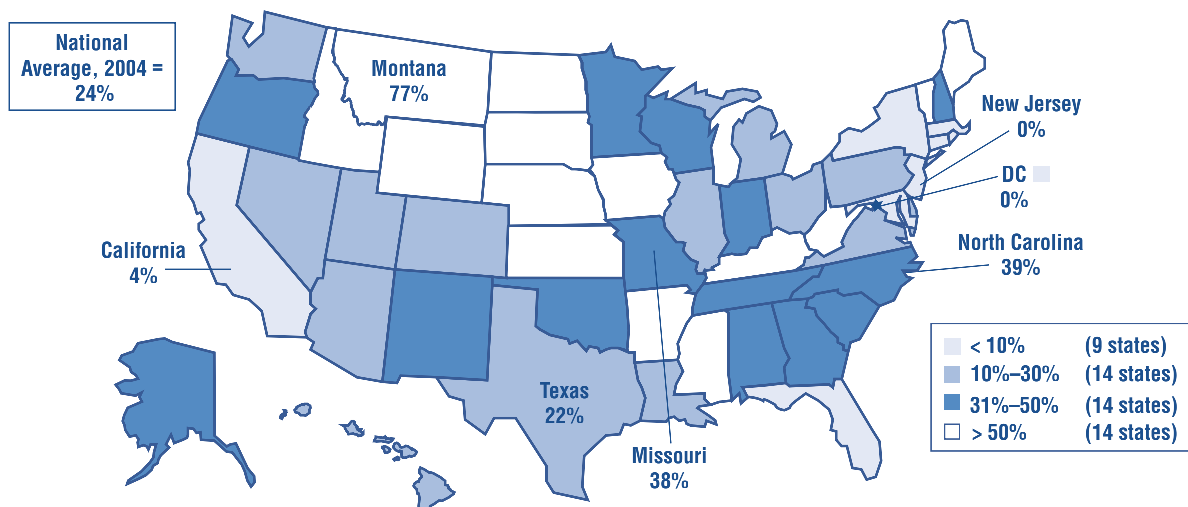
Figure 1.16
Medicare Beneficiaries as a Percent of State Populations, 2003



Note: Various states are identified to show cross-state variation.
SOURCE: Centers for Medicare and Medicaid Services Medicare State Enrollment data; and Census Bureau 2003 population estimates.

Medicare beneficiaries are approximately 14 percent of the total U.S. population, but within each state, their share of the total population varies. West Virginia has the largest proportion of state residents who are Medicare beneficiaries (19 percent), while Alaska has the smallest share (7 percent).

Figure 1.17
Percent of Medicare Beneficiaries Residing in Rural Counties, by State, 2004



Note: Rural refers to counties that are not in Metropolitan Statistical Areas (MSAs) according to the 2003 rural-urban classification scheme (RUCC) (Economic Research Service, USDA, 2003). Data are from March 2004. Various states are identified to show cross-state variation.
SOURCE: Mathematica Policy Research analysis of CMS State/County Market Penetration Files.

On average nationwide, 24 percent of Medicare beneficiaries live in rural counties. In nine states, less than 10 percent of the Medicare population lives in rural counties. (There are no rural counties in New Jersey or the District of Columbia.) In contrast, at least 50 percent of the Medicare population lives in rural counties in 14 states—with Vermont (74 percent) and Montana (77 percent) having the largest share of beneficiaries in rural areas.

Section 2

Medicare Benefits and Utilization

SECTION 2: MEDICARE BENEFITS AND UTILIZATION

Medicare consists of four parts: Part A for Hospital Insurance (HI), Part B for Supplementary Medical Insurance (SMI), Part C for Medicare Advantage (private health plans), and Part D (beginning in 2006) for prescription drugs. Medicare Part A, the Hospital Insurance program, covers inpatient hospital services, short-term care in skilled nursing facilities (SNFs), post-acute home health care, and hospice care. Most Medicare beneficiaries are not subject to a monthly premium for Part A, but typically have to pay a deductible for hospital inpatient care ($912 per spell of illness in 2005) and coinsurance for a nursing home stay lasting between 21 and 100 days ($114 per day). Medicare Part B, the Supplementary Medical Insurance program, covers physician services, outpatient hospital services, preventive services, laboratory and x-rays, and other ambulatory services. Medicare beneficiaries generally pay a monthly premium for Part B services ($78.20 in 2005) in addition to an annual deductible ($110) and other cost-sharing requirements. Medicare has limited long-term care benefits, does not cover eyeglasses, hearing aids, or dental care, and, until 2006, does not pay for outpatient prescription drugs.

Because of beneficiaries' advancing age and significant health needs, most beneficiaries use at least one Medicare service in a given year. Physician office visits are the most frequent, with 67 percent of beneficiaries reporting six or more visits in 2002. In that year, 19 percent of beneficiaries had at least one hospital stay, but hospitalization rates vary by patient characteristics, such as health status, age, and income. Those in fair or poor health, age 85 or older, with lower incomes, and living in rural areas had higher hospitalization rates than their respective counterparts. Beneficiaries with these characteristics were also found to have higher than average rates of home health care use.

Medicare covers a number of preventive services, such as flu shots, pneumococcal vaccines, prostate cancer screenings, mammograms, and Pap smears. Two-thirds of male Medicare beneficiaries report being screened for prostate cancer in 2002. Rates for preventive screenings among female Medicare beneficiaries are not quite as high. Nearly half of women with Medicare (47 percent) said they did not receive a mammogram in 2002, while over six in 10 women did not receive a Pap smear.

Figure 2.1
Medicare Part A—Hospital Insurance Benefits and Cost-Sharing Requirements, 2005

PART A

Financing
1.45% for both workers and employers
No premiums*

Benefits	Cost-Sharing
Inpatient hospital	Deductible of $912 per benefit period**
Days 1–60	No coinsurance
Days 61–90	$228 a day
Days 91–150	$456 a day
After 150 days	No benefits
Skilled nursing facility	
Days 1–20	No coinsurance
Days 21–100	$114 a day
After 100 days	No benefits
Home health	No coinsurance
Hospice	Copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care

Note: *People age 65 and older are automatically entitled to Medicare if they (or their spouse) worked for 40 quarters or more. Those who have worked up to 30 quarters may be able to get Part A coverage by paying a premium of $375 per month (2005). Those having between 30 and 39 quarters of Medicare-covered employment may be able to get Part A coverage by paying a smaller monthly premium of $206 (2005).
**A benefit period begins when a person is admitted to a hospital and ends 60 days after discharge from a hospital or a skilled nursing facility.
For more detailed information on preventive and other benefits, see http://www.Medicare.gov.
SOURCE: Centers for Medicare and Medicaid Services, *Medicare & You, 2005.*

Figure 2.2
Medicare Part B—Supplementary Medical Insurance Benefits and Cost-Sharing Requirements, 2005

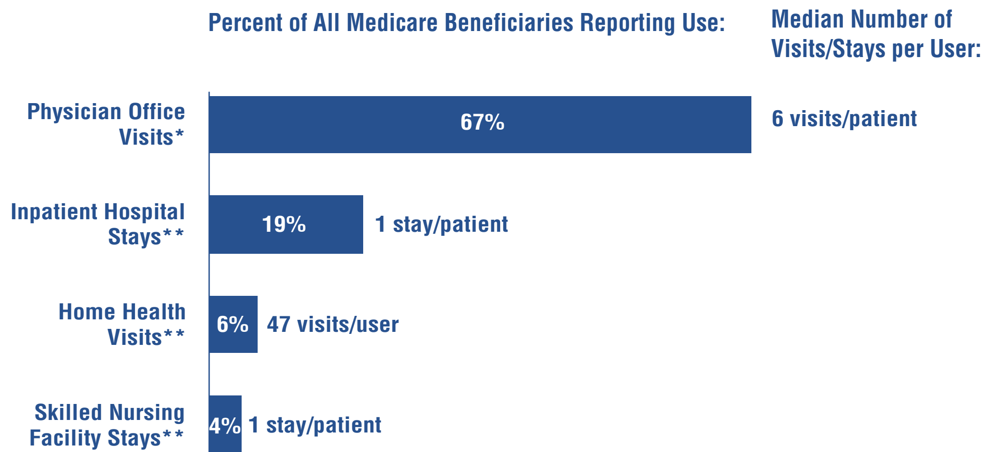
PART B

Financing
Premiums cover about 25% of Part B costs ($78.20 per month usually deducted from Social Security checks)
General revenues cover the remaining 75%

Benefits	Cost-Sharing
Deductible	$110 a year
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance plus up to 15% over Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance*
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance
Outpatient mental health services	50% coinsurance
"Welcome to Medicare" physical examination	20% coinsurance after deductible is met
Preventive services	
Annual flu shots	The Part B deductible and 20% coinsurance are waived for certain preventive services
Pneumococcal vaccines, colorectal and prostate cancer screenings, Pap smears, mammograms	
Bone mass measurement, diabetes monitoring, glaucoma screening	20% coinsurance after deductible is met

Note: *Coverage limit on Medicare outpatient therapy services ($1,590 limit per year for occupational therapy services, $1,590 limit per year for physical and speech-language therapy services combined).
For more detailed information on preventive and other benefits, see http://www.Medicare.gov.
SOURCE: Centers for Medicare and Medicaid Services, *Medicare & You, 2005.*

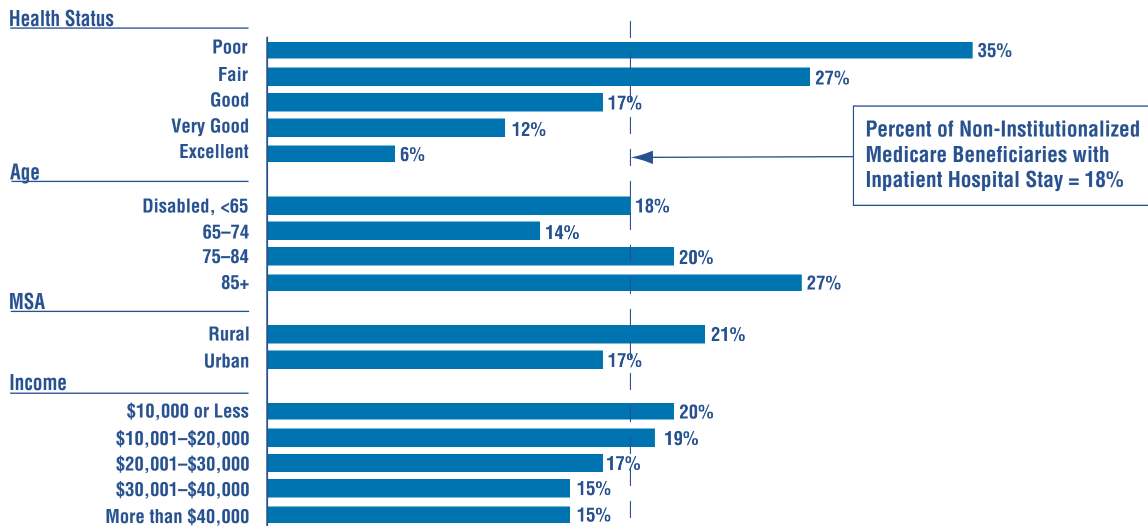
Figure 2.3
Medicare Beneficiaries' Utilization of Selected Medical and Long-Term Care Services, 2002



Note: *Percent of beneficiaries with Supplementary Medical Insurance (SMI) and/or Hospital Insurance (HI) with an office visit.
**Percent of beneficiaries with HI or both HI and SMI who had one or more stays/visits.
SOURCE: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File.

A majority of Medicare beneficiaries report using one or more Medicare-covered services during the course of a year. More than two-thirds (67 percent) of beneficiaries visited a physician in 2002, with a median number of six visits per patient. One in five reported at least one inpatient hospital stay. Only 6 percent reported using home health services, and the median number of visits per user was 47.

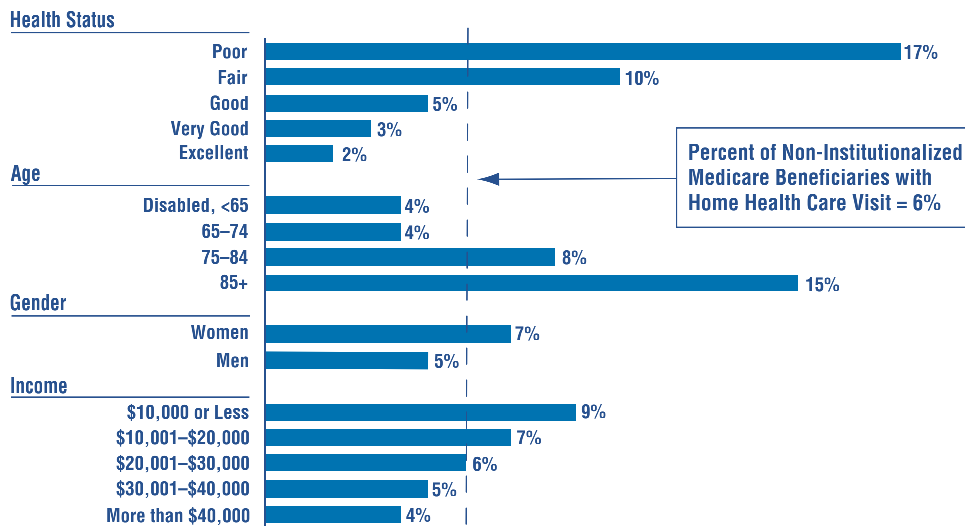
Figure 2.4
Inpatient Hospital Utilization by Non-Institutionalized Medicare Beneficiaries, by Selected Characteristics, 2002



Note: MSA is Metropolitan Statistical Area. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, 18 percent of non-institutionalized Medicare beneficiaries reported at least one inpatient hospital stay, but hospitalization rates varied by characteristics, such as health status, age, and income. A larger share of beneficiaries in fair or poor health and those age 85 or older reported a hospital stay, compared with beneficiaries who reported very good or excellent health and those who were younger. Hospitalization rates were somewhat higher among those with lower incomes and those who lived in rural areas.

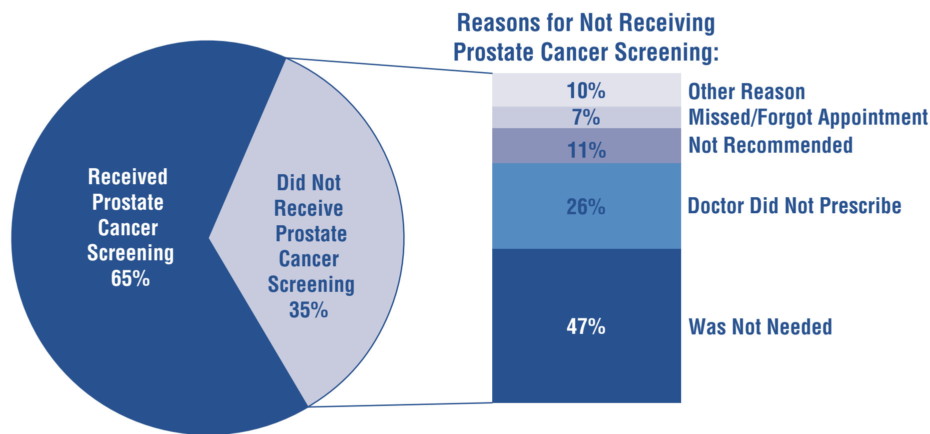
Figure 2.5
Home Health Care Utilization by Non-Institutionalized Medicare Beneficiaries, by Selected Characteristics, 2002



Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, 6 percent of Medicare beneficiaries used home health care services, but the rate of use varied substantially depending on beneficiaries' health status, age, and other circumstances. Beneficiaries in poor health and those age 85 or older had relatively high rates of home health use. Home health care use was somewhat higher among women than men and for those with lower incomes.

Figure 2.6
Preventive Service Utilization by Male Medicare Beneficiaries, 2002
Prostate Cancer Screening

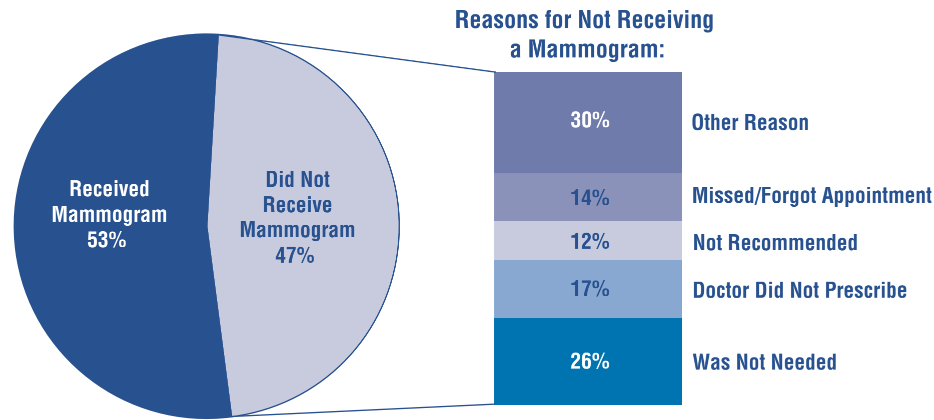


Total = 17.6 Million Male Medicare Beneficiaries, 2002

Note: Includes beneficiaries receiving either blood test or digital exam (or both) to screen for prostate cancer.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2002 Access to Care File.

Medicare covers annual prostate cancer screenings through Part B as a preventive service for all men on Medicare age 50 or older. Nearly two-thirds of male Medicare beneficiaries (65 percent) received a prostate cancer screening test in 2002. For the one-third of men who did not receive a screening test for prostate cancer, the most common reasons cited were that it was not needed or that their doctor did not prescribe it.

Figure 2.7
Preventive Service Utilization by Female Medicare Beneficiaries, 2002
Mammogram

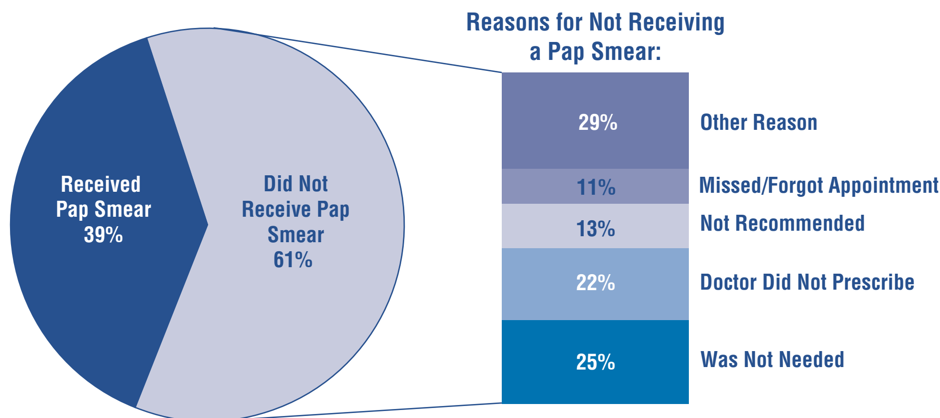


Total = 21.9 Million Female Medicare Beneficiaries, 2002

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2002 Access to Care File.

All women on Medicare age 40 or older are eligible to receive a mammogram once every 12 months, but only about half of female beneficiaries reported receiving a mammogram in 2002. Among those who did not receive a mammogram, commonly cited reasons were that the test was not needed, their doctor did not prescribe it, the patient missed or forgot the appointment, or the test was not recommended.

Figure 2.8
Preventive Service Utilization by Female Medicare Beneficiaries, 2002
Pap Smear



Total = 21.9 Million Female Medicare Beneficiaries, 2002

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2002 Access to Care File.

All women on Medicare are covered for a Pap smear once every 24 months (or once every 12 months if at high risk for cervical or vaginal cancer, or if they are of childbearing age and have had an abnormal Pap test in the past 36 months). Six in 10 female Medicare beneficiaries did not receive a Pap smear in 2002. The most commonly cited reasons were that the test was not needed or their doctor did not prescribe it.

Section 3

Supplemental Insurance Coverage and Medicare Advantage

SECTION 3: SUPPLEMENTAL INSURANCE COVERAGE AND MEDICARE ADVANTAGE

Most Medicare beneficiaries (88 percent) have some type of supplemental insurance coverage to help pay for Medicare's cost-sharing requirements and for benefits currently not covered by Medicare. Employer-sponsored coverage is the most common source of supplemental insurance (held by 35 percent of all non-institutionalized beneficiaries in 2002), followed by individually-purchased Medigap policies (21 percent), and Medicaid (17 percent) for those with extremely low incomes.

These sources of coverage vary by beneficiaries' income. More than half (56 percent) of beneficiaries with incomes of $10,000 or less have Medicaid coverage, while only 8 percent of this group has employer-sponsored coverage. Poorer beneficiaries are also among those most likely to have no coverage beyond traditional fee-for-service Medicare. Thirteen percent of beneficiaries with incomes of $10,000 or less and 17 percent of beneficiaries with incomes between $10,001 and $20,000 rely solely on Medicare, while only 6 percent of those with incomes of more than $40,000 lack supplemental insurance coverage.

Employer-Sponsored Retiree Health Coverage. In recent years, employer-sponsored retiree health coverage has eroded as health care costs have climbed, particularly costs for prescription drugs. Between 1988 and 2004, the share of large employers offering retiree health benefits fell from 66 percent to 36 percent. Employers that continue to provide coverage have made changes in the benefits they offer to limit their liability, including increasing retiree contributions to premiums, raising copayments or coinsurance for drugs and other health care services, providing access-only to health benefits with retirees paying 100 percent of costs, and eliminating coverage for *future* retirees. Most large employers predict continued cutbacks in the future, particularly if retiree health costs continue to rise at double-digit rates.

Medicaid. For more than 6 million Medicare beneficiaries with extremely low incomes, Medicaid pays Medicare's premiums and cost-sharing requirements and covers benefits, such as long-term care and prescription drugs (until Medicare Part D drug coverage begins in 2006). These beneficiaries are known as "full-benefit dual eligibles." While dual eligibles are a fairly small share of the Medicare and Medicaid populations, they account for a sizeable share of the dollars spent on benefits in each program because they tend to be sicker and require more costly health care than non-dual eligible beneficiaries. Through the Medicare Savings Programs, other Medicare beneficiaries with limited income and resources who do not qualify for full Medicaid benefits may be eligible for financial assistance from Medicaid with Medicare's Part B premium and cost-sharing requirements.

Medigap. Medicare beneficiaries can purchase a Medigap policy to supplement Medicare's traditional benefits, but these policies vary widely in the services they cover. Although federal legislation in 1990 limited Medigap coverage to 10 standard policies, one-third of all policies currently held are non-standard because they were issued prior to the reform. Among standard policies, Plans C and F are the most common, accounting for 23 percent and 37 percent of all standard Medigap policies held in 2001, respectively. Plans H, I, and J are the only Medigap policies that include prescription drug coverage, but only 9 percent of beneficiaries with a Medigap policy have one of these plans. Beginning in 2006, Medigap insurers will not be allowed to issue any new policies that include drug coverage, but two new packages of benefits (Plans K and L) will be available that provide coverage for catastrophic medical expenses.

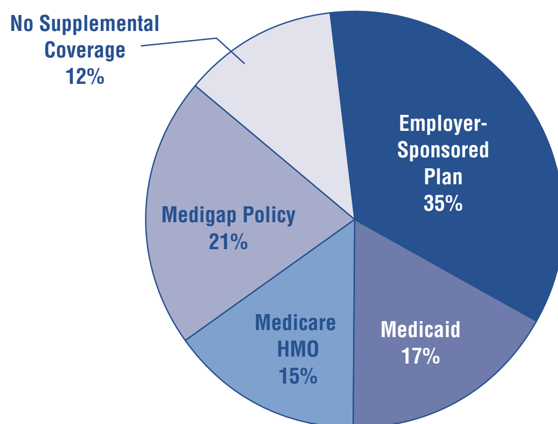
Medicare Advantage. In 2005, 13 percent of Medicare beneficiaries are covered under a Medicare Advantage (MA) (formerly Medicare+Choice) plan, primarily health maintenance organizations (HMOs). Although HMOs have been an option under Medicare since the 1970s, the Balanced Budget Act (BBA) of 1997 expanded the role of private plans to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. To date, HMOs remain the most prevalent option in the Medicare Advantage program. Enrollment in MA plans varies widely across states. Less than 1 percent of Medicare beneficiaries are enrolled in MA plans in 17 states, while at least 20 percent are enrolled in Arizona, California, Colorado, Oregon, Pennsylvania, and Rhode Island. Nationwide, more than one in four Medicare Advantage enrollees live in California.

