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

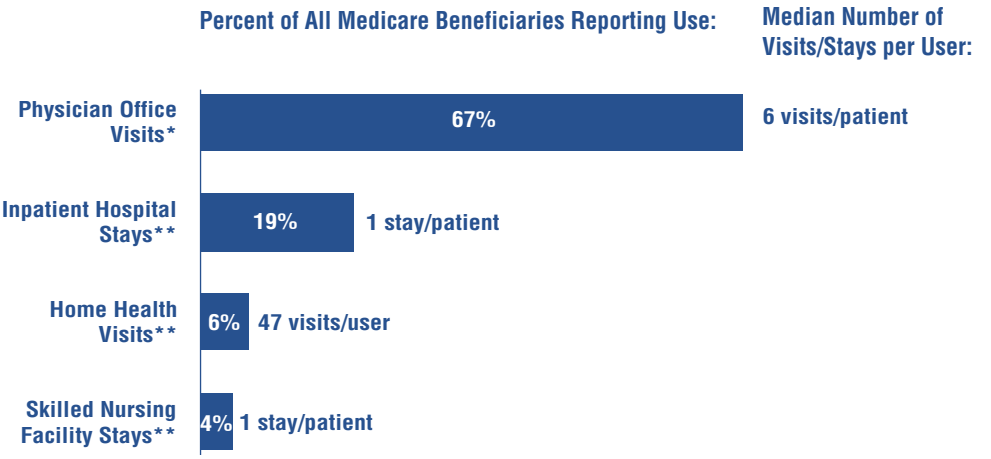
PART B

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*.

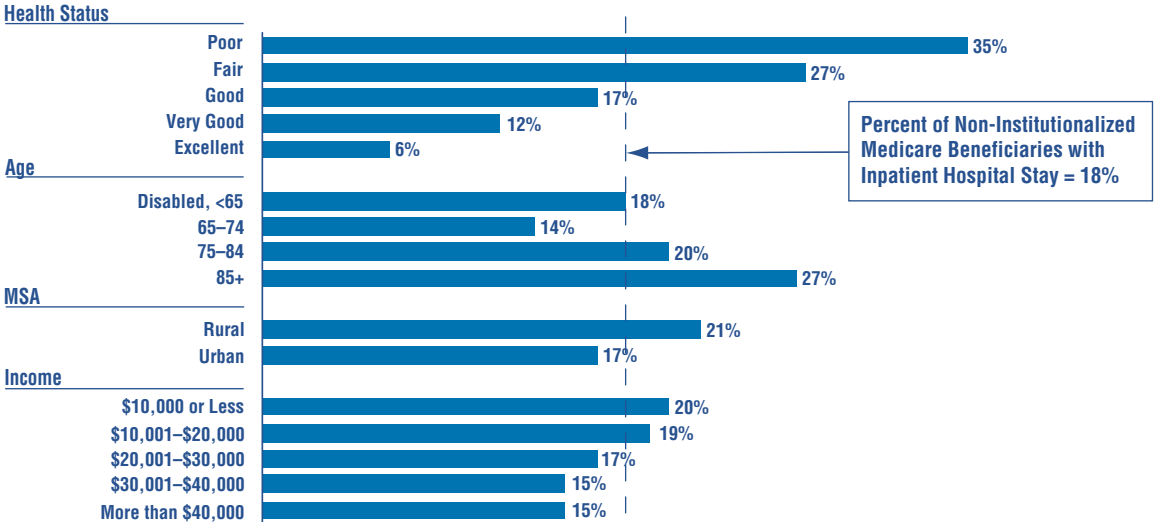
Figure 2.3
Medicare Beneficiaries' Utilization of Selected Medical and Long-Term Care Services, 2002



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

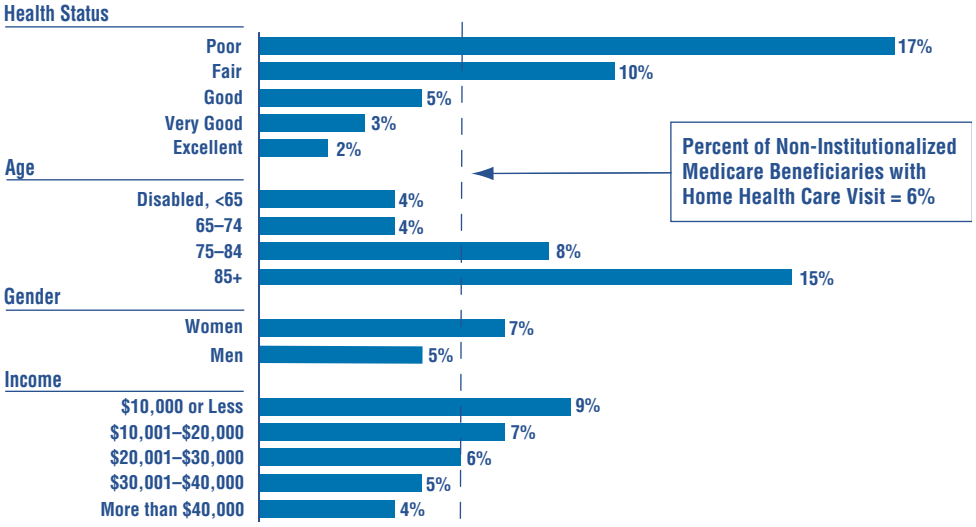


Note: MSA is Metropolitan Statistical Area. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