Overall MA plan participation and beneficiary enrollment have fluctuated in recent years. After a period of rapid growth between 1992 and 1998, the number of participating plans declined by half. In 2005, there are 179 Medicare HMOs with 4.8 million enrollees, down from a high of 6.3 million enrollees in 2000. Declining plan participation has been largely attributed to limited increases in Medicare payments to plans, increased administrative responsibilities, provider turnover in managed care networks, and other business concerns.

The Medicare Modernization Act (MMA) of 2003 made a number of changes to the MA program including increasing aggregate payments to plans, creating new regional PPOs that can operate in any of the 26 Medicare Advantage regions, and establishing a $10 billion stabilization fund that may be drawn upon to promote PPO participation on a regional basis. Private plans are expected to play a greater role in Medicare in the future, although enrollment projections vary widely. The Department of Health and Human Services estimates that by 2013, 30 percent of Medicare beneficiaries will be enrolled in Medicare Advantage plans, while the Congressional Budget Office projects an enrollment rate of 16 percent.

Supplemental Coverage/Medicare Advantage

Figure 3.1
Sources of Supplemental Insurance Coverage Among Medicare Beneficiaries, 2002

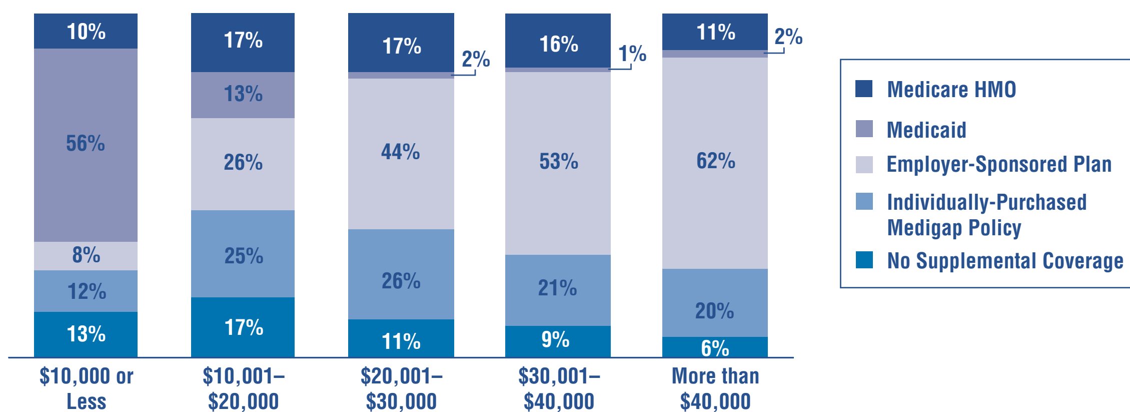


Total = 41.8 Million Medicare Beneficiaries, 2002

Note: Total number of Medicare beneficiaries is based on weighted number of respondents in the Medicare Current Beneficiary Survey 2002 Cost and Use file.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Most Medicare beneficiaries (88 percent) have supplemental health insurance coverage to help pay Medicare's cost-sharing requirements and pay for services not covered by Medicare. This coverage comes from a range of sources, including employer-sponsored insurance (covering 35 percent of all beneficiaries), individually-purchased Medigap policies (21 percent), Medicaid (17 percent), and HMOs and other Medicare Advantage plans (15 percent).

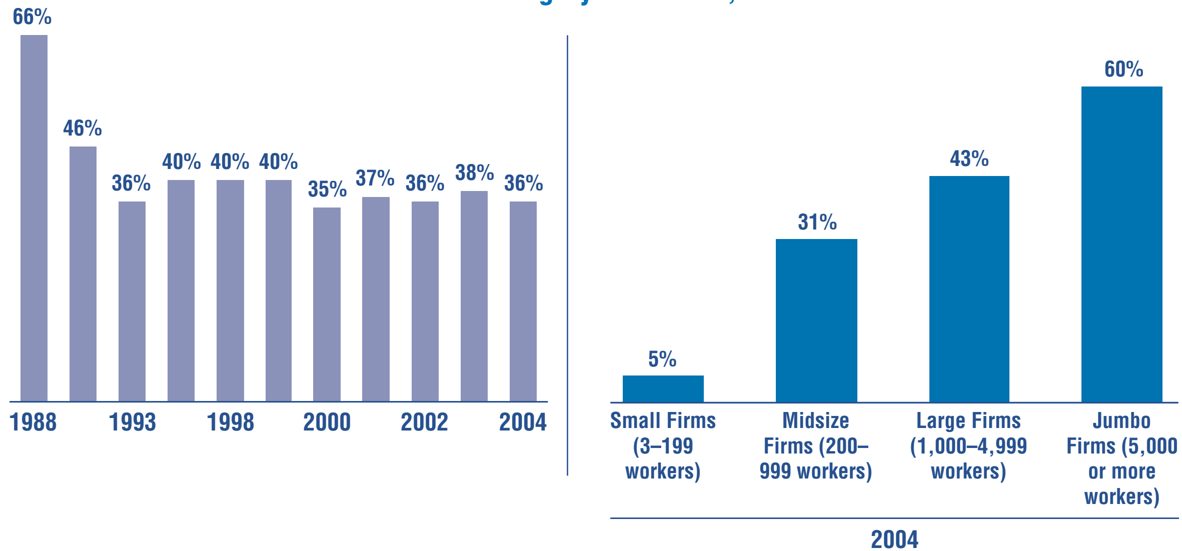
Figure 3.2
Primary Source of Supplemental Insurance Coverage Among Medicare Beneficiaries, by Income, 2002



Note: Numbers may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Supplemental insurance coverage varies greatly by beneficiaries' income, with lower-income beneficiaries less likely to have coverage to supplement Medicare. Medicaid provides supplemental coverage for over half (56 percent) of Medicare beneficiaries with the lowest incomes ($10,000 or less), while employer-sponsored coverage is the primary source of supplemental insurance for beneficiaries with the highest incomes (more than $40,000), covering 62 percent of this group.

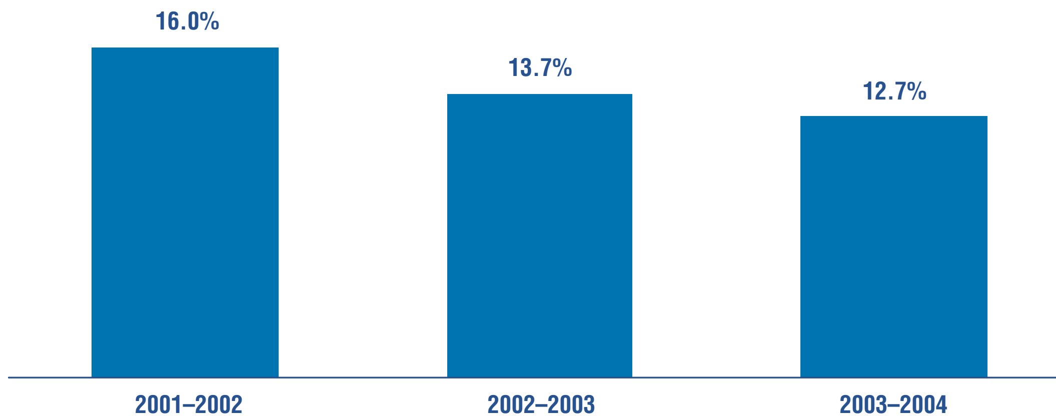
Figure 3.3
Percent of Large Employers Offering Retiree Health Benefits, 1988-2004, and Offering by Firm Size, 2004



Note: Large employers include firms with 200 or more workers.
SOURCE: Kaiser/HRET Employer-Sponsored Health Benefits, 2004.

The share of large employers providing health coverage to their retirees fell from 66 percent in 1988 to 36 percent in 2004, a trend which is expected to reduce the number of retirees with such coverage in the future. The share of employers that offer retiree health benefits varies substantially by firm size. Thirty-six percent of firms with 200 or more employees offer retiree health benefits, compared to just 5 percent of small firms (those with fewer than 200 employees).

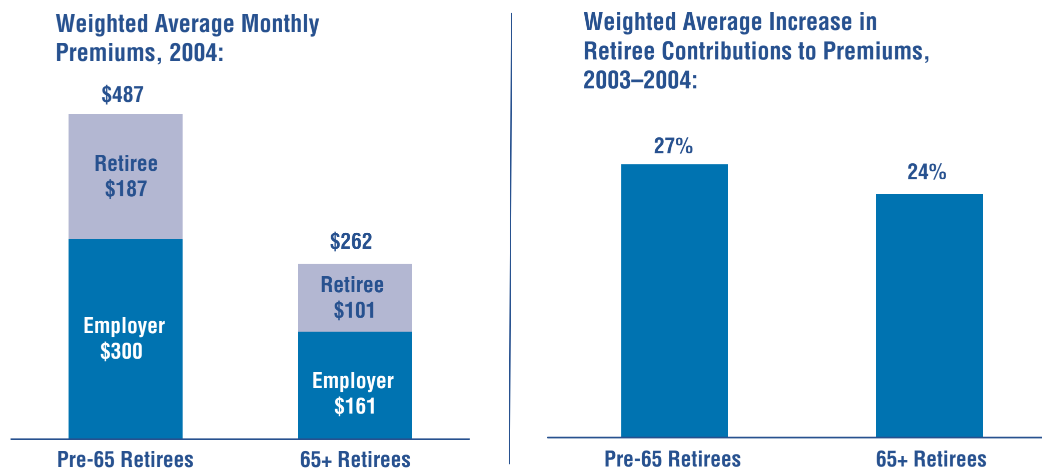
Figure 3.4
Average Increase in Total Retiree Health Costs, 2001–2004



SOURCE: Kaiser/Hewitt Survey on Retiree Health Benefits, 2002, 2003, and 2004.

Despite ongoing efforts to manage the cost of retiree health benefits, the total cost of providing these benefits has increased rapidly in recent years. Large, private-sector employers (with 1,000 or more employees) offering retiree health benefits report that retiree health costs have risen at double-digit rates in each of the last three years—increasing by an estimated 12.7 percent between 2003 and 2004.

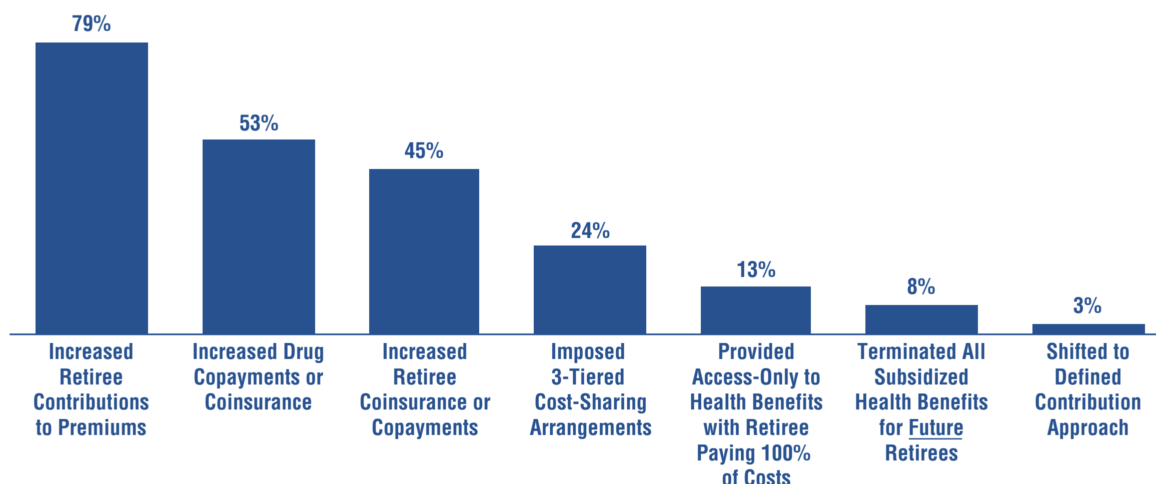
Figure 3.5
Average Monthly Premiums for New Retirees, 2004



Note: Includes firms that do not require retiree contributions. Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits. Premiums for retiree-only coverage for full-time employees retiring on or after January 1, 2004 (new retirees), in plans with the largest number of enrolled retirees.
SOURCE: Kaiser/Hewitt 2004 Survey on Retiree Health Benefits, December 2004.

Retirees of large private-sector firms experienced double-digit increases in premium contributions between 2003 and 2004. A typical worker under the age of 65 who retired in 2004 would pay $2,244 in premiums annually ($187 per month), which is 27 percent more than a pre-65 worker who retired in 2003. A typical Medicare-eligible worker (age 65 or older) who retired in 2004 would pay $1,212 in premiums annually ($101 per month), which is 24 percent more than they would have paid in 2003.

Figure 3.6
Percent of Large Private-Sector Employers Making Changes to Retiree Health Benefits in the Past Year



Note: Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2004 Survey on Retiree Health Benefits, December 2004.

Employers offering retiree health benefits have made substantial changes to manage rising costs. The majority of firms have increased retiree contributions to premiums (79 percent) and nearly half (45 percent) have increased general cost-sharing requirements. Prescription drug costs also remain a major focus for employers, with just over half (53 percent) reporting that they have recently increased copayments or coinsurance amounts for prescription drugs.

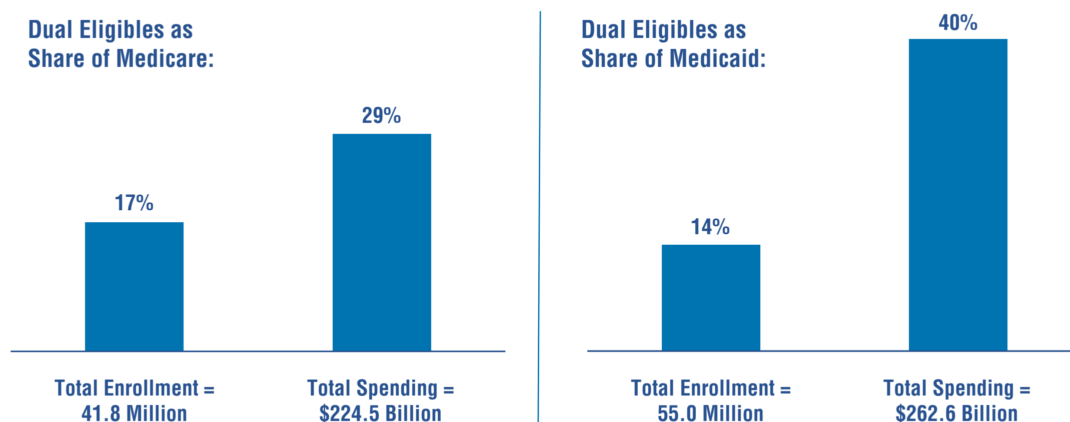
Figure 3.7
Medicaid Eligibility and Benefits for Medicare Beneficiaries, 2005

Pathway to Eligibility	Income Eligibility	Asset Limit Individual/Couple	Medicaid Benefits	Medicare Premiums & Cost-Sharing
Mandatory Coverage				
SSI Cash Assistance*	≤ 74% of poverty (SSI income eligibility)	$2,000 $3,000	✓	✓
Qualified Medicare Beneficiary (QMB)	≤ 100% of poverty	$4,000 $6,000		✓
Specified Low-Income Beneficiary (SLMB)	100%–120% of poverty	$4,000 $6,000		premium only
Optional Coverage				
Medically Needy	Individuals who spend income down to a specified level	$2,000 $3,000	✓**	✓
Poverty Level	≤ 100% of poverty	$2,000 $3,000	✓	✓
Special Income Rule for Nursing Home Residents	Institutionalized individuals with income < 300% of the SSI level	$2,000 $3,000	✓	✓
HCBS Waivers	Must be eligible for institutional care		✓	✓

Note: *States that elect the so-called "(209b)" option can set lower levels.
**Medicaid benefits may be more limited than for SSI.
SOURCE: Kaiser Commission on Medicaid and the Uninsured.

Medicare beneficiaries can obtain Medicaid through different eligibility pathways and receive varying levels of assistance. Medicare's poorest beneficiaries receive assistance with Medicare premiums and cost-sharing and coverage of Medicaid benefits, such as prescription drugs (until 2006), dental services, and long-term care. Those with incomes or resources just above the federal poverty level receive more limited assistance, primarily coverage of Medicare premiums.

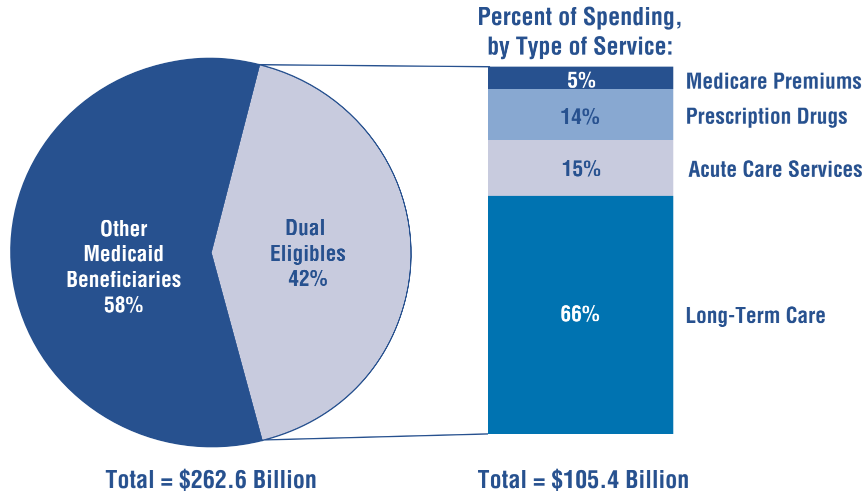
Figure 3.8
Dual Eligibles as a Share of Medicare and Medicaid Enrollment and Spending, 2002–2003



SOURCE: Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2001 MSIS data applied to CMS-64 FY2003 data.

Medicare beneficiaries who also are enrolled in their state Medicaid program, known as "dual eligibles," comprise a relatively small share of the Medicare and Medicaid populations but account for a disproportionate share of spending by both programs. In 2003, 14 percent of the 55 million people with Medicaid coverage were dual eligibles, accounting for 40 percent of total Medicaid benefit spending. Dual eligibles were 17 percent of the Medicare population in 2002, and accounted for 29 percent of total Medicare spending.

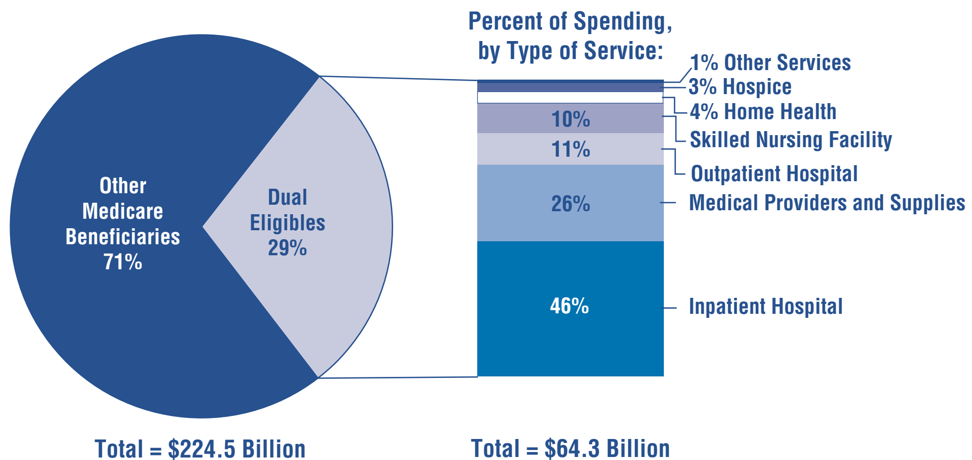
Figure 3.9
Medicaid Expenditures for Dual Eligibles, FY2003



SOURCE: Urban Institute estimates for KCMU based on an analysis of 2001 MSIS and Financial Management reports (CMS Form 64 FY2003).

Medicaid spending for dual eligibles totaled $105.4 billion in FY2003. The majority of Medicaid expenditures for dual eligibles are for long-term care services (66 percent); 15 percent of spending on dual eligibles is for acute care services, 14 percent of spending is for prescription drugs, and 5 percent is for payment of Medicare premiums for dual eligibles.

Figure 3.10
Medicare Expenditures for Dual Eligibles, 2002



Note: Other services include prescription drugs, dental, and long-term care facility stays.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare spending for dual eligibles totaled $64.3 billion in 2002. The majority of Medicare expenditures for dual eligibles are for inpatient hospital events and services (46 percent); 26 percent of spending on dual eligibles is for medical provider services and supplies, 11 percent for outpatient hospital services, 10 percent for short-term skilled nursing facility stays, and 4 percent for home health visits.

Figure 3.11
Standard Medigap Plan Benefits

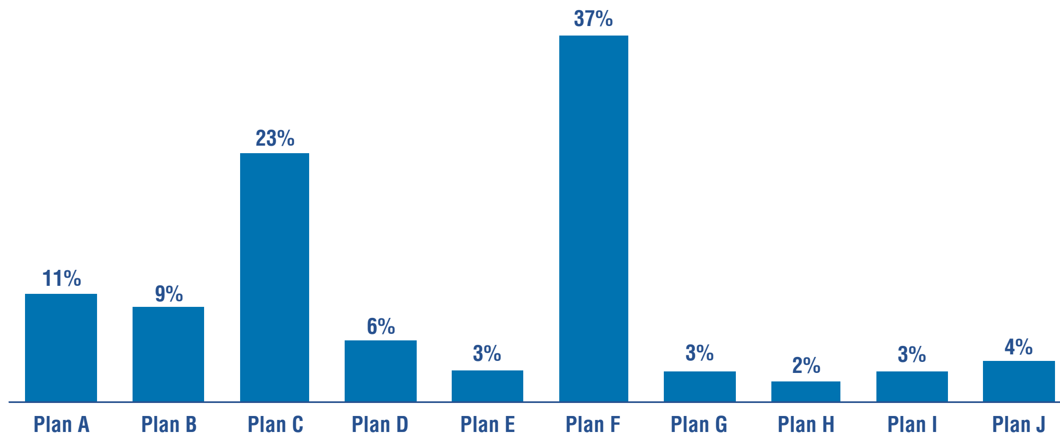
Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F[a]	Plan G	Plan H	Plan I	Plan J[a]	Plan K[b]	Plan L[b]
Coverage for:												
– Part A coinsurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
– 365 additional hospital days during lifetime	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
– Part B coinsurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
– Blood products	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
Skilled nursing facility coinsurance			100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
Part A deductible		100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
Part B deductible			100%			100%				100%		
Part B balance billing (excess charges)[c]						100%	80%		100%	100%		
Foreign travel emergency			100%	100%	100%	100%	100%	100%	100%	100%		
Home health care				100%			100%		100%	100%		
Prescription drugs (not available for purchase after 2005)								50%[d]	50%[d]	50%[d]		
Preventive medical care				100%						100%		
Part A hospice coinsurance											50%	75%
Part B Medicare-covered preventive benefits											100%	100%
Medicare cost-sharing out-of-pocket maximum											X[e]	X[e]

Note: Amount in table is the plan's coinsurance amount for each covered benefit after beneficiary pays deductibles or cost-sharing amounts, where applicable.
[a] Plans F and J also have a high-deductible option that requires the beneficiary to pay $1,730 (the deductible in 2005) before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs ($250 per year for plan J) and foreign travel emergency ($250 per year for plans F and J) which are required in these plans with or without the high-deductible option.
[b] Plans K and L will be available for purchase beginning in 2006.
[c] Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15% higher than the Medicare payment rate.
[d] Plans H and I pay 50% of drug charges up to $1,250 per year and have a $250 annual deductible. Plan J pays 50% of drug charges up to $3,000 per year and has a $250 annual deductible.
[e] Plan K pays all covered items at 100% after beneficiary pays $4,000 out of pocket. Plan L pays all covered items at 100% after beneficiary pays $2,000 out of pocket.
SOURCE: Medicare Payment Advisory Commission, Report to Congress: Assessing Medicare Benefits, June 2002; Centers for Medicare and Medicaid Services, Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare, April 2005.

In 2002, 21 percent of beneficiaries reported having an individually-purchased private health insurance policy to supplement Medicare, known as Medigap. Two-thirds of Medigap policies conform to one of 10 standard benefit packages (Plans A through J). Beginning in 2006, Medigap insurers will not be allowed to issue new policies that include drug coverage (Plans H, I, and J). Two new packages of benefits that offer catastrophic coverage (Plans K and L) will be available.

Supplemental Coverage/Medicare Advantage

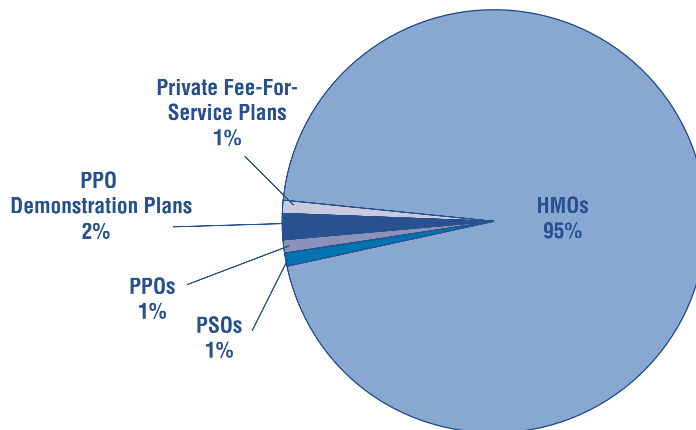
Figure 3.12
Enrollment in Standard Medigap Plans, 2001



SOURCE: Medicare Payment Advisory Commission analysis of 2001 Medicare Supplemental Exhibits from the National Association of Insurance Commissioners.

Of the 10 standardized Medigap policies, Plans C and F are the most popular, accounting for 23 percent and 37 percent of all standard Medigap policies held in 2001, respectively. These policies pay most of Medicare's cost-sharing requirements but do not cover prescription drugs. Plans H, I, and J include some drug coverage but are only a small share (9 percent) of Medigap policies held.

Figure 3.13
Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2005

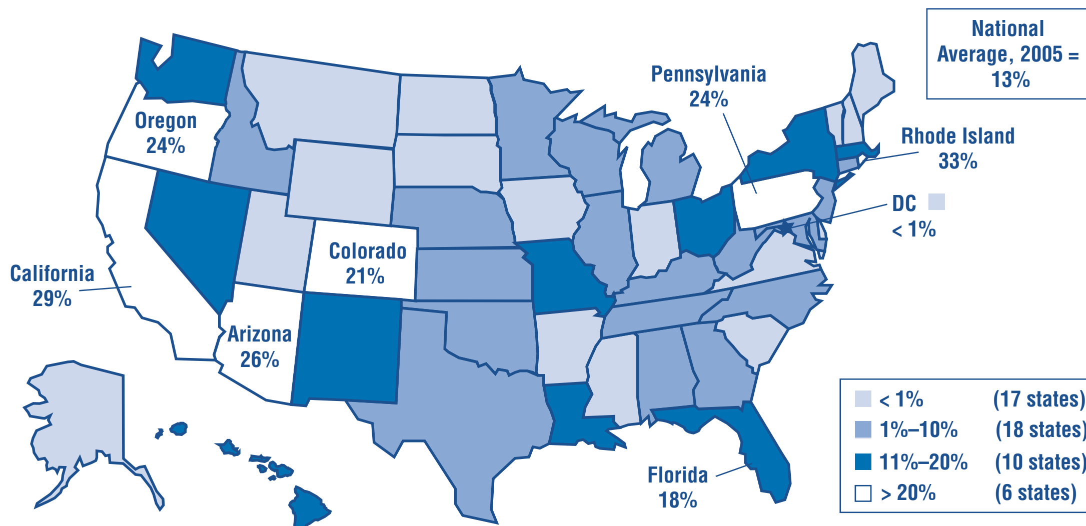


Total = 4.9 Million Medicare Beneficiaries in Medicare Advantage Plans, 2005

Note: Total includes approximately 100,000 beneficiaries enrolled in the PPO demonstration plans.
SOURCE: Mathematica Policy Research, Inc. analysis of CMS Geographic Service Area File for AARP Public Policy Institute, January 2005.

Nearly 5 million Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans. A majority of MA enrollees are in local Medicare HMOs, which have been an option under Medicare since the 1970s. The Balanced Budget Act (BBA) of 1997 expanded the types of private plans to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and private fee-for-service (PFFS) plans, but a relatively small share of beneficiaries are enrolled in these plans currently.

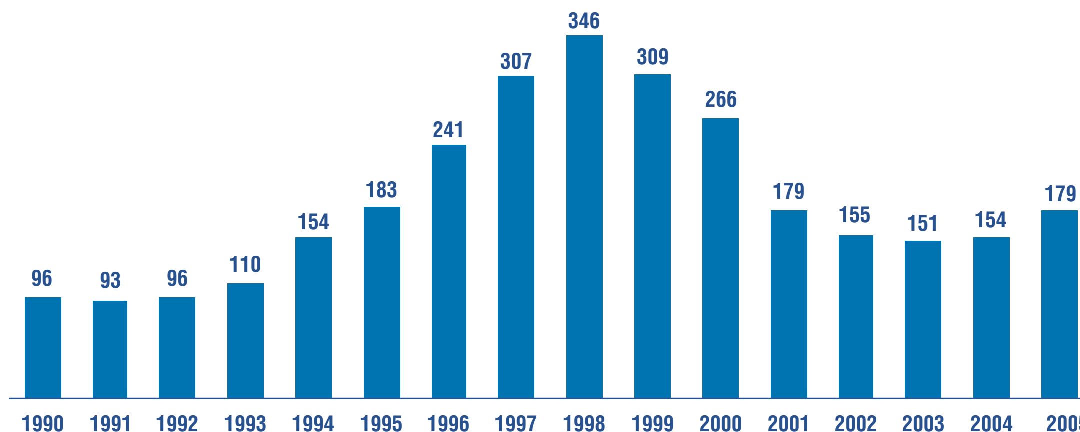
Figure 3.14
Medicare Advantage Enrollees as a Percent of Medicare Beneficiaries, by State, 2005



Note: Various states are identified to show cross-state variation. Share of Medicare Advantage enrollees include beneficiaries enrolled in Medicare HMOs, PPOs (demonstration and non-demonstration), and PSO plans, and excludes private fee-for-service cost contract enrollees, and other demonstration plans. National average shows enrollment in all MA plan types.
SOURCE: Mathematica Policy Research, Inc analysis of Centers for Medicare and Medicaid Services State/County Market Penetration Files, March 2005.

Medicare Advantage enrollment varies widely across states. Less than 1 percent of Medicare beneficiaries are enrolled in HMOs, PPOs, and POS plans in 17 states, while at least 20 percent are enrolled in MA plans in Arizona, California, Colorado, Oregon, Pennsylvania, and Rhode Island. Overall, more than one in four Medicare Advantage enrollees live in California.

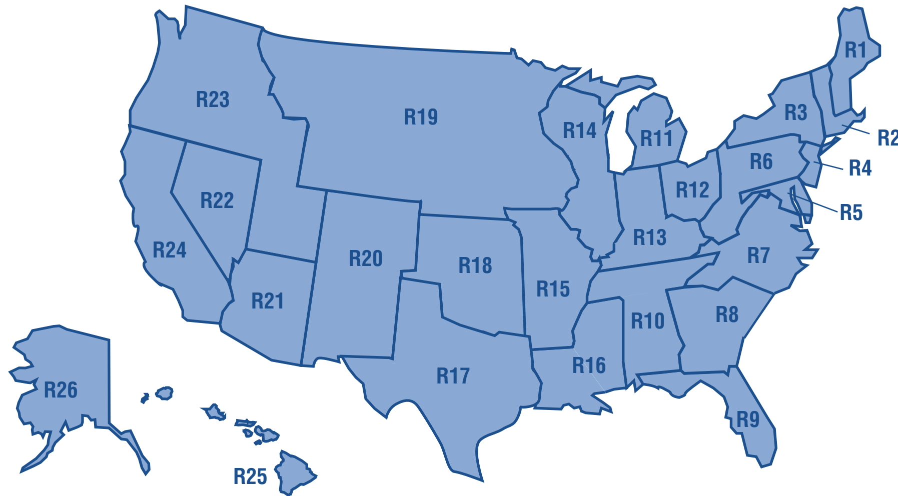
Figure 3.15
Number of Medicare Advantage Plans, 1990-2005



Note: All data are from December of the given year, except 2005 data are from March. Number of plans include Medicare HMOs, PPOs (non-demonstration), and PSO contracts; excludes PFFS, demonstrations, and cost contracts.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report.

Medicare Advantage plan participation and enrollment have fluctuated in recent years. After a period of rapid growth in the MA program between 1992 and 1998, the number of plans participating in Medicare Advantage declined by half. As of March 2005, there were 179 Medicare Advantage plans (Medicare HMOs, non-demonstration PPOs, and PSO contracts) in operation nationwide.

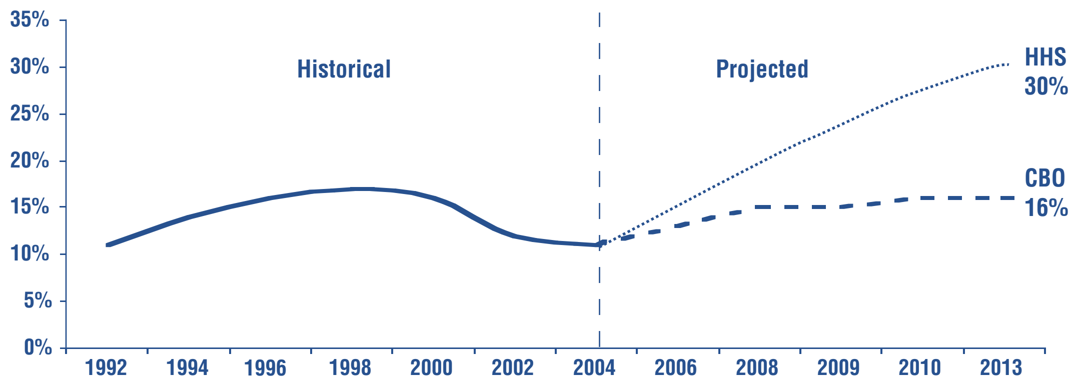
Figure 3.16
Medicare Advantage Regions



Note: R = Region Number. Total number of MA regions = 26.
SOURCE: Centers for Medicare and Medicaid Services, December 2004.

Beginning in 2006, there will be 26 Medicare Advantage regions comprised of single states or groups of states. Regional PPO plans will also be available, in addition to county-based private plans currently participating in the Medicare Advantage program. PPO plans that want to enter the Medicare Advantage market are required to serve a region in its entirety and must offer the same benefits within a region.

Figure 3.17
Historical and Projected Share of the Medicare Population Enrolled in Medicare Advantage Plans, 1992–2013



Note: All actual data are from December of the given year. HHS = Department of Health and Human Services. CBO = Congressional Budget Office.
SOURCE: Historical data from CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report. Projections from President's FY2006 Budget, Office of Management and Budget, February 7, 2005; and CBO Medicare Baseline, March 2005.

Enrollment of Medicare beneficiaries in Medicare HMOs and other private plans increased from 11 percent in 1992 to 17 percent in 1998, then decreased to approximately 11 percent in 2004. Private plans are expected to play a greater role in Medicare in the future, although enrollment projections vary widely. The U.S. Department of Health and Human Services estimates that 30 percent of Medicare beneficiaries will be enrolled in Medicare Advantage plans by 2013, while the Congressional Budget Office projects an enrollment rate of 16 percent that year.

Section 4

Out-of-Pocket Spending

SECTION 4: OUT-OF-POCKET SPENDING

Despite significant financial protections provided by Medicare, gaps in the benefit package and relatively high cost-sharing requirements result in beneficiaries paying a substantial share of their total health and long-term care costs out of pocket. In 2002, Medicare covered less than half (45 percent) of beneficiaries' total per capita medical and long-term care expenses ($11,714, on average). Beneficiaries paid, on average, 19 percent of total expenses, or $2,223, out of pocket. Of the $93 billion spent by beneficiaries out of pocket for medical and long-term care that year, two-thirds of this spending was for benefits and services for which Medicare currently provides limited or no coverage, including long-term care (36 percent), prescription drugs (22 percent), and dental services (8 percent).

Out-of-pocket spending is highly skewed. Just over half of all beneficiaries spent less than $1,000 out of pocket in 2002, while almost 10 percent of beneficiaries spent $5,000 or more. Average spending by beneficiaries also increases with age and varies by health status. In 2002, beneficiaries between the ages of 65 and 74 spent $1,371, on average, while those age 85 or older spent substantially more ($1,724). As might be expected, as health status declines, out-of-pocket spending rises. In 2002, beneficiaries in poor health spent $1,000 more out of pocket on their health care than did those in fair health and more than twice as much as those in excellent or very good health.

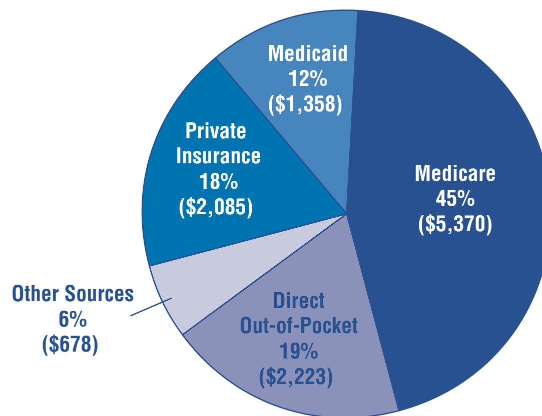
Out-of-pocket spending among Medicare beneficiaries also varies by source of supplemental insurance coverage—reflecting differences in the scope of covered services and variations in the health care needs of those with different types of coverage. Beneficiaries without supplemental coverage of any kind and those with individually-purchased Medigap policies pay more, on average, than beneficiaries with employer-sponsored coverage. Medicare beneficiaries with Medicaid—the dual eligibles—generally have the lowest average out-of-pocket costs (despite being in relatively poor health), because Medicaid provides relatively comprehensive coverage of prescription drugs and long-term care costs, in addition to covering Medicare premiums and other cost-sharing requirements.

Because Medicare provides no coverage for prescription drugs used in an outpatient setting (until 2006), the cost of medications has been a significant concern. In 2005, almost 60 percent of beneficiaries are projected to have no or relatively low ($750 or less) out-of-pocket drug expenses, while at the upper end of spending, 7 percent of beneficiaries are projected to have out-of-pocket drug costs of more than $3,600. Between 2000 and 2004, average out-of-pocket spending on prescription drugs increased by 64 percent, from $613 to $1,005. In 2005, average per capita out-of-pocket spending on prescription drugs among Medicare beneficiaries is estimated to be $1,139. Once coverage begins under the new drug benefit in 2006, per capita out-of-pocket drug spending is estimated to be $970.

Out-of-pocket spending on prescription drugs varies by a number of factors including gender, income, health status, and urban/rural residence. Those in poor health have out-of-pocket spending in 2005 that is estimated to be more than twice as much as spending by those in very good or excellent health. In addition, women spend more than men and those in rural areas spend more than those living in urban areas. Out-of-pocket spending on drugs also varies by source of supplemental coverage. For example, beneficiaries with Medigap drug coverage spent, on average, one-third more out of pocket on their prescriptions than beneficiaries with employer-sponsored coverage.

Beginning in 2006, Medicare will help pay for outpatient prescription drugs for beneficiaries who enroll in private prescription drug plans (PDPs) or Medicare Advantage plans that cover prescription drugs (MA-PDs). (See Section 5 for an overview of the Medicare prescription drug benefit.) For the majority of beneficiaries who enroll in Medicare drug plans, average out-of-pocket spending for prescription drugs in 2006 is projected to be lower than it would have been in the absence of the Medicare drug benefit. Many beneficiaries—particularly those who previously lacked drug coverage and receive low-income subsidies—are projected to have substantially lower out-of-pocket spending. Many beneficiaries will continue to face high out-of-pocket costs when the new benefit goes into effect, however, especially those who are projected to have drug spending that is subject to 100 percent coinsurance.

Figure 4.1
Sources of Payment for Medicare Beneficiaries' Medical and Long-Term Care Services, 2002

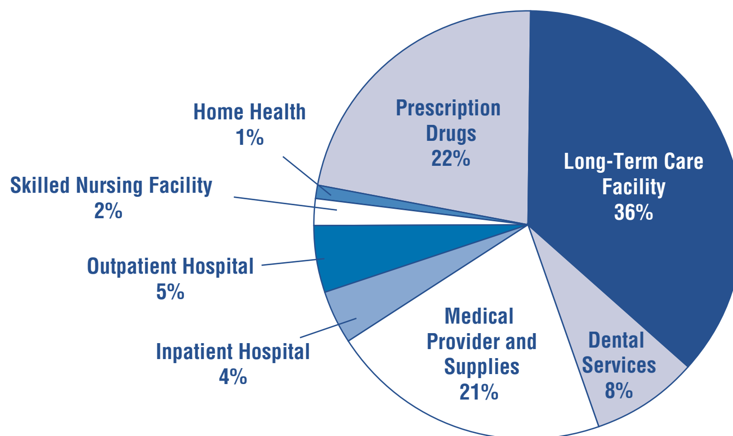


Total = $11,714 in Expenses per Beneficiary, 2002

Note: Figure shows average total spending for both non-institutionalized and institutionalized beneficiaries, including long-term care, skilled nursing facility, and prescription drug spending, but excluding spending on premiums or deductibles for Medicare Parts A, B, and C and private health insurance.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Each year, a majority of beneficiaries use Medicare to help pay for their hospital, physician, other medical care, and long-term care services. In 2002, Medicare paid less than half (45 percent) of the $11,714 in total medical expenses per beneficiary, while beneficiaries themselves paid 19 percent out of pocket.

Figure 4.2
Distribution of Out-of-Pocket Spending by Medicare Beneficiaries for Medical and Long-Term Care Services, 2002

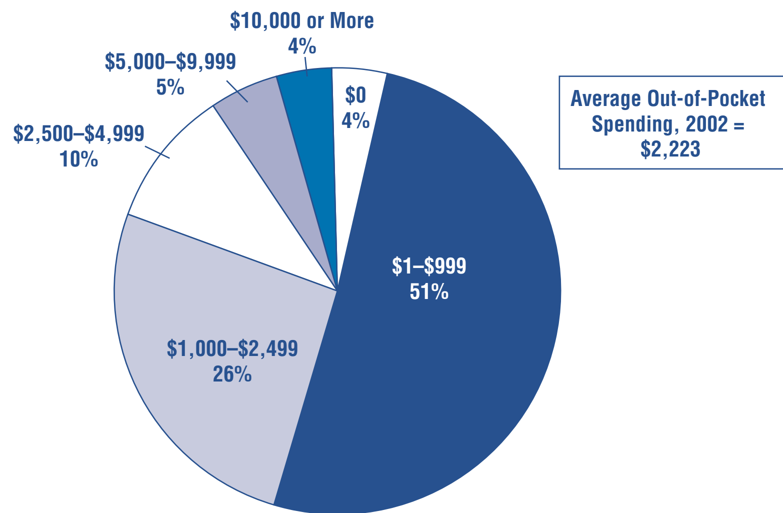


Total = $93 Billion in Out-of-Pocket Expenses, 2002

Note: Figure shows distribution of total out-of-pocket spending for both non-institutionalized and institutionalized beneficiaries, including long-term care, skilled nursing facility, and prescription drug spending, but excluding spending on premiums or deductibles for Medicare Parts A, B, and C and private health insurance.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, Medicare beneficiaries spent $93 billion out of pocket for medical and long-term care services. Two-thirds of beneficiaries' out-of-pocket spending was for benefits and services for which Medicare currently provides only partial or no coverage, including long-term care expenses (36 percent), prescription drugs (22 percent), and dental services (8 percent).

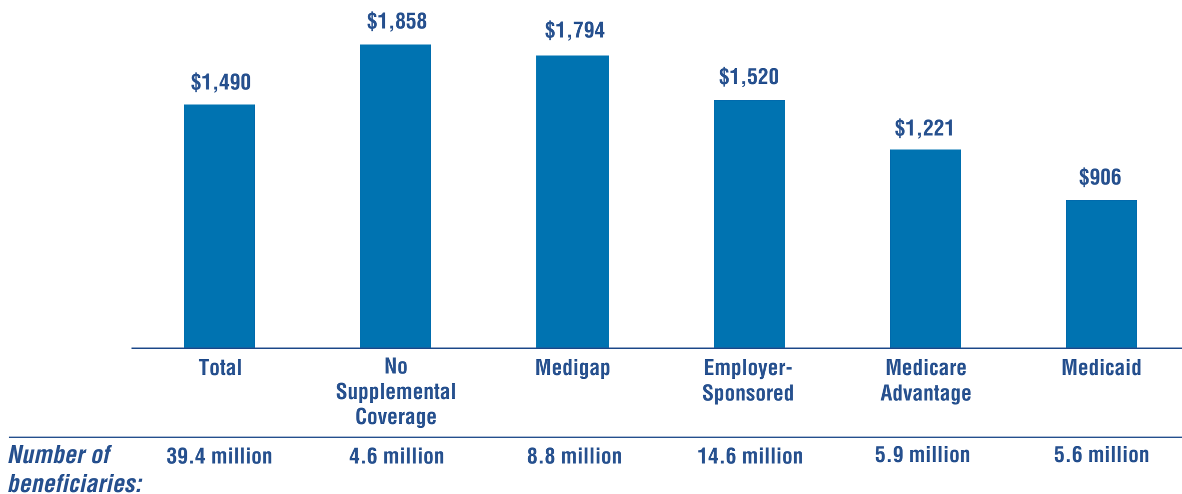
Figure 4.3
Distribution of Medicare Beneficiaries, by Per Capita Out-of-Pocket Spending, 2002



SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Average per capita out-of-pocket spending among the Medicare population was $2,223 in 2002. Only a small share of beneficiaries (4 percent) had no out-of-pocket expenses. Although half (51 percent) spent less than $1,000 out of pocket, nearly one in 10 beneficiaries spent $5,000 or more out of pocket, accounting for over half of all out-of-pocket spending by Medicare beneficiaries in 2002.

Figure 4.4
Per Capita Out-of-Pocket Spending by Non-Institutionalized Medicare Beneficiaries, by Primary Source of Supplemental Coverage, 2002

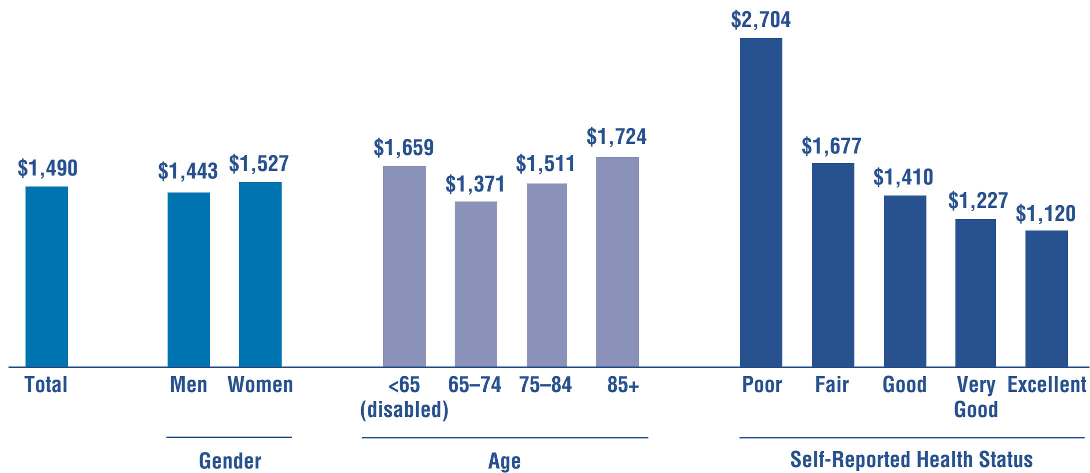


	Total	No Supplemental Coverage	Medigap	Employer-Sponsored	Medicare Advantage	Medicaid
Number of beneficiaries:	39.4 million	4.6 million	8.8 million	14.6 million	5.9 million	5.6 million

Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Out-of-pocket spending by Medicare beneficiaries varies by the type of supplemental insurance coverage they have. On average, Medicare beneficiaries who resided in the community incurred $1,490 in out-of-pocket costs in 2002. Out-of-pocket spending by those without supplemental coverage averaged $1,858. Medicare beneficiaries with Medicaid incurred the lowest out-of-pocket costs, because Medicaid covers Medicare's deductibles, coinsurance, and premiums, and currently covers benefits not offered by Medicare, including prescription drugs (until 2006) and long-term care.