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



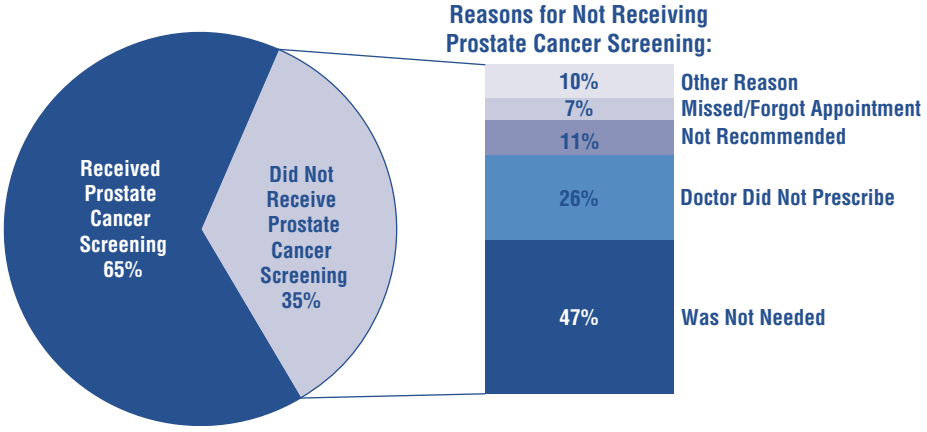
Note: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

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

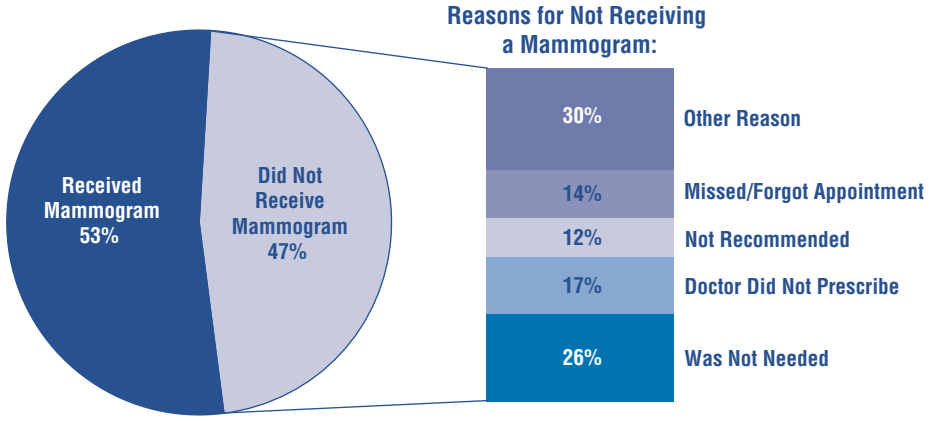


Total = 17.6 Million Male Medicare Beneficiaries, 2002

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

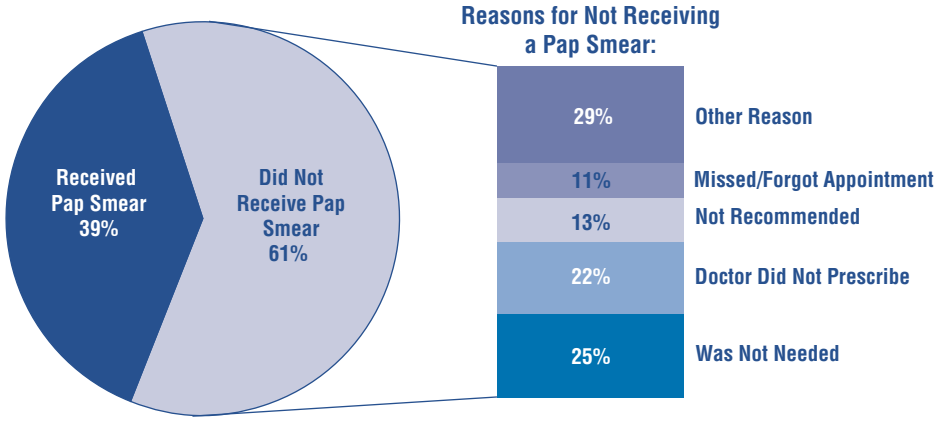


Total = 21.9 Million Female Medicare Beneficiaries, 2002

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.