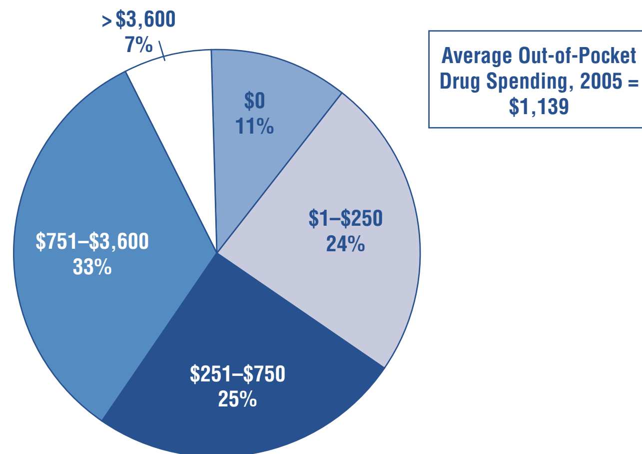
Figure 4.5
Per Capita Out-of-Pocket Spending by Non-Institutionalized Medicare Beneficiaries, by Gender, Age, and Health Status, 2002



Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Out-of-pocket spending on health care increases with declining health status and advancing age. Beneficiaries in poor health spent $1,000 more out of pocket on their health care in 2002 than did than those in fair health and more than twice as much as those in very good or excellent health. Those age 85 or older and nonelderly beneficiaries with disabilities had higher out-of-pocket expenditures than elderly beneficiaries between the ages of 65 and 84, reflecting the unique health needs of these subgroups of the Medicare population.

Figure 4.6
Distribution of Non-Institutionalized Medicare Beneficiaries, by Per Capita Out-of-Pocket Prescription Drug Spending, 2005



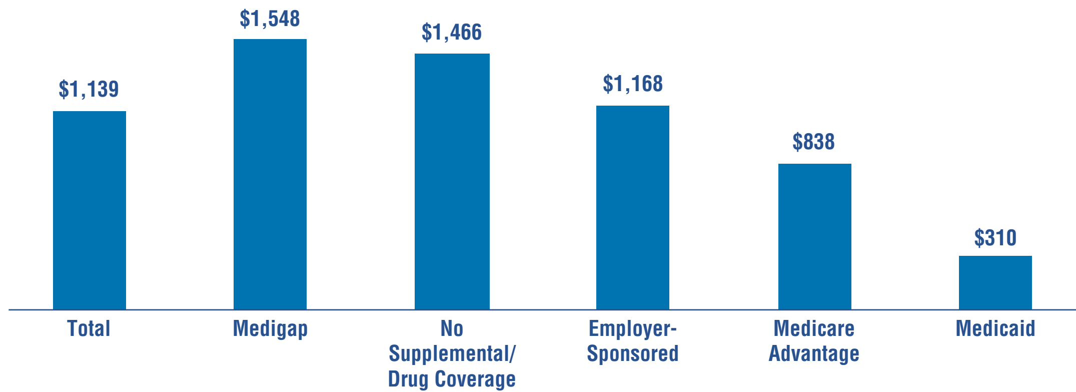
Total = 42.1 Million Medicare Beneficiaries, 2005

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, May 2005.

A significant share of out-of-pocket spending by Medicare beneficiaries is for prescription drugs. Average per capita out-of-pocket spending on prescription drugs among Medicare beneficiaries is projected to be $1,139 in 2005. Sixty percent of beneficiaries are projected to have $750 or less in out-of-pocket drug expenses in 2005, while 7 percent are projected to have more than $3,600 in out-of-pocket drug costs.

Figure 4.7

Per Capita Out-of-Pocket Prescription Drug Spending by Non-Institutionalized Medicare Beneficiaries, by Primary Source of Supplemental Coverage, 2005

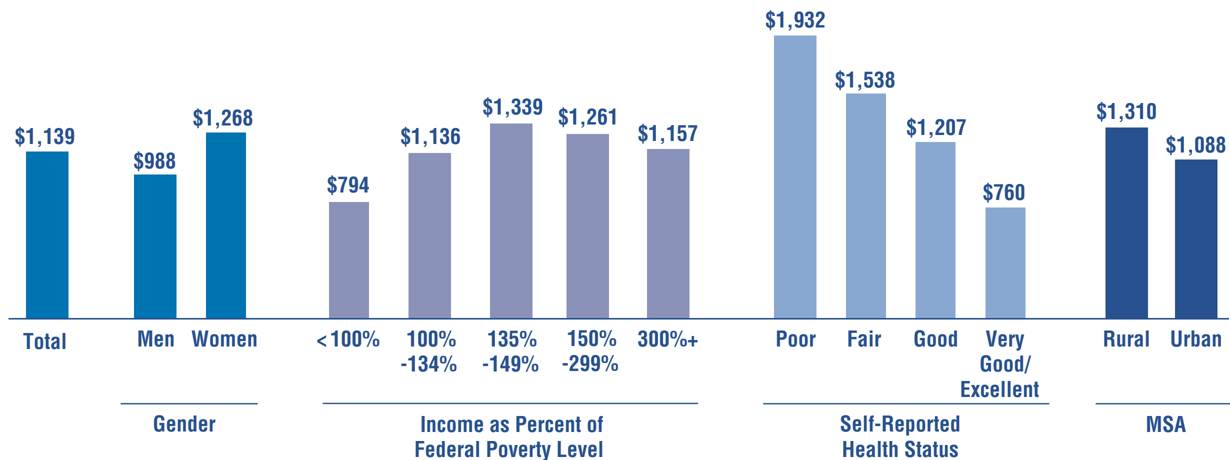


Note: Medicaid includes beneficiaries with both full-year and part-year coverage.
SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, May 2005.

Annual 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. On average, Medicare beneficiaries enrolled in Medicaid spend the least out of pocket on prescription drugs, because Medicaid has very low or no cost-sharing requirements for drugs. Medicare beneficiaries with no supplemental coverage and those with Medigap policies spend the most out of pocket on prescription drugs.

Figure 4.8

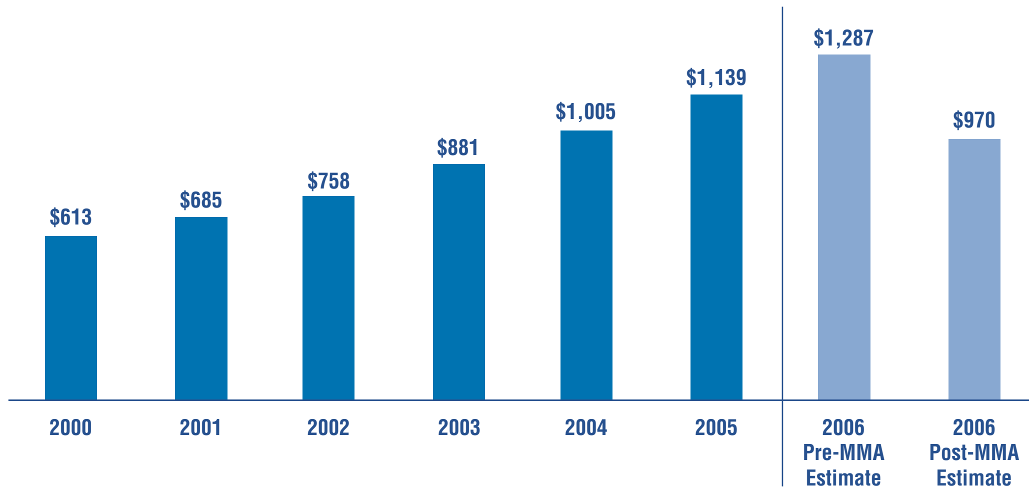
Per Capita Out-of-Pocket Prescription Drug Spending by Non-Institutionalized Medicare Beneficiaries, by Selected Characteristics, 2005



Note: In 2005, 100% of the federal poverty level was $9,570/individual and $12,830/couple. MSA is Metropolitan Statistical Area.
SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, May 2005.

Out-of-pocket drug spending by Medicare beneficiaries varies by individual characteristics, such as health status, gender, and urban/rural residence. Those in poor health are projected to spend more than twice as much out of pocket on drugs as those in very good or excellent health. Out-of-pocket drug expenses are greater for women than men, on average, and for those living in rural areas than in urban areas.

Figure 4.9
Per Capita Out-of-Pocket Prescription Drug Spending by Medicare Beneficiaries, 2000–2006



Note: Dollar amounts reflect out-of-pocket spending on prescription drugs only, excluding spending on premiums for drug coverage that beneficiaries might incur.
SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, May 2005.

In recent years, Medicare beneficiaries have spent increasing amounts out of pocket for their prescription drugs. Between 2000 and 2005, average out-of-pocket spending on prescription drugs by Medicare beneficiaries increased by 86 percent, from $613 to $1,139. In 2006, when coverage under the Medicare prescription drug benefit begins, average per capita out-of-pocket drug spending by beneficiaries is projected to be $970.

Section 5

Medicare and Prescription Drugs

SECTION 5: MEDICARE AND PRESCRIPTION DRUGS

Medicare beneficiaries are highly dependent on prescription drugs to manage their acute and chronic health conditions, yet, until 2006, Medicare does not cover the cost of outpatient prescription drugs. Virtually all beneficiaries (91 percent) take at least one medication. Despite the relatively heavy use of pharmaceuticals, nearly half of all beneficiaries lacked 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 the 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). In addition, as of March 2005, 34 states had adopted some type of program to assist beneficiaries with the cost of prescription drugs, although large programs exist in only a few states.

More than half of all beneficiaries who lacked drug coverage for the full year in 2002 had incomes of less than $20,000 (individual and spouse); 21 percent had incomes of $10,000 or less. Beneficiaries with incomes between $10,001 and $20,000 are at greatest risk of being without drug coverage for the full year, because they are less likely than the lowest-income beneficiaries to have Medicaid, and less likely than higher-income beneficiaries to have employer-sponsored retiree health coverage. Beneficiaries age 85 or older are more likely than their younger counterparts to lack drug coverage for the full year. Beneficiaries living in rural areas also are substantially more likely than those living in urban areas to lack drug coverage.

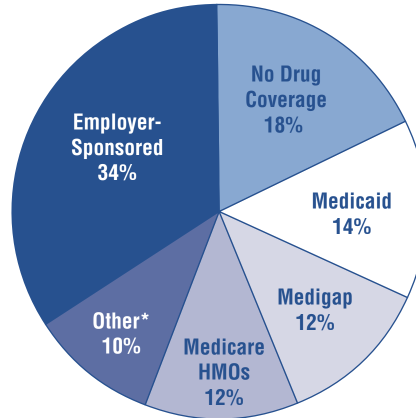
Lack of drug coverage is a concern because beneficiaries without it fill fewer prescriptions due to costs and have higher out-of-pocket drug spending, on average, than those with coverage. Medicare beneficiaries without drug coverage filled one-third fewer prescriptions, on average, than beneficiaries with some form of drug coverage—a difference in drug use that persists across a range of individual characteristics, including health status and income.

Average per capita drug spending among Medicare beneficiaries in 2005 is estimated to be $2,864. However, drug spending is highly skewed and concentrated among a small share of beneficiaries. In 2005, nearly one in five beneficiaries (18 percent) had total drug expenditures exceeding $5,100, accounting for more than half of all drug expenditures incurred by the Medicare population. At the lower end of the spectrum, another one in five beneficiaries (20 percent) had total expenditures of $250 or less in 2005, accounting for only 1 percent of total drug expenditures. As noted in Section 4, out-of-pocket spending for prescription drugs is also highly skewed. Just over half of all beneficiaries spent less than $1,000 out of pocket in 2002, while almost 10 percent of beneficiaries spent $5,000 or more.

Beginning in January 2006, Medicare beneficiaries will have access to drug coverage through private prescription drug plans (PDPs) or Medicare Advantage plans that cover prescription drugs (MA-PDs). Under the standard benefit design, beneficiaries who enroll in a Medicare prescription drug plan will pay a monthly premium, an annual deductible, and coinsurance or copayments for their covered drugs. Standard amounts for deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Medicare drug benefit spending. Medicare will provide premium and cost-sharing subsidies to assist those beneficiaries who have limited incomes and financial resources. Medicare will contract with risk-bearing drug plans in each of 34 regions nationwide to provide the new prescription drug benefit. Premiums, cost-sharing requirements, and formularies are expected to vary across plans, subject to certain limitations imposed by the federal government.

Of the estimated 43.1 million Medicare beneficiaries in 2006, 29.3 million are expected to enroll in Medicare prescription drug plans that year, according to the Administration. Another 9.8 million are expected to get prescription drug coverage from an employer plan. Of the 14.5 million beneficiaries estimated to be eligible for low-income subsidies, 10.9 million are expected to receive them. The net federal cost of the Medicare drug benefit is estimated to be $37 billion in 2006, increasing to $67 billion in 2010, and totaling $724 billion for the decade from 2006 to 2015. Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, contributions from states, and general revenues.

Figure 5.1
Prescription Drug Coverage Among Non-Institutionalized Medicare Beneficiaries, 2002

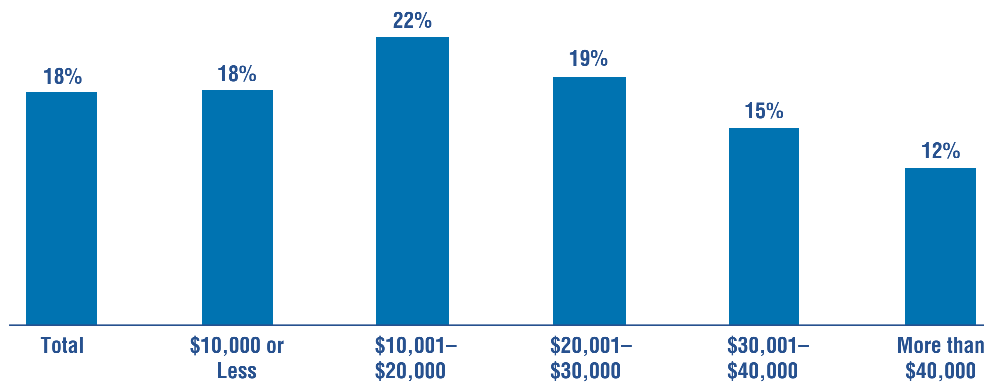


Total = 39.4 Million Non-Institutionalized Medicare Beneficiaries, 2002

Note: *Includes public programs such as Veterans Administration, Department of Defense, and State Pharmaceutical Assistance Programs for low-income elderly. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, almost one in five non-institutionalized Medicare beneficiaries (18 percent) lacked coverage for prescription drug expenses for the full year and another 27 percent lacked coverage for part of the year. Beneficiaries with drug coverage obtained it from a variety of sources: employer-sponsored plans (34 percent), Medicaid (14 percent), Medicare HMOs (12 percent), individually-purchased Medigap policies (12 percent), and other public sources (10 percent).

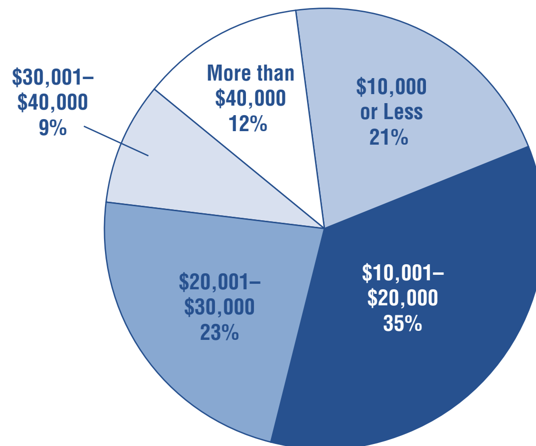
Figure 5.2
Percent of Non-Institutionalized Medicare Beneficiaries Without Prescription Drug Coverage, by Income, 2002



Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

A smaller share of low-income beneficiaries have prescription drug coverage than those with higher incomes. In 2002, a greater share of beneficiaries with annual incomes between $10,001 and $20,000 lacked drug coverage than those with incomes of $10,000 or less, because Medicaid currently covers prescription drugs for many of Medicare's lowest-income beneficiaries.

Figure 5.3
Distribution of Non-Institutionalized Medicare Beneficiaries Without Prescription Drug Coverage, by Income, 2002

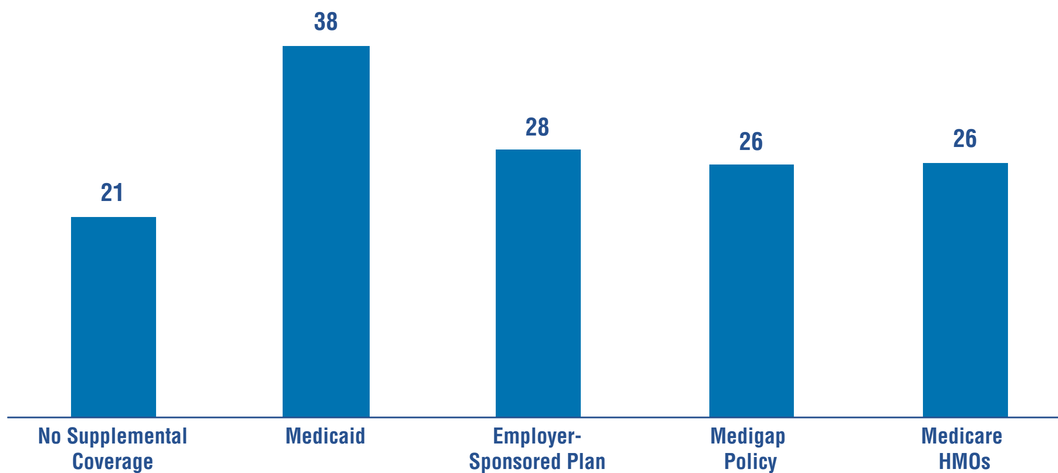


Total = 7.0 Million Medicare Beneficiaries Without Drug Coverage for the Full Year, 2002

Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Although low-income Medicare beneficiaries are more likely than higher-income beneficiaries to lack prescription drug coverage, more than one in four Medicare beneficiaries (44 percent) without prescription drug coverage in 2002 had an annual income of more than $20,000.

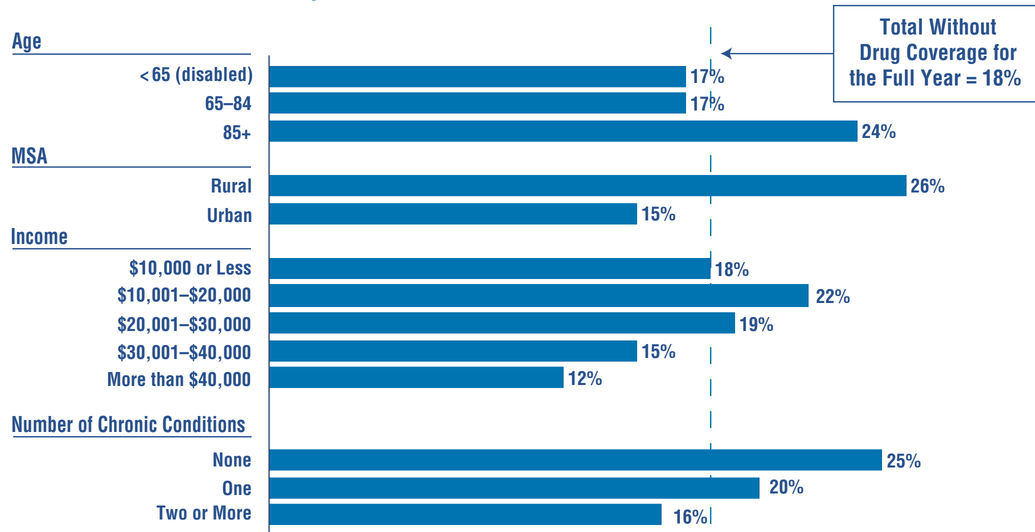
Figure 5.4
Average Number of Prescriptions Filled by Non-Institutionalized Medicare Beneficiaries, by Primary Source of Supplemental Coverage, 2002



Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare beneficiaries without coverage to supplement Medicare's traditional benefits fill fewer prescriptions than those with some type of supplemental insurance coverage. Among beneficiaries with supplemental insurance, Medicare beneficiaries who are covered by Medicaid (dual eligibles) fill, on average, at least 10 more prescriptions per capita than those with other sources of coverage. Dual eligible beneficiaries tend to have greater medical needs than other Medicare beneficiaries.

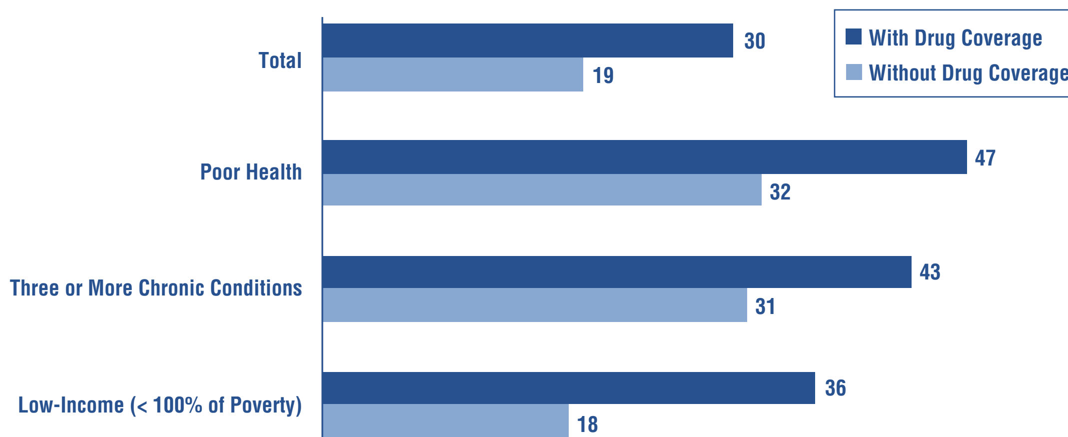
Figure 5.5
Percent of Medicare Beneficiaries Without Prescription Drug Coverage, by Selected Characteristics, 2002



Note: MSA = Metropolitan Statistical Area. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Overall, 18 percent of non-institutionalized Medicare beneficiaries lacked prescription drug coverage for the entire year in 2002. Certain types of beneficiaries are at greater risk of having no drug coverage, including beneficiaries age 85 or older (24 percent), those living in rural areas (26 percent), and those with annual incomes between $10,001 and $20,000 (22 percent).

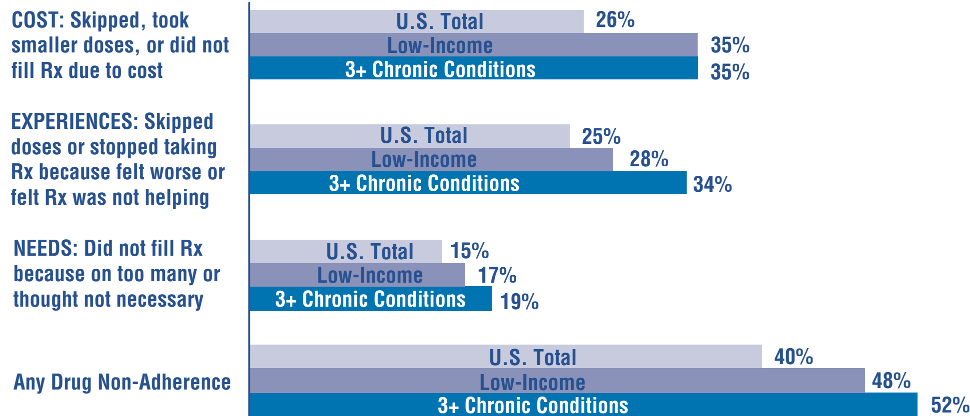
Figure 5.6
Average Number of Prescriptions Filled by Non-Institutionalized Medicare Beneficiaries With and Without Drug Coverage, by Selected Characteristics, 2002



Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare beneficiaries without prescription drug coverage fill fewer prescriptions than those with some form of drug coverage—an average of one-third fewer prescriptions in 2002. This difference in prescription drug use persists across a range of individual characteristics, including health status and income.

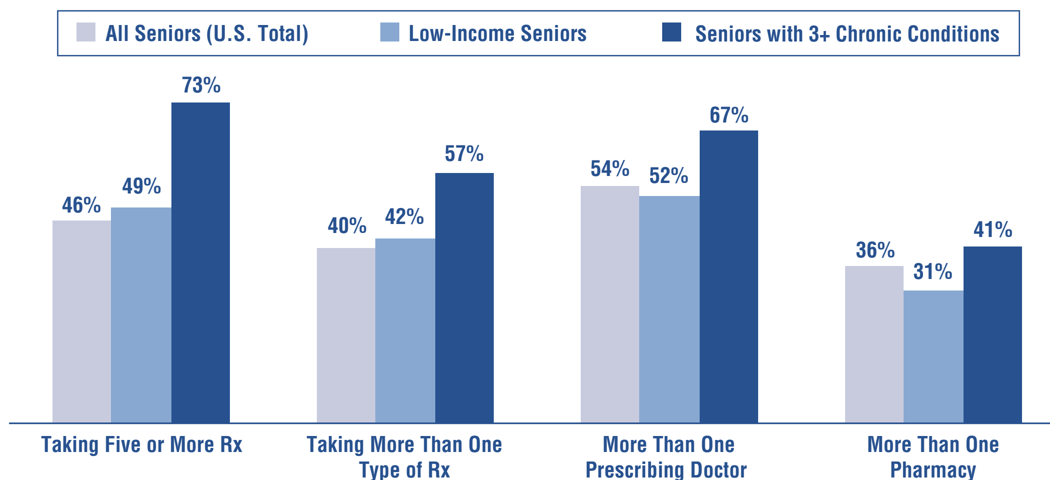
Figure 5.7
Prescription Drug Non-Adherence Among Seniors, Overall and by Disease Burden, 2003



Note: Low-income is defined as equal to or less than 200% of the federal poverty level. Rx = prescription medication.
SOURCE: Kaiser/Commonwealth/Tufts-New England Medical Center 2003 National Survey of Seniors and Prescription Drugs.

In the face of complex and costly drug regimens, two in five seniors (40 percent) reported not taking their medications as prescribed in 2003. Costs and poor experiences with medications contributed to relatively high rates of non-adherence among seniors. About half of seniors with incomes less than or equal to twice the poverty level and those with three or more chronic conditions reported non-adherence.

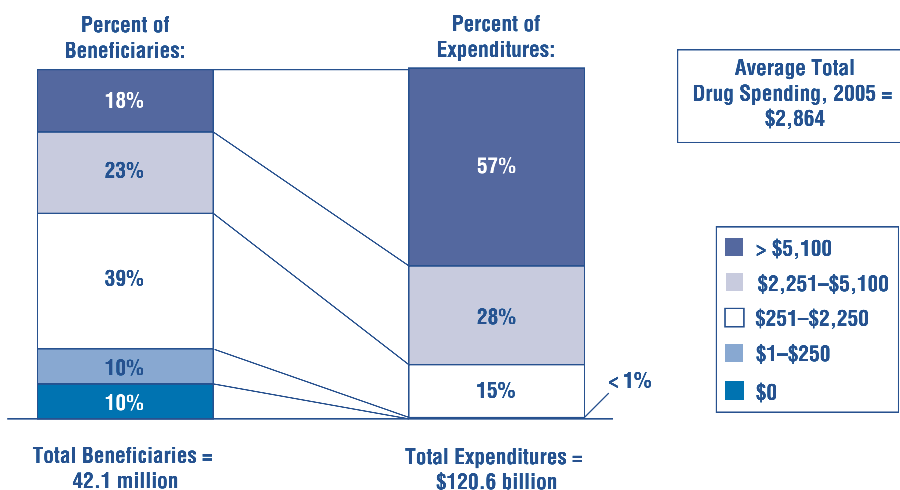
Figure 5.8
Complex Prescription Drug Regimens Among Seniors, 2003



Note: Low-income is defined as equal to or less than 200% of the federal poverty level. Rx = prescription medication. Type of Rx = pills, inhalers, injections, creams, or eye drops.
SOURCE: Kaiser/Commonwealth/Tufts-New England Medical Center 2003 National Survey of Seniors and Prescription Drugs.

Seniors – especially those with three or more chronic conditions – rely heavily on prescription drugs to maintain their health. Many have multiple prescribing doctors (54 percent) and use more than one pharmacy to obtain their medications (36 percent). Rates are even higher among seniors with three or more chronic conditions.

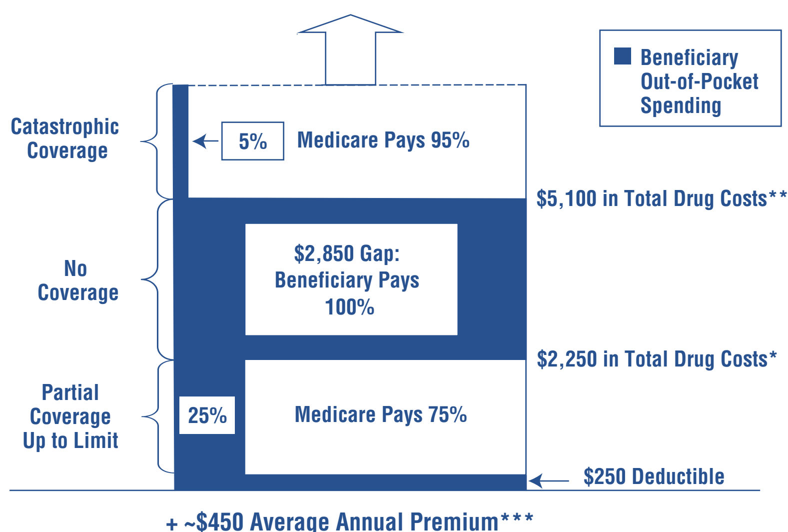
Figure 5.9
Distribution of Medicare Beneficiaries and Total Prescription Drug Spending, 2005



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, May 2005.

Average per capita drug spending among the Medicare population is projected to be $2,864 in 2005. Drug spending is highly skewed, however, and concentrated among a relatively small share of beneficiaries. Ten percent of beneficiaries are projected to have no drug costs and another 10 percent are projected to have expenses of $250 or less. In contrast, 18 percent of beneficiaries are projected to have total drug costs of $5,100 or more in 2005, accounting for 57 percent of total drug spending on behalf of Medicare beneficiaries.

Figure 5.10
Standard Medicare Prescription Drug Benefit, 2006



Note: *Equivalent to $750 in out-of-pocket spending. **Equivalent to $3,600 in out-of-pocket spending. ***Annual amount based on $37.37 monthly Part D premium estimate from 2005 Annual Report of the Medicare Boards of Trustees.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit described in the Medicare Modernization Act of 2003.

Beginning in 2006, Medicare beneficiaries will have access to prescription drug coverage through private plans. Under the standard benefit design, beneficiaries who enroll in a Medicare drug plan will pay a monthly premium, annual deductible, and copayments for their prescription drugs. In 2006, the monthly premium for the standard drug benefit is estimated to average $37, but this amount will vary across plans.

Figure 5.11
Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligibles with incomes <100% of poverty ($9,570/individual; $12,830/couple in 2005)	$0	$0	$1/generic $3/brand-name; no copays after out-of-pocket drug spending reaches $3,600 ($5,100 total)
Full-benefit dual eligibles with incomes ≥100% of poverty; and individuals with incomes <135% of poverty ($12,920/individual; $17,321/couple in 2005) **and assets < $6,000/individual; $9,000/couple**	$0	$0	$2/generic $5/brand-name; no copays after out-of-pocket drug spending reaches $3,600 ($5,100 total)
Individuals with incomes 135%–150% of poverty ($12,920–$14,355/individual; $17,321–$19,245/couple in 2005) **and assets < $10,000/individual; $20,000/couple**	sliding scale up to ~$37	$50	15% of total drug costs up to $5,100; $2/generic $5/brand-name thereafter

Note: Cost-sharing subsidies paid by the Centers for Medicare and Medicaid Services count toward the out-of-pocket threshold.
SOURCE: Kaiser Family Foundation summary of Medicare drug benefit low-income subsidies in 2006.

Medicare beneficiaries with low incomes may be eligible for premium and cost-sharing subsidies for the prescription drug benefit. Medicare beneficiaries with Medicaid drug coverage, and those enrolled in Medicare Savings Programs, are automatically deemed eligible for these subsidies. Other low-income beneficiaries will have to meet both an income and asset test and apply to a private drug plan separately. Of the 7.8 million non-dual eligible beneficiaries with incomes below 150 percent of poverty who would otherwise be eligible for assistance in 2006, the Congressional Budget Office estimates that 1.8 million beneficiaries will not qualify as a result of the asset test.

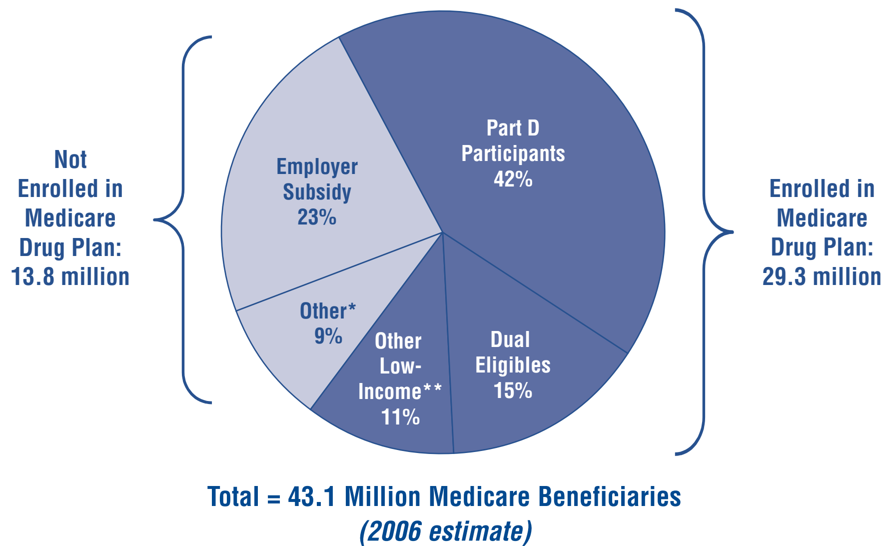
Figure 5.12
Medicare Prescription Drug Benefit Premiums and Cost-Sharing Amounts for Selected Years

	2006	2010	2014
Monthly Premium (estimated average)	$37.37	$48.94	$64.26
Annual Deductible	$250	$331	$437
Initial Coverage Limit	$2,250	$2,980	$3,934
Coverage Gap (difference between initial coverage limit and catastrophic threshold)	$2,850	$3,774	$4,984

SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Standard benefit limits, catastrophic thresholds, and cost-sharing requirements for the Medicare prescription drug benefit are indexed to rise with the growth in per capita Part D spending. The annual deductible is estimated to increase from $250 in 2006 to $437 in 2014, while the coverage gap between partial and catastrophic coverage is estimated to increase from $2,850 to $4,984 over the same period.

Figure 5.13
Estimated Medicare Prescription Drug Benefit Participation, 2006

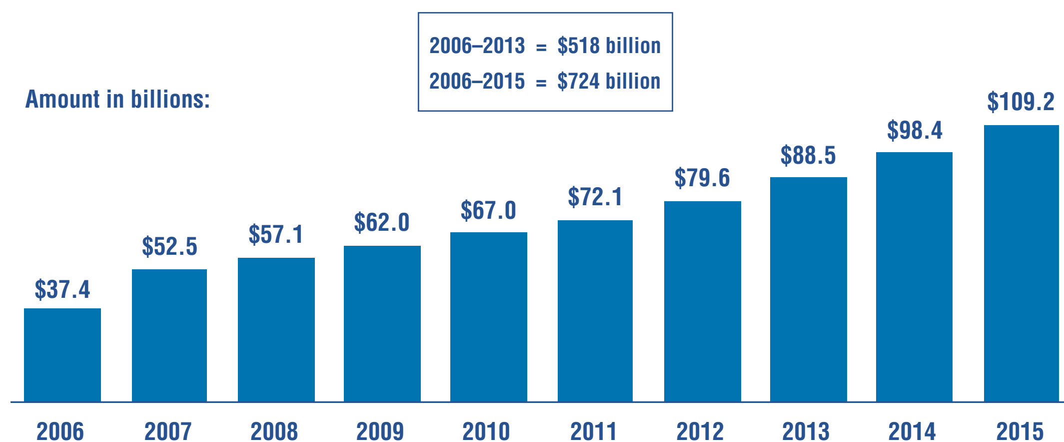


Total = 43.1 Million Medicare Beneficiaries
(2006 estimate)

Note: *Other non-participants include federal retirees with drug coverage through FEHBP or TRICARE, and those who lack drug coverage.
**Other low-Income includes non-dual eligibles with incomes <150% FPL.
SOURCE: HHS Office of the Actuary, Medicare Modernization Act Final Rule, January 2005.

Of the estimated 43.1 million Medicare beneficiaries in 2006, the U.S. Department of Health and Human Services expects 29.3 million beneficiaries to enroll in Medicare prescription drug plans that year. Another 9.8 million are expected to get prescription drug coverage through an employer-sponsored plan. Of the 14.5 million low-income beneficiaries estimated to be eligible for financial assistance with the Medicare drug benefit, 10.9 million beneficiaries are expected to receive it.

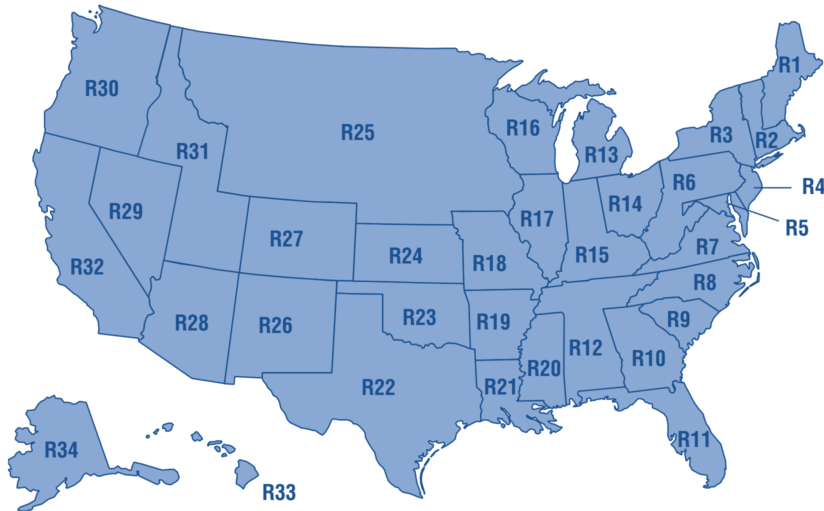
Figure 5.14
Projected Net Federal Cost of the Medicare Prescription Drug Benefit, 2006–2015



SOURCE: Administration's FY2006 Budget.

The net federal cost of the Medicare drug benefit is projected to be $724 billion between 2006 and 2015. Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, state contributions (commonly referred to as the "clawback"), and general revenues.

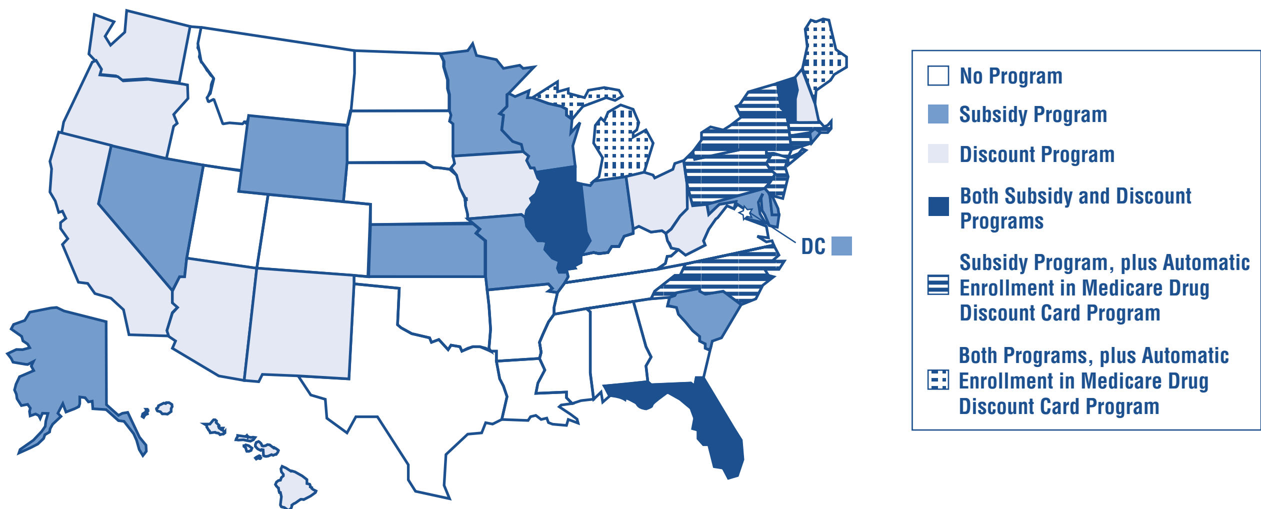
Figure 5.15
Medicare Prescription Drug Plan (PDP) Regions



Note: Each territory is its own PDP region. R = Region. Total number of PDP regions = 34.
SOURCE: Centers for Medicare and Medicaid Services, February 2005.

Medicare will contract with risk-bearing prescription drug plans (PDPs) in each of 34 regions nationwide to provide the prescription drug benefit. If two or more risk-bearing plans are not available in a region (including at least one freestanding prescription drug plan), Medicare will contract with a "fallback" plan to serve beneficiaries in that area. (The PDP regions differ from the regions served by Medicare Advantage drug plans—see Figure 3.16.)

Figure 5.16
State Senior Pharmaceutical Assistance Programs, 2005



Note: A subsidy program provides prescriptions drugs to low-income seniors for a nominal fee. A discount program offers discounts negotiated by states with pharmaceutical companies and with discount cards to low-income seniors on prescription drugs.
SOURCE: National Conference of State Legislatures, March 2005.

As of March 2005, 34 states have created some type of program to assist Medicare beneficiaries with the cost of prescription drugs: a subsidy program in 24 states, a discount program in 15 states, and both types of programs in five states. During 2004 and 2005, eight states facilitated enrollment into the Medicare Drug Discount Card Program for qualifying Medicare beneficiaries, in addition to offering a pharmaceutical assistance program.

Section 6

Medicare Spending

SECTION 6: MEDICARE SPENDING

In FY2004, Medicare benefit payments totaled $295 billion, Medicare spending accounted 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 national personal health care expenditures, but Medicare's share of spending 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 20 percent of spending on physician services, but less than 2 percent of prescription drug costs.

Currently, inpatient hospital services are the largest category of Medicare benefit payments (39 percent), followed by payments for physicians and suppliers (26 percent). Home health care and skilled nursing facility services account for less than 10 percent of total benefit spending. 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. The distribution of Medicare payments has shifted over time, reflecting changes in health care delivery and how Medicare pays for services. For example, hospitalizations accounted for 87 percent of program spending in 1966, but 38 percent in 2004, while spending on physician and other outpatient services more than tripled from 12 percent to 37 percent.

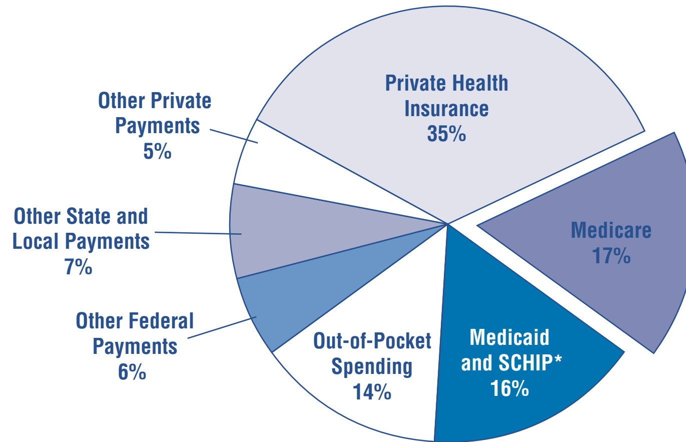
Medicare payments for each beneficiary enrolled in the traditional fee-for-service program averaged $6,110 in 2002. Per capita payments for the elderly ($6,002) were nearly $1,500 higher than they were for the nonelderly disabled ($4,547). As expected, Medicare per capita spending increases as health status declines. Per capita spending is more than twice the amount for beneficiaries residing in long-term care facilities than for beneficiaries living in the community. Medicare spending is also significantly higher for beneficiaries in their last year of life: $24,856 for beneficiaries who died in 1999 compared to $3,669 for those who were alive at the end of that year.[1]

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. Twelve 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.

On a per capita basis, Medicare spending has grown at a slightly slower pace, on average, than private health insurance spending for comparable services. 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. Administrative expenditures currently account for less than 2 percent of Medicare benefit expenditures, significantly lower than the cost of running private health plans.

[1] Calfo, S., et al. "Last Year of Life Study." Office of the Actuary, Centers for Medicare and Medicaid Services.

Figure 6.1
National Health Expenditures in the United States, by Source of Payment, 2003

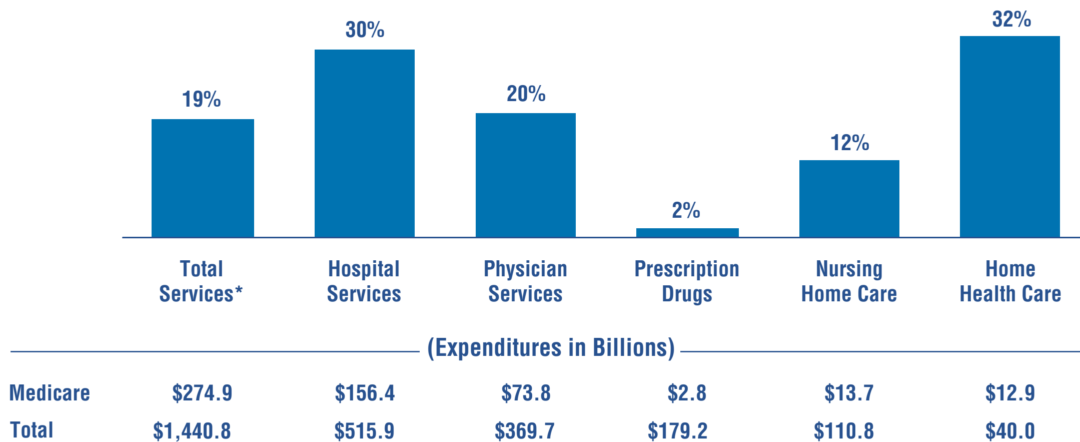


Total = $1.7 Trillion in National Health Expenditures, 2003

Note: *Medicaid and SCHIP include funds from both federal and state governments. SCHIP is the Title XIX State Children's Health Insurance Expansion.
SOURCE: C. Smith, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, 24 (January/February 2005) 185-194.

Health care expenditures in the United States totaled $1.7 trillion in 2003. Medicare represented 17 percent ($283 billion) of these expenditures, while private health insurance financed 35 percent ($601 billion), and consumers paid about 14 percent ($231 billion) out of pocket.

Figure 6.2
Medicare's Share of National Personal Health Expenditures, by Type of Service, 2003



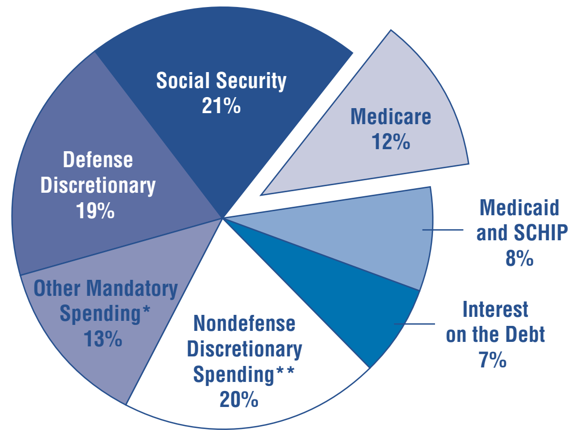
(Expenditures in Billions)

	Total Services*	Hospital Services	Physician Services	Prescription Drugs	Nursing Home Care	Home Health Care
Medicare	$274.9	$156.4	$73.8	$2.8	$13.7	$12.9
Total	$1,440.8	$515.9	$369.7	$179.2	$110.8	$40.0

Note: *Also includes dental care, durable medical equipment, other professional services and other personal health care services and products.
SOURCE: C. Smith, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, 24 (January/February 2005) 185-194.

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 all hospital spending and 32 percent of home health care spending but less than 2 percent of prescription drug costs.

Figure 6.3
Medicare Spending as a Share of the Federal Budget, FY2004

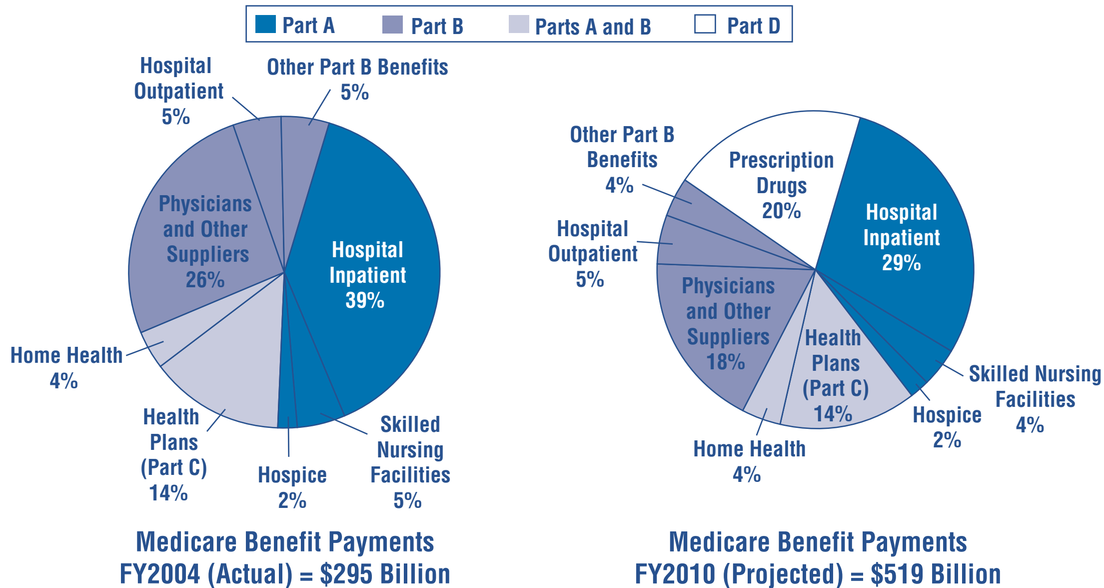


Total = $2,292 Billion in FY2004 Federal Spending

Note: *Includes other retirement and disability programs, unemployment compensation, and farm price supports; also includes offsetting receipts.
**Includes funding for homeland security, transportation, education, and public health.
SOURCE: Office of Management and Budget, Budget of the U.S. Government, FY2006.

Total federal spending in FY2004 was almost $2.3 trillion. Spending on Medicare was $265 billion (including offsets), or 12 percent of the total. Spending on Social Security, the single largest program in the federal budget, totaled 21 percent ($492 billion), while defense spending accounted for 19 percent ($436 billion).

Figure 6.4
Medicare Benefit Payments, by Type of Service, FY2004 (Actual) and FY2010 (Projected)



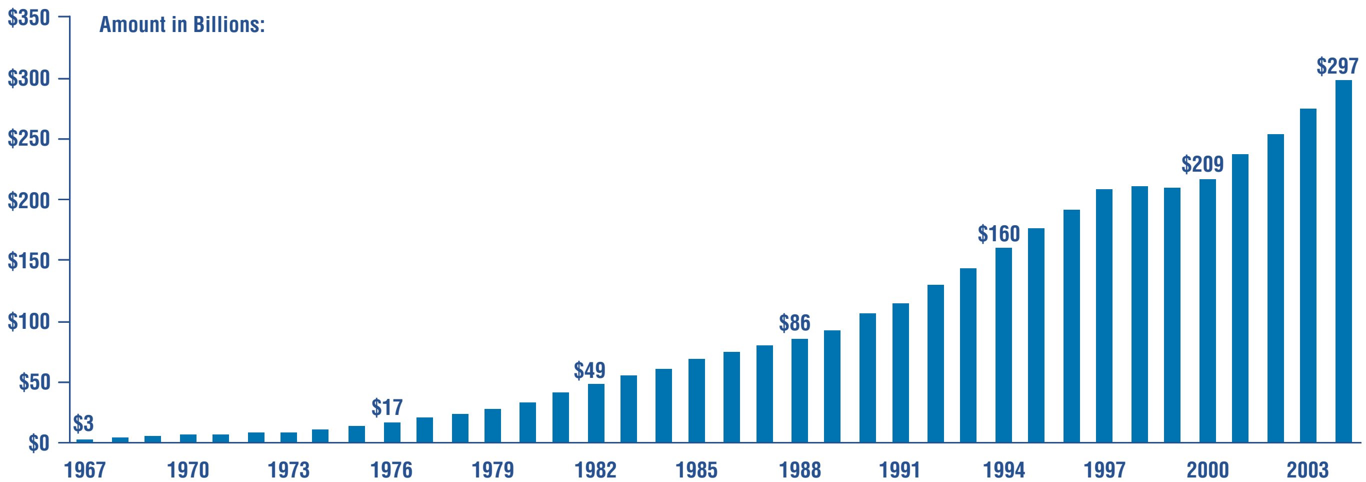
Medicare Benefit Payments FY2004 (Actual) = $295 Billion

Medicare Benefit Payments FY2010 (Projected) = $519 Billion

Note: Figures do not include administrative expenses. Amount for FY2004 excludes Part D low-income subsidy payments.
SOURCE: Congressional Budget Office, Medicare Fact Sheet, March 2005.

Medicare benefit payments in FY2004 totaled $295 billion. Currently, the largest category of Medicare benefit payments is inpatient hospital services (39 percent). The composition of Medicare benefit payments will shift with the addition of prescription drug coverage in 2006. In FY2010, prescription drugs are projected to account for 20 percent of Medicare benefit payments.

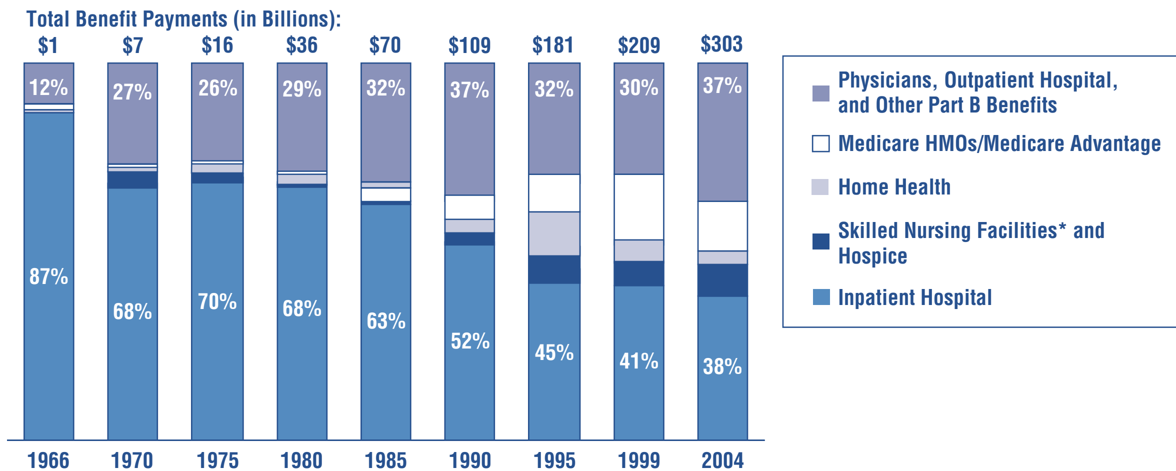
Figure 6.5
Medicare Spending, Fiscal Years 1967–2004



SOURCE: Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2006–2015*, January 2005.

Total Medicare spending was $297 billion in FY2004. Medicare spending has increased each year since the program began in 1966, with the exception of FY1998-1999, when changes in provider payment policies contributed to a reduction in program spending. Since then, Medicare spending has increased annually.

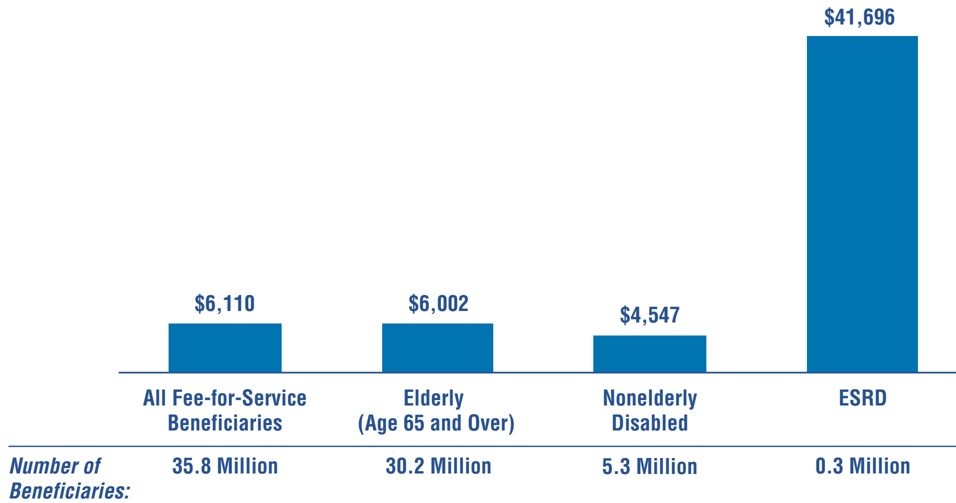
Figure 6.6
Distribution of Medicare Benefit Payments, Calendar Years 1966–2004



Note: *Coverage for skilled nursing facilities was effective January 1, 1967. Total includes expenditures for ESRD beneficiaries, but excludes administrative payments.
SOURCE: All data are from the Health Care Financing Administration (Office of the Actuary, Medicare and Medicaid Cost Estimates Group), December 2000, except for 2004 data, which are from the 2005 Annual Report of the Medicare Trustees.

The distribution of Medicare benefit payments has shifted over time, reflecting changes in health care delivery and how Medicare pays for services. Hospitalizations constituted 87 percent of program spending in 1966, but only 38 percent in 2004, while spending on physician services and other Part B services more than tripled from 12 percent in 1966 to 37 percent in 2004.

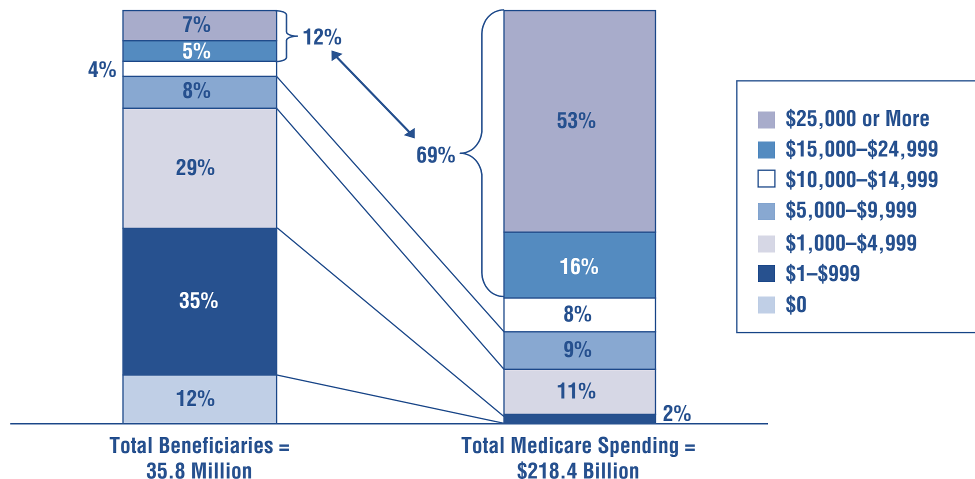
Figure 6.7
Medicare Spending Per Beneficiary, by Eligibility Category, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans. ESRD is end-stage renal disease.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

In 2002, Medicare payments for each beneficiary enrolled in the fee-for-service program (excluding those enrolled in Medicare Advantage plans) averaged $6,110. These payments vary across different types of beneficiaries. Medicare spending on each elderly beneficiary averaged $6,002, while spending for nonelderly disabled beneficiaries was 25 percent less, averaging $4,547. Spending is highest for those beneficiaries who are eligible for Medicare because they have end-stage renal disease (ESRD)—$41,696 on average in 2002.

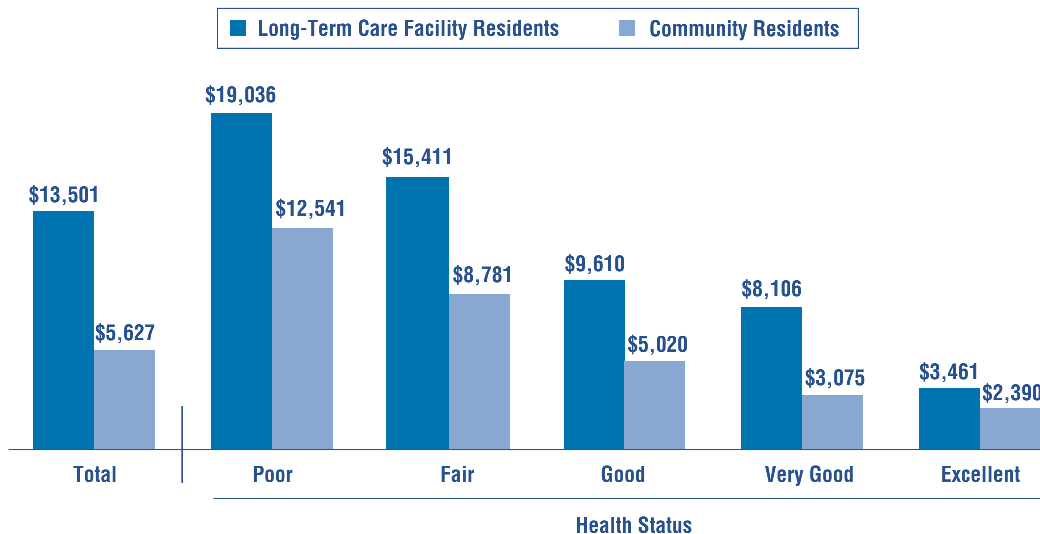
Figure 6.8
Distribution of Fee-for-Service Medicare Beneficiaries and Per Capita Medicare Spending, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare spending is concentrated among a relatively small share of beneficiaries. In 2002, 12 percent of fee-for-service beneficiaries (those not enrolled in Medicare Advantage plans) incurred no Medicare spending. More than one-third of beneficiaries (35 percent) incurred less than $1,000 in Medicare spending per person, accounting for about 2 percent of total Medicare spending. Medicare spending for the 12 percent of beneficiaries who incurred $15,000 or more in per capita costs accounted for 69 percent of program spending.

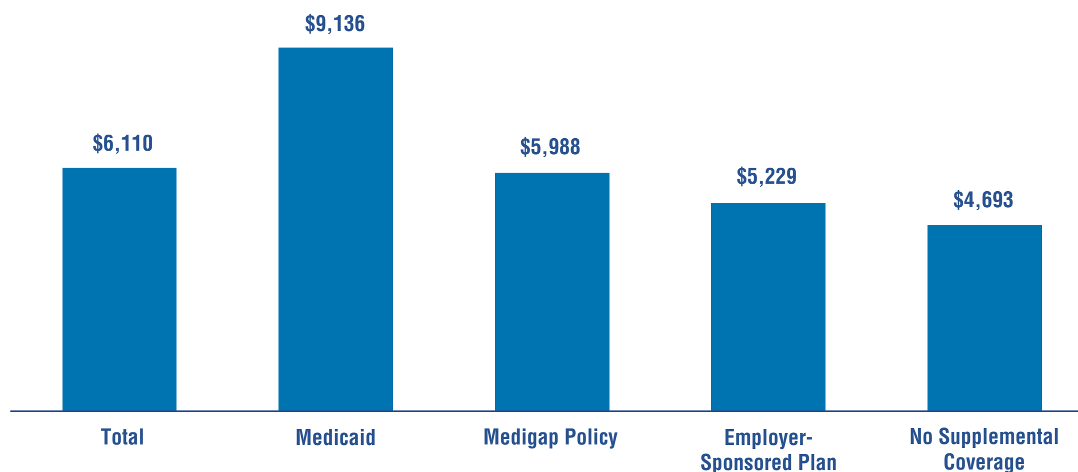
Figure 6.9
Medicare Spending Per Beneficiary, by Health Status and Residence Status, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Across all levels of self-reported health status, beneficiaries who reside in long-term care facilities incur higher per capita Medicare expenses than those living in the community. Regardless of residence status, however, Medicare spending increases as health status decreases, with spending for those in poor health more than five times higher than for those who report excellent health.

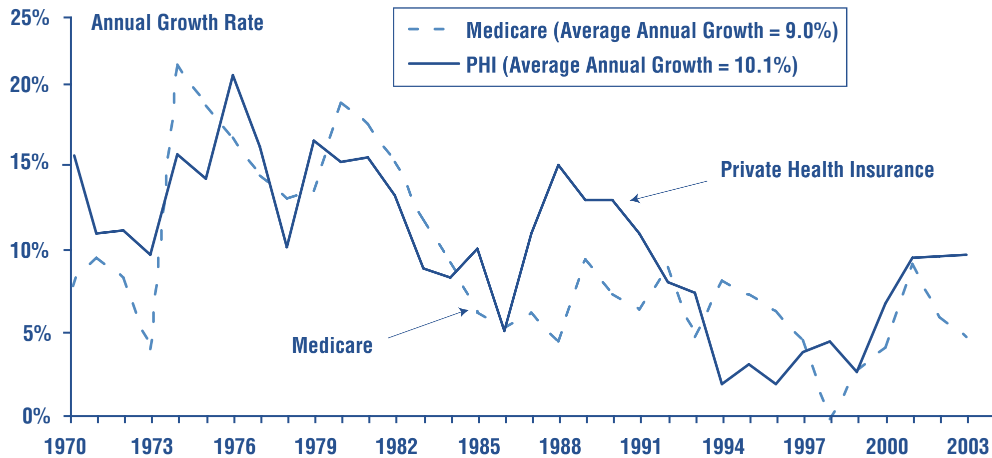
Figure 6.10
Medicare Spending Per Beneficiary, by Primary Source of Supplemental Coverage, 2002



Note: Excludes beneficiaries enrolled in Medicare HMO plans.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare spending per beneficiary varies by source of supplemental insurance coverage, reflecting both differences in health status among those with different types of coverage and the relative generosity of various sources of coverage. In 2002, average Medicare spending for beneficiaries with Medicaid ($9,136) was higher than for other Medicare beneficiaries, reflecting the greater medical care needs and poorer health status of the dual eligible population.

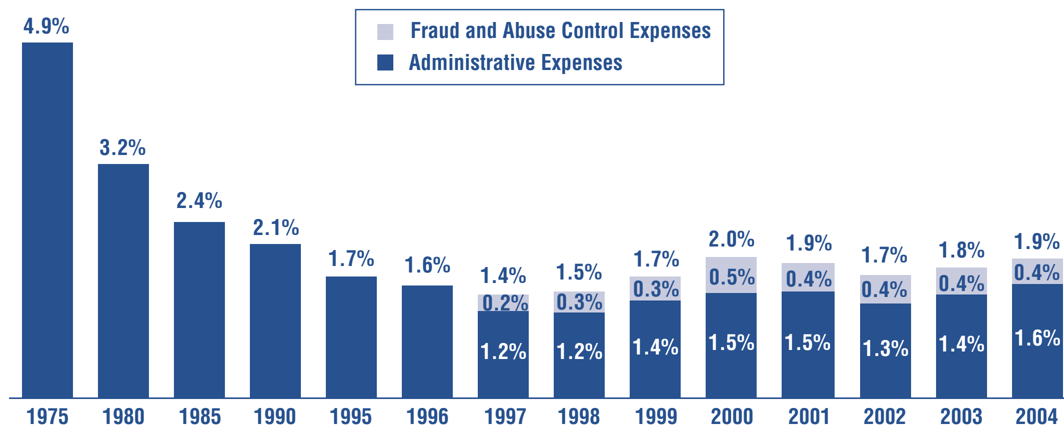
Figure 6.11
Annual Percentage Change in Per Capita Medicare and Private Health Insurance Spending, 1970–2003



Note: Figure shows spending on comparable services covered by Medicare and private health insurance, including hospital services, physician and clinical services, other professional services, and durable medical products. PHI is private health insurance.
SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2004.

On a per capita basis, Medicare spending has grown at a slightly slower pace, on average, than private health insurance spending for comparable services. Private health insurance spending grew at an average annual rate of 10.1 percent in the years between 1970 and 2003, while Medicare spending for similar benefits and services grew at an average rate of 9.0 percent.

Figure 6.12
Medicare Administrative Expenditures as a Share of Medicare Benefit Payments, Fiscal Years 1975–2004



Note: Numbers may not sum to total due to rounding.
SOURCE: 1999-2001 Annual Reports of the Federal Hospital Insurance Trust Fund, 2002-2005 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Administrative expenses currently account for less than 2 percent of Medicare benefit payments, which is significantly lower than the cost of running private health plans. Between 1975 and 2004, Medicare's administrative budget declined from 4.9 percent to 1.9 percent of total benefit spending, despite more complicated reimbursement rules and more health care service delivery options available to beneficiaries.

Section 7

Medicare Financing and Future Projections

SECTION 7: MEDICARE FINANCING AND FUTURE PROJECTIONS

Medicare Parts A and B are financed differently. Part A, paid through the Hospital Insurance (HI) Trust Fund, is financed primarily through a 1.45 percent payroll tax paid by both employees and their employers. In 2006, these taxes will account for 86 percent of income to the Part A Trust Fund, with the remainder coming from interest, taxation of Social Security benefits, and other sources. Part B is financed through the Supplementary Medical Insurance (SMI) Trust Fund and funded by general revenue (75 percent in 2006), beneficiary premiums (24 percent), and interest (2 percent).

Part D, Medicare's new prescription drug benefit, is financed through a separate account within the SMI Trust Fund. When the benefit takes effect in 2006, it will be financed through general revenue (78 percent), payments from states (11 percent), beneficiary premiums (10 percent), and other sources (1 percent). The payments from states (known as the "clawback") are meant to partially cover the costs of low-income Medicare beneficiaries previously eligible for prescription drug benefits under state Medicaid programs.

In FY2006, total Medicare revenues are projected to be $439.5 billion. These funds will come from general revenue (41 percent), payroll taxes (40 percent), beneficiary premiums (11 percent), interest (4 percent), taxation of Social Security benefits (2 percent), and other sources (2 percent). The share of Medicare revenue from payroll taxes, the largest source of income to the Medicare trust funds in 2004, has decreased since the early 1970s, largely as a result of faster growth in Part B expenditures, which are not funded by the payroll tax. General revenue accounted for almost one-third of total Medicare revenue in 2004, but will represent a larger share in the future.

As part of an annual assessment of Medicare's financial outlook, the Boards of Trustees of Medicare issue a report on the current and projected status of the program, including the HI and SMI Trust Funds. Since Medicare's implementation, the primary sources of income for Part B (the SMI Trust Fund)—premiums and general revenues—have been set each year at a level sufficient to pay benefits. Because the HI Trust Fund can theoretically become insolvent, its status has become a proxy for Medicare's overall financial health. In almost every year to date, total HI Trust Fund income has exceeded expenditures. While income from all sources is expected to exceed expenditures in the short run, spending will begin to exceed income in 2012, according to the Trustees' intermediate assumptions.

The Medicare Trustees also project how long the HI Trust Fund will remain solvent. In 2005, the Trustees projected that fund reserves will be exhausted and have insufficient funds to pay benefits in 2020. This projection varies from year to year due to changes in underlying economic conditions, expectations about future health care costs, and legislated changes in the Medicare program. For example, the number of years through which the Trustees have projected the HI Trust Fund to have sufficient funds to pay benefits has ranged from four to 28 over the last decade alone. In 2004, the solvency projection fell from 23 years to 15 years, due in part to the economic downturn and faster than expected expenditure growth, along with legislative changes to increase payments to Medicare Advantage plans and rural health providers (enacted as part of the Medicare Modernization Act of 2003).

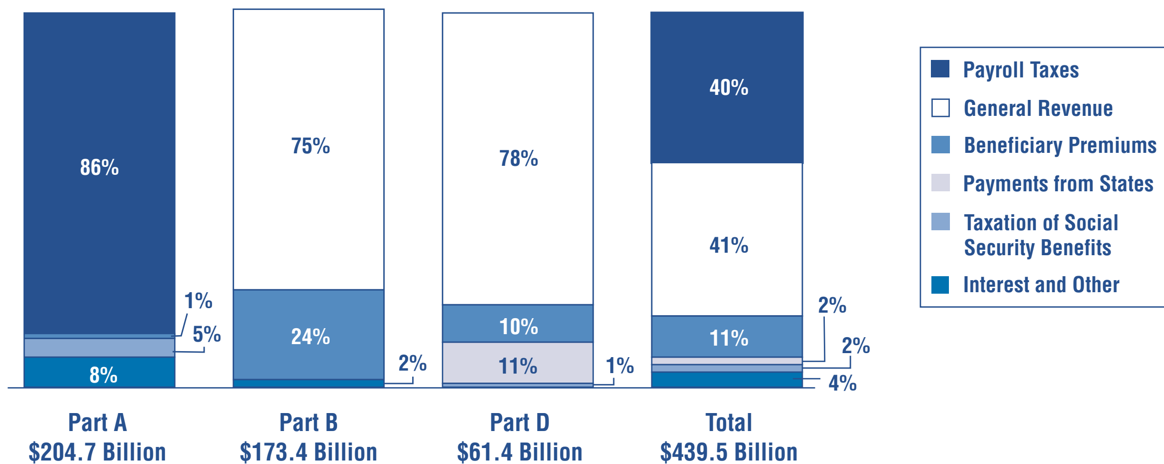
The Medicare Modernization Act established a new process for reviewing the role of general revenue in financing Medicare. Beginning in 2005, the Medicare Boards of Trustees are required to report annually whether general revenue will finance 45 percent or more of Medicare spending in any of the next seven years. If the 45 percent level is projected to be reached, a determination of "excess general revenue" is triggered. If this determination is made two years in a row, a "Medicare funding warning" is issued, and the President must submit to Congress proposed

legislation to respond to the warning. Congress then considers this legislation on an expedited basis. In 2005, the Trustees projected that general revenue financing will reach the 45 percent threshold in 2012. If this projection holds, the first "excess general revenue" determination would be made in 2006, and the Medicare funding warning and legislative process may be triggered as early as 2007.

Over the long term, Medicare will face significant financing challenges due to the aging of the U.S. population. The first of the "Baby Boom" generation will reach age 65 and become eligible for Medicare in 2010. Between 2000 and 2030, the number of Medicare beneficiaries is projected to almost double, from 40 million to 78 million. The aging of the population has significant implications for Medicare financing. Because the HI Trust Fund is financed primarily through payroll taxes, its income is directly related to the number of individuals in the workforce. The number of workers is projected to rise slower than the number of beneficiaries, thus increasing the implicit burden on each worker over the next generation. There were 3.9 workers per Medicare beneficiary in 2003, but there are projected to be only 2.4 workers per beneficiary in 2030.

With the aging of the population and expected increases in overall health care costs, largely due to new and more expensive medical technologies, 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 overall economy, as measured by the gross domestic product (GDP), is estimated to triple from 2.3 percent to 6.8 percent. The addition of the prescription drug benefit to Medicare accounts for more than one-third of that increase.

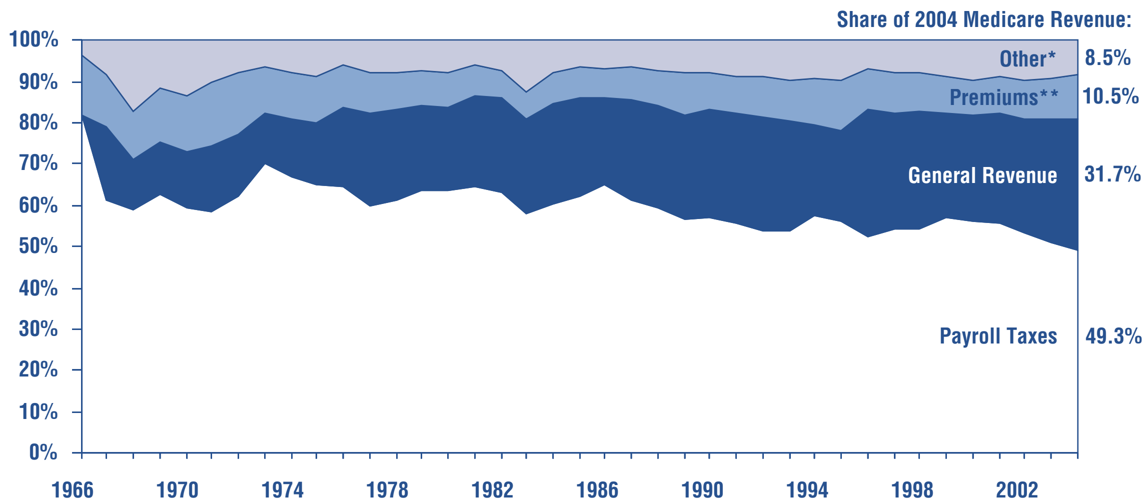
Figure 7.1
Sources of Medicare Revenue, FY2006



SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Medicare Parts A, B, and D (beginning in 2006) are financed differently. Payroll taxes finance the majority of Part A, while general revenues fund three-fourths of Parts B and D. In FY2006, total Medicare revenue is estimated to come largely from general revenue (41 percent), payroll taxes (40 percent), and beneficiary premiums (11 percent).

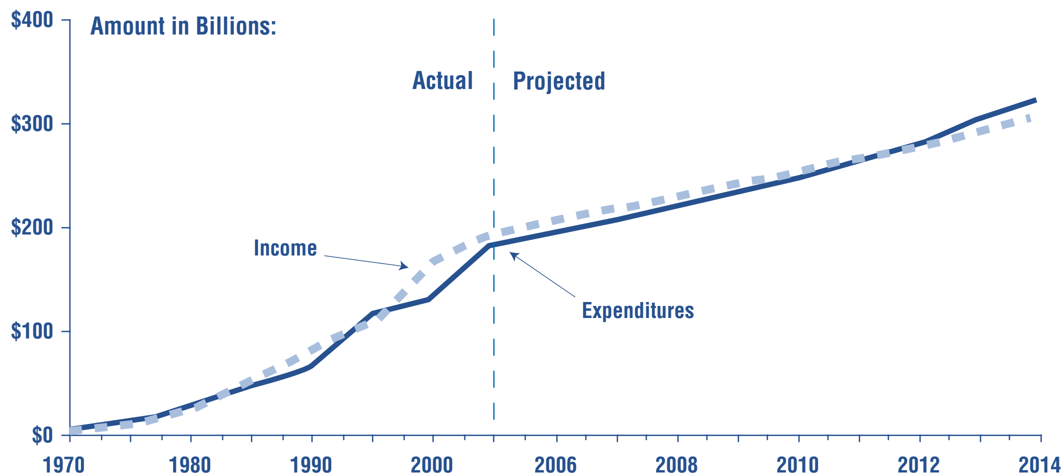
Figure 7.2
Income of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, by Source, 1966–2004



Note: *Includes income from taxation of Social Security benefits, railroad retirement account transfers, reimbursement for uninsured persons, payments for military wage credits, recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund, amounts from the fraud and abuse control system, interest, and a small amount of miscellaneous income. **Includes premiums from voluntary enrollees in the Hospital Insurance Program and all enrollees in the Supplementary Medical Insurance Program.
SOURCE: Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, various years.

Payroll taxes are the largest source of Medicare revenue, although they have decreased from about two-thirds of all revenue in the early 1970s to just under half in 2004. This has resulted from faster growth in Part B spending than Part A spending, which is funded primarily by general revenue (75 percent) and beneficiary premiums (25 percent). General revenue accounted for almost one-third of total Medicare revenue in 2004.

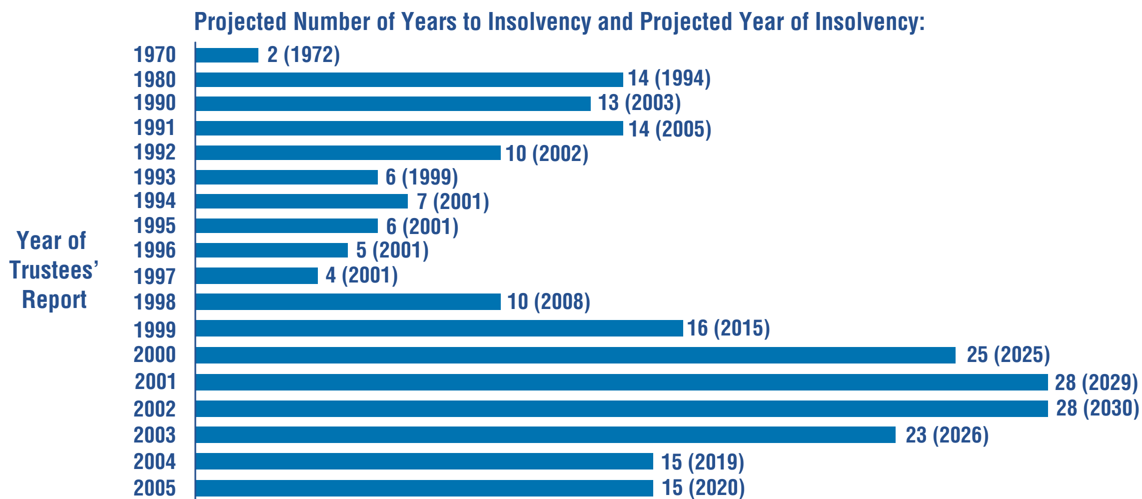
Figure 7.3
Operations of the Hospital Insurance Trust Fund, 1970–2014



SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

In almost every year to date since Medicare's inception, total income to the Hospital Insurance Trust Fund has exceeded expenditures, except during the 1995–1997 period. While income from all sources is expected to exceed expenditures in the short run, spending will begin to exceed income in 2012, according to the intermediate assumptions made by the Medicare Trustees in 2005.

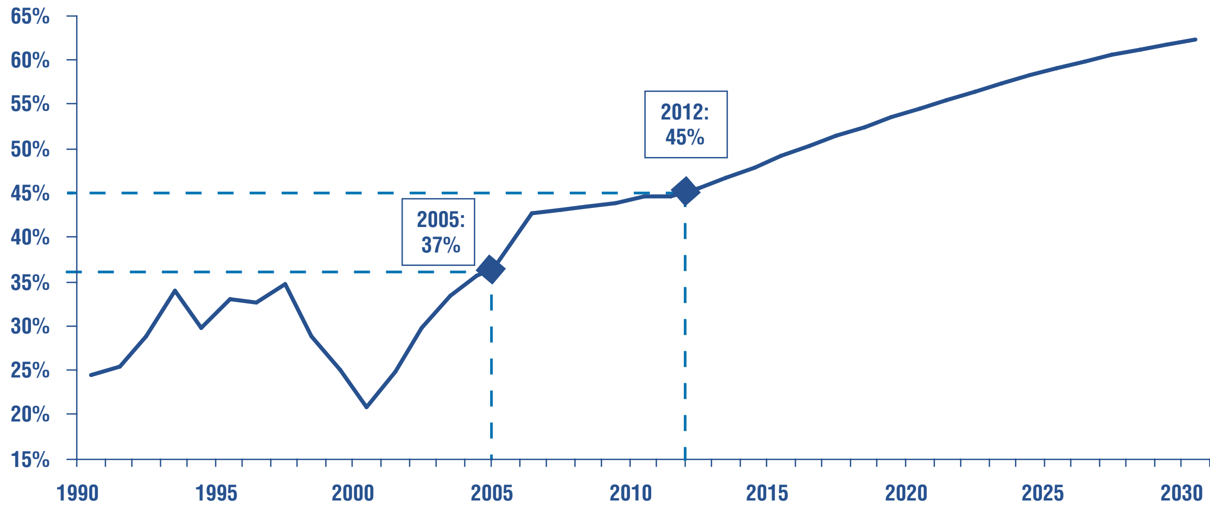
Figure 7.4
Solvency Projections of the Hospital Insurance Trust Fund, 1970–2005



Note: No specific projections were made for 1973–1975 and 1989. For all other years not displayed, the Hospital Insurance Trust Fund was projected to remain solvent for 17 or fewer years.
SOURCE: Intermediate projections from 1970–2005 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

The Medicare Trustees' assessment of the financial outlook for the Medicare Hospital Insurance Trust Fund has varied significantly from year to year, with projections ranging from four years to 28 years of remaining solvency over the last decade alone. Between 2003 and 2005, the solvency projection fell from 23 years to 15 years, due in part to an economic downturn, faster than expected expenditure growth, and increased payments to Medicare Advantage plans and rural health providers.

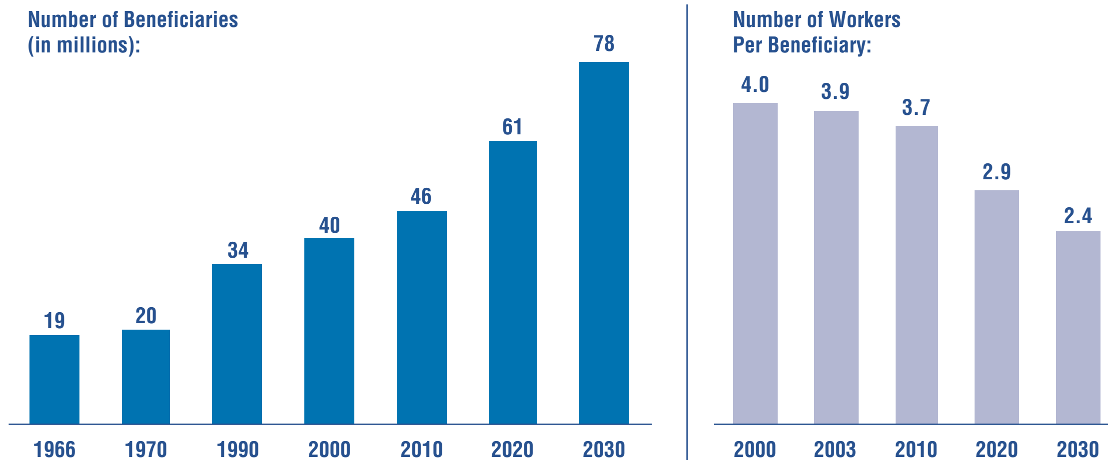
Figure 7.5
General Revenue as a Share of Medicare Spending, 1990–2030



SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

The Medicare Trustees are required to report annually whether general revenue will finance 45 percent or more of total Medicare spending in any of the next seven years. In 2005, the Trustees projected that general revenue will exceed 45 percent of total spending in 2012.

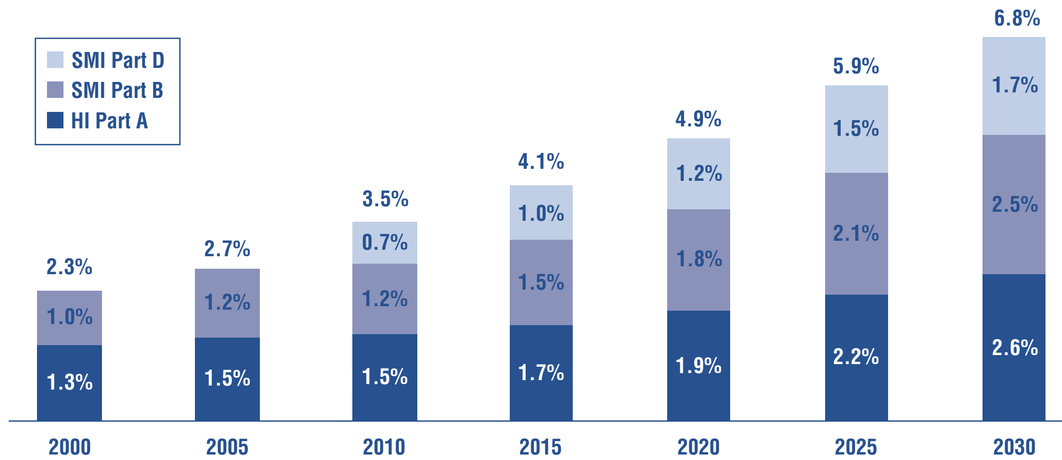
Figure 7.6
Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary



SOURCE: 2001 and 2005 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Between 2000 and 2030, the number of Medicare beneficiaries is projected to increase from 40 million to 78 million. Because the Hospital Insurance Trust Fund is financed primarily through payroll taxes, its income is related to the number of people in the workforce. As the number of beneficiaries increases, the number of workers per beneficiary is projected to decrease from 4.0 in 2000 to 2.4 in 2030.

Figure 7.7
Projected Medicare Spending as a Percent of Gross Domestic Product (GDP), 2000–2030



Note: HI is Hospital Insurance. SMI is Supplementary Medical Insurance. Numbers may not sum to total due to rounding.
SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

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, as measured by the gross domestic product (GDP). Between 2000 and 2030, Medicare's share of GDP is estimated to triple from 2.3 percent to 6.8 percent. The addition of the prescription drug benefit (Part D) in 2006 accounts for more than one-third of the increase.

Appendices

APPENDIX A
MEDICARE TIMELINE, 1965–2005

January 1965 President Johnson's first legislative message to the 89th Congress, *Advancing the Nation's Health,* detailed a program including hospital insurance for the aged under Social Security and health care for needy children.

March–July 1965 The House of Representatives (307-116) and the Senate (70-24) passed "the Mills Bill" (H.R. 6675), a package of health benefits and Social Security improvements.

July 30, 1965 President Johnson signed H.R. 6675 (Public Law 89-97) to establish Medicare for the elderly and Medicaid for the indigent in Independence, Missouri, in the presence of Harry S. Truman who advocated for such legislation in a message to Congress in 1945.

President Truman was the first to enroll in Medicare.

Medicare Part A deductible: $40/year
Medicare Part B premium: $3/month

1966 The Social Security Administration announced the selection of private insurance companies to perform the major administrative functions of bill processing and benefit payment functions for Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) of the Medicare program.

July 1, 1966 Medicare coverage began. All persons age 65 and over were automatically covered under Part A. Coverage began for seniors who signed up for the voluntary medical insurance program (Part B). More than 19 million individuals ages 65 and older were enrolled in Medicare.

1969 The Task Force on Prescription Drugs, chaired by Dr. Philip Lee, released its final report on the costs and feasibility of adding prescription drug coverage to Medicare.

1970 Medicare Part A deductible: $52/year
Medicare Part B premium: $4/month
Total Medicare population: 20.4 million beneficiaries

October 30, 1972 President Nixon signed the Social Security Amendments of 1972 (P.L. 92-603), the first major adjustment to Medicare after its enactment. Medicare eligibility was extended to individuals under age 65 with long-term disabilities (who were receiving SSDI payments for two years) and to individuals with end-stage renal disease (ESRD). The amendments also established professional standards review organizations (PSROs) to review patient care, encouraged the use of health maintenance organizations (HMOs), and gave Medicare the authority to conduct demonstration programs.

Medicare benefits were expanded to include some chiropractic services, speech therapy, and physical therapy.

1973 Medicare coverage began for individuals receiving Social Security Disability Insurance (SSDI) cash payments for two or more years. Nearly 2 million people under age 65 with long-term disabilities or ESRD were covered.

1975 Medicare Part A deductible: $92/year
Medicare Part B premium: $6.70/month
Total Medicare population: 24.9 million beneficiaries

1977 Joe Califano, Secretary of the Department of Health, Education and Welfare, created the Health Care Financing Administration (HCFA) to administer both the Medicare and Medicaid programs. About 1,500 employees were transferred to HCFA from the Social Security Administration.

1980 The Omnibus Reconciliation Act of 1980 expanded home health services by eliminating the limit on the number of home health visits, the prior hospitalization requirement, and the deductible for any Part B benefits. It also required the Secretary to develop a list of surgical procedures that could be done on an outpatient basis in an ambulatory surgical center and would be reimbursed on a prospective payment system. The "Baucus Amendments" brought Medicare supplemental insurance, also called "Medigap," under federal oversight and established a voluntary certification program for Medigap policies.

Medicare Part A deductible: $180/year
Medicare Part B premium: $8.70/month
Total Medicare population: 28.4 million beneficiaries

1981 The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) included provisions to slow the growth in Medicare spending, including a change that resulted in an increase in the inpatient hospital deductible.

1982 The Tax Equity and Fiscal Responsibility Act (TEFRA) increased the Part B premium to cover 25% of program costs as part of policies designed to slow the growth of Medicare spending. Hospice services for the terminally ill were added to Medicare's covered benefits. TEFRA facilitated HMOs' participation in the Medicare program and established a risk-based prospective payment system for these plans. The Act also expanded HCFA's quality oversight efforts by replacing Professional Standards Review Organizations (PSROs) with Peer Review Organizations (PROs). TEFRA imposed a ceiling on the amount Medicare would pay for a hospital discharge and required HHS to submit a plan for prospective payments to hospitals and nursing homes. TEFRA required federal employees to begin paying the HI payroll tax.

1983 The Social Security amendments of 1983 established an inpatient hospital prospective payment system (PPS) for the Medicare program. The PPS is based on diagnosis-related groups, or DRGs, a pre-determined payment for treating a specific condition. The system was adopted to replace cost-based payments.

1984 The Deficit Reduction Act of 1984 (DEFRA) froze physician fees, established the Participating Physicians' Program, and established fee schedules for laboratory services, all of which were intended to slow the growth of Medicare's spending and constrain the federal deficit.

1985 The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) made Medicare coverage mandatory for newly hired state and local government employees. In addition, COBRA established the Emergency Medical Treatment and Labor Act (EMTALA), which required hospitals participating in Medicare that operate active emergency rooms to provide appropriate medical screenings and stabilizing treatments.

The Emergency Extension Act of 1985 froze PPS payment rates for inpatient hospital care and continued physician payment freezes to slow the growth of Medicare spending.

Medicare Part A deductible: $400/year
Medicare Part B premium: $15.50/month
Total Medicare population: 31.1 million beneficiaries

1986 The Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) revised several of the payment procedures for various Medicare services in order to help slow the growth in Medicare spending.

1987 The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) imposed quality standards for Medicare- and Medicaid-certified nursing homes—in response to well-documented quality problems facing seniors in nursing homes. OBRA 87 also modified payments to providers under Medicare as part of the deficit reduction legislation.

The Medicare and Medicaid Patient and Program Protection Act of 1987 was enacted to improve antifraud efforts and strengthen beneficiary protection programs.

The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 froze Medicare payment rates in an attempt to slow Medicare spending.

1988 The Medicare Catastrophic Coverage Act of 1988, the largest expansion of the program since the enactment of Medicare, provided an outpatient prescription drug benefit, placed a cap on beneficiaries' out-of-pocket expenses, and expanded hospital and skilled nursing facility benefits. Medicaid began coverage of Medicare premiums and cost-sharing for Medicare beneficiaries with incomes below 100% of the federal poverty level, known as Qualified Medicare Beneficiaries (QMBs). The U.S. Bipartisan Commission on Comprehensive Health Care (which became known as the Pepper Commission after the late Congressman Claude Pepper of Florida) was established to assess the feasibility of a long-term care benefit under Medicare.

The Clinical Laboratory Improvement Amendments were enacted to strengthen quality performance requirements for clinical laboratories to provide more accurate and reliable laboratory tests.

1989 The Medicare Catastrophic Coverage Repeal Act of 1989 retracted the major provisions of the Medicare Catastrophic Coverage Act of 1988, including both the outpatient drug benefit and the out-of-pocket expense limit. QMB benefits were retained.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) established the Resource-Based Relative Value Scale (RBRVS) for physicians, replacing charge-based payments. Limits were placed on physician balance billing. Physicians were prohibited from referring Medicare patients to clinical laboratories in which they have a financial interest. OBRA 1989 also included a number of other provisions designed to slow the growth in Medicare spending.

1990 The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) established the Specified Low-Income Medicare Beneficiary (SLMB) eligibility group requiring state Medicaid programs to cover premiums for beneficiaries with incomes between 100% and 120% of the federal poverty level. Medicare was expanded to cover screening mammography and partial hospitalization services in community mental health centers. Federal standards were established for Medigap policies, including standardized benefit packages and minimum loss ratios, replacing the voluntary certification system.

The U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) recommended the creation of a new Medicare long-term care program that would provide nursing home and home- and community-based services. These recommendations were not enacted.

Medicare Part A deductible: $592/year
Medicare Part B premium: $28.60/month
Total Medicare population: 34.3 million beneficiaries

1993 The Omnibus Budget Reconciliation Act of 1993 modified payments to Medicare providers, as part of overall deficit reduction legislation, and lifted the cap on the amount of wages subject to the HI payroll tax.

States started to cover Medicare Part B premiums for SLMBs.

1995 Medicare Part A deductible: $716/year
Medicare Part B premium: $46.10/month
Total Medicare population: 37.6 million beneficiaries

1996 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Medicare Integrity Program, which dedicated funds for program integrity activities.

1997 The Balanced Budget Act of 1997 (BBA) included a broad range of changes in provider payments to slow the growth in Medicare spending as part of legislation to balance the federal budget. It also established the Medicare+Choice program, a new structure for Medicare HMOs and other private health plans offered to beneficiaries. The BBA also required HCFA to develop and implement five new Medicare prospective payment systems: inpatient rehabilitation hospital or unit services; skilled nursing facility services; home health services; hospital outpatient services; and outpatient rehabilitation services. The law also provided additional assistance with Medicare Part B premiums for beneficiaries with incomes between 120% and 135% of poverty (QI-1s) through a first-come first-served block grant program administered by state Medicaid programs. The law provided for partial assistance with premiums for beneficiaries with incomes between 135% and 175% of poverty (QI-2s). The BBA also established the National Advisory Commission on the Future of Medicare and the Medicare Payment Advisory Commission (which replaced both the Prospective Payment Assessment Commission and the Physician Payment Review Commission).

1998 The internet site www.Medicare.gov was launched to provide updated information about Medicare.

1999 The toll-free number, 1-800-MEDICARE (1-800-633-4227), was made available nationwide. The first annual *Medicare & You* handbook was mailed to all Medicare beneficiary households.

The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work.

The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and reduced or froze payment rates for other Medicare services. BBRA also increased payments to Medicare+Choice plans.

The National Advisory Commission on the Future of Medicare completed its work on Medicare reform but lacked sufficient votes to report out a formal recommendation.

2000 The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 further increased Medicare payments to providers and Medicare+Choice plans, reduced certain Medicare beneficiary copayments, and added coverage for certain preventive services. BIPA also enabled people with amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) to enroll in Medicare upon diagnosis instead of having to satisfy the 24-month waiting period.

Medicare Part A deductible: $776/year
Medicare Part B premium: $54.40/month
Total Medicare population: 39.7 million beneficiaries

2001 Secretary of Health and Human Services, Tommy Thompson, renamed HCFA, as the Centers for Medicare and Medicaid Services (CMS).

Medicare began covering people with ALS.

2002 The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, along with other public health measures, temporarily moved deadlines for submitting Medicare+Choice plan information. The law stated that in 2005, individuals enrolled in M+C plans would only be able to make and change elections to an M+C plan on a more limited basis, which was later changed by the Medicare Modernization Act of 2003.

2003 The Consolidated Appropriations Resolution (CAR) of 2003 increased payments for some hospitals, updated the physician fee schedule, and extended payment of the Part B premium for QI-1s.

QI-2 beneficiaries no longer received assistance from Medicaid in paying their Part B premiums.

December 8, 2003 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was passed by the House (220-215) and the Senate (54-44) in November and signed into law (P.L. 108-173) by President Bush on December 8, 2003, providing a new outpatient prescription drug benefit under Medicare beginning in 2006. For 2004 and 2005, it established a temporary prescription drug discount card and transitional assistance program. The MMA also established a new income-related Part B premium for beneficiaries with higher incomes (beginning in 2007), indexed the Part B deductible, created regional PPOs under the Medicare Advantage program (previously called Medicare+Choice), and established financial and other incentives for private health plans to contract with Medicare. The MMA also established a new way of assessing Medicare's financial status by measuring general revenue as a share of total Medicare spending.

2004 A temporary Medicare-Approved Drug Discount Card Program began, along with a transitional assistance program to provide a $600 annual credit to low-income Medicare beneficiaries without prescription drug coverage in 2004 and 2005.

2005 Medicare began covering a "Welcome to Medicare" physical, along with other preventive services, such as cardiovascular screening blood tests and diabetes screening tests. Medicare also began education and outreach activities for beneficiaries related to the prescription drug benefit beginning on January 1, 2006.

Medicare Part A deductible: $912/year
Medicare Part B premium: $78.20/month
Total Medicare population: 42.3 million beneficiaries

Appendix B
Medicare Beneficiary Premiums, Deductibles, and Coinsurance, 1966–2014

		Part A					Part B		Part D	
	Year	Inpatient Hospital Deductible	Daily Coinsurance (61st–90th Day)	60 Lifetime Reserve Days Daily Coinsurance	SNF Daily Coinsurance* (21st–100th Day)	Full Part A Monthly Premiums**	Monthly Premium***	Annual Deductible	Monthly Premium	Annual Deductible
Actual	1966	$40	$10	-	-	-	$3.00	$50	-	-
	1971	$60	$15	$30	$7.50	-	$5.60	$50	-	-
	1976	$104	$26	$52	$13.00	$45	$7.20	$60	-	-
	1981	$204	$51	$102	$25.50	$89	$11.00	$60	-	-
	1987	$520	$130	$260	$65.00	$226	$17.90	$75	-	-
	1988	$540	$135	$270	$67.50	$234	$24.80	$75	-	-
	1989	$560	N/A	N/A	$25.50	$156	$31.90	$75	-	-
	1990	$592	$148	$296	$74.00	$176	$28.60	$75	-	-
	1991	$628	$157	$314	$78.50	$177	$29.90	$100	-	-
	1992	$652	$163	$326	$81.50	$192	$31.80	$100	-	-
	1993	$676	$169	$338	$84.50	$221	$36.60	$100	-	-
	1994	$696	$174	$348	$87.00	$245 ($184)	$41.10	$100	-	-
	1995	$716	$179	$358	$89.50	$261 ($183)	$46.10	$100	-	-
	1996	$736	$184	$368	$92.00	$289 ($188)	$42.50	$100	-	-
	1997	$760	$190	$380	$95.00	$311 ($187)	$43.80	$100	-	-
	1998	$764	$191	$382	$95.50	$309 ($170)	$43.80	$100	-	-
	1999	$768	$192	$384	$96.00	$309 ($170)	$45.50	$100	-	-
	2000	$776	$194	$388	$97.00	$301 ($166)	$45.50	$100	-	-
	2001	$792	$198	$396	$99.00	$300 ($165)	$50.00	$100	-	-
	2002	$812	$203	$406	$101.50	$319 ($175)	$54.00	$100	-	-
	2003	$840	$210	$420	$105.00	$316 ($174)	$58.70	$100	-	-
	2004	$876	$219	$438	$109.50	$343 ($189)	$66.60	$100	-	-
	2005	$912	$228	$456	$114.00	$375 ($206)	$78.20	$110	-	-
Projected	2006	$956	$239	$478	$119.50	$386 ($212)	$87.70	$123	$37.37	$250
	2007	$1,004	$251	$502	$125.50	$403 ($222)	$87.70	$123	$41.22	$270
	2008	$1,056	$264	$528	$132.00	$421 ($232)	$87.70	$123	$43.73	$290
	2009	$1,108	$277	$554	$138.50	$438 ($241)	$89.30	$125	$46.31	$310
	2010	$1,164	$291	$582	$145.50	$457 ($251)	$92.00	$129	$48.94	$331
	2011	$1,220	$305	$610	$152.50	$476 ($262)	$94.80	$133	$51.58	$352
	2012	$1,276	$319	$638	$159.50	$494 ($272)	$99.70	$140	$55.45	$373
	2013	$1,336	$334	$668	$167.00	$514 ($283)	$107.10	$150	$59.74	$404
	2014	$1,396	$349	$698	$174.50	$533 ($293)	$114.70	$161	$64.26	$437

Note: *In 1989, the SNF coinsurance applied to days 1-8 of the 150 days allowed annually; for the other years, it applies to days 21–100 of the 100 days allowed per benefit period.
**Amount in parentheses is for people who have paid Medicare taxes during at least 30 of the 40 quarters required to be fully insured.
***Part B premium was originally 50% of projected costs. Congress set it at 25% permanently in 1997.
N/A is not applicable. SNF is skilled nursing facility.
SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Appendix C
Characteristics of the Medicare Population, 2002

		Total Community	Aged Community (No ESRD)	Disabled Community (No ESRD)	ESRD* Community	Total Facility
Number of Beneficiaries		39,424,106	33,731,915	5,363,555	328,636	2,384,285
Gender	Male	44.6%	42.8%	55.4%	59.5%	33.2%
	Female	55.4%	57.2%	44.6%	40.5%	66.8%
Age	Under 65	14.1%	N/A	100.0%	57.2%	15.9%
	65–74	44.9%	52.2%	N/A	24.3%	11.0%
	75–84	31.3%	36.4%	N/A	14.8%	31.1%
	85 and over	9.7%	11.3%	N/A	3.8%	42.1%
Living Arrangement	Lives alone	30.7%	31.6%	25.0%	29.0%	N/A
	Lives with spouse	52.1%	54.2%	39.7%	46.1%	N/A
	Lives with children	9.5%	9.3%	11.2%	7.2%	N/A
	Lives with others	7.7%	4.9%	24.0%	17.7%	N/A
	Lives in long-term care facility	N/A	N/A	N/A	N/A	100.0%
Race/Ethnicity	White, non-Hispanic	78.7%	80.8%	67.1%	50.8%	89.4%
	African American, non-Hispanic	9.4%	8.0%	17.0%	30.2%	9.0%
	Hispanic	7.6%	7.0%	10.6%	10.3%	4.6%
	Asian	2.0%	2.2%	1.1%	1.4%	0.6%
	Other	2.3%	1.9%	4.2%	7.4%	0.3%
Marital Status	Married	53.6%	55.6%	40.7%	49.8%	19.0%
	Widowed	28.8%	32.5%	7.1%	11.1%	50.5%
	Divorced/Separated	10.3%	8.6%	27.8%	26.4%	9.0%
	Never married	6.0%	3.1%	23.7%	12.7%	21.0%
Lives in a Metropolitan Area	Yes	76.3%	76.8%	72.7%	80.7%	76.6%
	No	23.6%	23.1%	26.9%	19.3%	23.4%
Education	8th grade or less	15.0%	14.5%	15.0%	15.7%	25.7%
	Some high school	16.2%	15.6%	19.4%	18.9%	17.1%
	High school graduate	29.8%	29.7%	31.1%	25.3%	22.5%
	Some college or 2-year degree	23.8%	23.3%	26.4%	27.2%	14.9%
	College graduate or more	15.2%	16.4%	8.1%	12.9%	7.3%
Income	$10,000 or less	20.0%	16.6%	40.4%	37.2%	46.3%
	$10,001–$20,000	29.5%	29.6%	28.8%	28.3%	31.2%
	$20,001–$30,000	21.2%	22.7%	14.2%	13.8%	12.8%
	$30,001–$40,000	10.8%	11.6%	6.3%	3.0%	3.6%
	More than $40,000	18.3%	19.5%	10.4%	17.8%	6.1%
Supplemental Insurance Coverage	No supplemental coverage	11.6%	9.7%	24.0%	8.9%	23.5%
	Medicare HMO	14.9%	15.9%	8.6%	7.5%	8.1%
	Employer-sponsored	37.0%	39.2%	23.2%	39.5%	4.0%
	Medigap	22.4%	25.4%	4.6%	6.4%	3.3%
	Medicaid	14.1%	9.9%	39.7%	37.6%	61.3%
Self-Reported Health Status	Poor	8.7%	5.5%	27.1%	37.8%	18.2%
	Fair	19.3%	16.6%	35.8%	22.5%	40.0%
	Good	31.2%	32.3%	23.8%	30.7%	28.7%
	Very good	26.0%	28.9%	8.9%	6.2%	9.6%
	Excellent	14.4%	16.2%	4.1%	0.5%	2.9%

Note: *ESRD (end-stage renal disease) includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD.
N/A is not applicable. Numbers may not sum to 100% due to rounding or exclusion of missing/don't know/refused responses in same categories.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

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Appendix C
Characteristics of the Medicare Population, 2002 (continued)

	Total Community	Aged (No ESRD)	Disabled (No ESRD)	Ages 65–84 (No ESRD)	Ages 85+ (No ESRD)	ESRD* Community	Total Facility
Number of Beneficiaries	39,424,106	33,731,915	5,363,555	30,046,796	3,825,895	328,636	2,384,285
Presence of Chronic Conditions	**Percentage of Beneficiaries with Health Condition**						
No Chronic Conditions**	13.0%	12.3%	18.5%	12.9%	6.9%	90.0%	23.7%
1 Chronic Condition	23.8%	24.0%	22.8%	24.3%	21.4%	11.7%	26.6%
2 or more Chronic Conditions	63.2%	63.7%	58.7%	62.8%	71.7%	87.4%	49.7%
3 or more Chronic Conditions	36.1%	36.0%	35.7%	35.2%	42.9%	55.6%	24.1%
4 or more Chronic Conditions	16.1%	15.9%	17.1%	15.3%	20.4%	29.1%	9.0%
5 or more Chronic Conditions	5.6%	5.4%	6.6%	5.3%	6.8%	8.3%	2.3%
Hypertension	59.5%	60.2%	53.0%	59.9%	63.5%	94.7%	39.4%
Emphysema	15.7%	14.4%	23.4%	14.8%	11.7%	13.1%	8.9%
Diabetes	20.1%	19.4%	22.2%	20.2%	14.8%	56.0%	20.5%
Heart Condition***	42.2%	42.6%	38.4%	41.3%	54.2%	58.2%	30.9%
Arthritis	58.0%	58.9%	52.2%	58.1%	65.3%	54.4%	19.1%
Osteoporosis	18.2%	18.7%	15.1%	18.3%	21.8%	13.3%	12.3%
Broken Hip	3.5%	3.6%	2.8%	2.7%	10.7%	8.9%	3.4%
Parkinson's Disease	1.3%	1.5%	60.0%	1.4%	1.7%	0.0%	5.8%
Stroke	11.8%	11.7%	11.7%	11.2%	16.7%	14.7%	14.1%
Alzheimer's Disease	3.1%	3.4%	1.5%	2.5%	10.2%	2.6%	18.0%
Skin Cancer	17.7%	19.5%	6.9%	18.8%	25.3%	12.4%	70.0%
Other Types of Cancer	18.0%	19.0%	12.7%	18.8%	20.3%	9.0%	4.7%
Urinary Incontinence****	8.8%	9.1%	7.1%	8.0%	17.4%	5.7%	44.8%
Cognitive/Mental Impairment*****	25.9%	20.5%	59.4%	19.1%	31.9%	32.3%	77.6%
1 or more Limitations in Activities of Daily Living (ADLs)	31.8%	27.8%	49.0%	24.9%	51.1%	45.3%	N/A

Note: *ESRD (end-stage renal disease) includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD.
**The count for chronic conditions includes diagnosis with arthritis, diabetes, emphysema, hypertension, osteoporosis, Parkinson's disease, stroke, incontinence, broken hip, and/or angina/chronic heart disease.
***Heart condition is defined as diagnosis with hardening of arteries, angina, myocardial infarction, congestive heart failure, or problem with heart valves or heart rhythm.
****Urinary incontinence is defined as loss of urine control more than once per week in the last 12 months.
*****Cognitive/mental impairment is defined as presence of mental retardation, mental disorder, Alzheimer's disease, or memory loss that interferes with daily activity. For facility residents, definition also includes presence of schizophrenia and/or dementia.
N/A is not applicable. Numbers may not sum to 100% due to rounding or exclusion of missing/don't know/refused responses in some categories.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Appendix D
Characteristics of the Medicare Population, by State, Selected Years

	Number of Medicare Beneficiaries (2003)	Projected Age 65+ (2030)	Age 65+ (2003)	Under Age 65 (2003)	Residing in Rural Areas (2004)	Income <100% of Poverty (2002–2003)	Income 100%–199% of Poverty (2002–2003)	Enrolled in Medicaid (2002)	Enrolled in Medicare Advantage Plans (2004)
United States Total	40,172,605 (14% of U.S. Population)	20% of U.S. Population	85% of U.S. Medicare Population	15% of U.S. Medicare Population	24% of U.S. Medicare Population	12% of U.S. Medicare Population	32% of U.S. Medicare Population	18% of U.S. Medicare Population	11% of U.S. Medicare Population
STATE	**Medicare Beneficiaries with Characteristic as a Percent of State Medicare Population**								
Alabama	719,246 (16%)	21%	79%	21%	35%	15%	32%	23%	6%
Alaska	47,749 (7%)	15%	82%	18%	42%	11%	21%	20%	0%
Arizona	728,885 (13%)	22%	86%	14%	16%	8%	32%	9%	26%
Arkansas	452,676 (17%)	20%	80%	20%	61%	17%	36%	27%	0%
California	4,078,426 (11%)	18%	87%	13%	4%	11%	30%	23%	29%
Colorado	493,454 (11%)	17%	86%	14%	23%	11%	26%	15%	21%
Connecticut	522,403 (15%)	22%	88%	12%	9%	10%	27%	16%	5%
Delaware	119,302 (15%)	24%	85%	15%	29%	9%	26%	13%	0%
District of Columbia	73,794 (13%)	13%	86%	14%	0%*	19%	29%	26%	0%
Florida	2,920,971 (17%)	27%	88%	12%	8%	12%	33%	14%	18%
Georgia	973,794 (11%)	16%	81%	19%	39%	14%	30%	19%	1%
Hawaii	174,633 (14%)	22%	90%	10%	28%	16%	29%	16%	11%
Idaho	177,700 (13%)	18%	86%	14%	71%	6%	31%	7%	6%
Illinois	1,661,454 (13%)	18%	87%	13%	21%	13%	30%	13%	4%
Indiana	877,954 (14%)	18%	85%	15%	31%	12%	36%	15%	0%
Iowa	482,340 (16%)	22%	88%	12%	62%	9%	30%	14%	1%
Kansas	394,206 (14%)	20%	87%	13%	50%	10%	33%	12%	3%
Kentucky	648,400 (16%)	20%	77%	23%	56%	13%	35%	33%	2%
Louisiana	620,196 (14%)	20%	81%	19%	27%	13%	38%	23%	10%
Maine	226,696 (17%)	27%	81%	19%	62%	10%	41%	22%	0%
Maryland	674,448 (12%)	18%	87%	13%	10%	12%	26%	14%	1%
Massachusetts	965,943 (15%)	21%	85%	15%	2%	13%	34%	22%	16%
Michigan	1,444,987 (14%)	20%	84%	16%	22%	12%	31%	15%	1%
Minnesota	676,156 (13%)	19%	88%	12%	39%	10%	32%	15%	6%
Mississippi	436,677 (15%)	21%	77%	23%	72%	18%	36%	32%	0%
Missouri	884,449 (16%)	20%	84%	16%	38%	9%	32%	18%	11%
Montana	142,457 (16%)	26%	86%	14%	77%	9%	35%	11%	0%
Nebraska	257,171 (15%)	21%	88%	12%	58%	13%	27%	15%	3%
Nevada	273,724 (12%)	19%	86%	14%	14%	11%	30%	11%	11%

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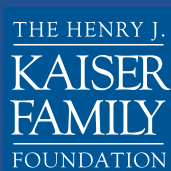
Appendix D
Characteristics of the Medicare Population, by State, Selected Years *(continued)*

	Number of Medicare Beneficiaries (2003)	Projected Age 65+ (2030)	Age 65+ (2003)	Under Age 65 (2003)	Residing in Rural Areas (2004)	Income <100% of Poverty (2002–2003)	Income 100%–199% of Poverty (2002–2003)	Enrolled in Medicaid (2002)	Enrolled in Medicare Advantage Plans (2004)
United States Total	40,172,605 (14% of U.S. Population)	20% of U.S. Population	85% of U.S. Medicare Population	15% of U.S. Medicare Population	24% of U.S. Medicare Population	12% of U.S. Medicare Population	32% of U.S. Medicare Population	18% of U.S. Medicare Population	11% of U.S. Medicare Population
STATE	**Medicare Beneficiaries with Characteristic as a Percent of State Medicare Population**								
Alabama	719,246 (16%)	21%	79%	21%	35%	15%	32%	23%	6%
New Hampshire	179,564 (14%)	21%	85%	15%	45%	10%	39%	11%	1%
New Jersey	1,219,935 (14%)	20%	88%	12%	0%*	12%	31%	14%	7%
New Mexico	250,113 (13%)	26%	84%	16%	45%	15%	33%	16%	14%
New York	2,763,299 (14%)	20%	85%	15%	9%	13%	31%	22%	15%
North Carolina	1,205,466 (14%)	18%	81%	19%	39%	15%	36%	23%	4%
North Dakota	103,220 (16%)	25%	89%	11%	65%	11%	33%	15%	0%
Ohio	1,727,096 (15%)	20%	86%	14%	20%	12%	31%	13%	11%
Oklahoma	521,286 (15%)	19%	85%	15%	46%	10%	31%	18%	7%
Oregon	513,253 (14%)	18%	87%	13%	36%	8%	31%	14%	23%
Pennsylvania	2,110,470 (17%)	23%	87%	13%	17%	10%	35%	16%	23%
Rhode Island	172,474 (16%)	21%	84%	16%	8%	12%	39%	19%	33%
South Carolina	606,323 (15%)	22%	80%	20%	33%	17%	30%	20%	0%
South Dakota	121,777 (16%)	23%	88%	12%	70%	12%	36%	15%	0%
Tennessee	871,938 (15%)	19%	81%	19%	39%	10%	35%	29%	7%
Texas	2,390,053 (11%)	16%	86%	14%	22%	19%	31%	21%	5%
Utah	220,221 (9%)	13%	88%	12%	30%	11%	28%	9%	0%
Vermont	92,724 (15%)	24%	84%	16%	74%	9%	32%	31%	0%
Virginia	946,470 (13%)	19%	84%	16%	25%	13%	27%	16%	0%
Washington	775,358 (13%)	18%	86%	14%	23%	9%	28%	14%	15%
West Virginia	347,459 (19%)	25%	78%	22%	59%	14%	40%	15%	1%
Wisconsin	803,678 (15%)	21%	87%	13%	38%	12%	30%	16%	3%
Wyoming	68,590 (14%)	27%	87%	13%	69%	7%	35%	13%	0%

Note: *There are no rural areas in the District of Columbia or the state of New Jersey.
SOURCE: CMS Statistics: Medicare State Enrollment; Census Bureau 2003 population estimates; State Interim Population Projections by Age and Sex: 2004-2030, Census Bureau; Mathematica Policy Research analysis of CMS State/County Market Penetration Files; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002–2004 CPS; Urban Institute estimates based on data from MSIS prepared for Kaiser Commission on Medicaid and the Uninsured.



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