AN OVERVIEW OF THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES' COSTS AND SERVICE USE

Statement of

Juliette Cubanski, Ph.D.

Associate Director, Program on Medicare Policy
The Henry J. Kaiser Family Foundation

Before the
Special Committee on Aging
U.S. Senate

"Strengthening Medicare for Today and the Future"

February 27, 2013

Good afternoon, Chairman Nelson, Ranking Member Collins, and distinguished members of the committee. I am Juliette Cubanski, Associate Director of the Program on Medicare Policy at The Henry J. Kaiser Family Foundation in Washington, D.C. The Kaiser Family Foundation is an independent, non-profit private operating foundation that is focused on health policy analysis, communications, and journalism. I appreciate the opportunity to be with you here this afternoon to provide an overview of the Medicare program and the beneficiary experience in Medicare today, as part of your hearing on strengthening Medicare for today and the future.

Medicare's Role in Providing Financial and Health Security to Elderly and Disabled Americans

Health insurance coverage is important to people of all ages, but is especially important for seniors and adults with disabilities who are significantly more likely than others to need costly medical care. Since its establishment nearly 50 years ago, Medicare has made a significant contribution to the lives of older Americans and people with disabilities by bolstering their economic and health security and relieving millions of older Americans from relying on charity care or having to bear the full burden of their health expenses. Prior to Medicare, more than half of all Americans over age 65 were uninsured (De Lew 2000) and nearly a third of seniors were in poverty; today virtually all seniors have Medicare coverage and the official poverty rate among those ages 65 and older is just under 9 percent (U.S. Bureau of the Census 2012). For younger people living with disabilities, Medicare has provided life-saving and life-sustaining access to care and treatment that would otherwise be out of reach for many and has allowed millions to stay in their homes rather than be institutionalized.

Today, the vast majority of seniors (80 percent) say that Medicare is working well for them **(Exhibit 1)**. Beneficiaries generally have reliable access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures. According to a recent survey by the Medicare Payment Advisory Commission (MedPAC), Medicare beneficiaries are about as likely as privately insured individuals to report problems finding a doctor who would see them, and this problem does not appear to be widespread (MedPAC 2012). Among the Medicare population at large, only 2 percent of Medicare beneficiaries looked for a new primary care physician in 2011 and reported a problem finding one. And a relatively small share of Medicare beneficiaries report experiencing problems accessing needed medical care. For example, according to the

Foundation's analysis of the Medicare Current Beneficiary Survey, only 5 percent of all beneficiaries reported trouble getting health care in 2010, while 9 percent said they delayed seeking medical care due to cost, and 9 percent said they had a serious medical problem for which they should have seen a doctor but did not.

An Overview of Medicare and Who Is Covered

Medicare was established in 1965 to provide health insurance coverage to people ages 65 and older, and was expanded in 1972 to cover younger people with permanent disabilities. Today, one in six Americans—50 million people—are covered by Medicare, including 41 million seniors and 9 million non-elderly adults living with permanent disabilities. Medicare covers people without regard to their income or medical history and provides the same set of benefits to everyone who is entitled to Medicare coverage. These benefits include hospitalizations, physician visits, preventive services, post-acute care, and a prescription drug benefit delivered through private plans, which have been playing an increasingly larger role in delivering all Medicare benefits in recent years.

Medicare covers a population that on the whole tends to have significant health needs and modest financial resources **(Exhibit 2)**. Four in 10 Medicare beneficiaries have three or more chronic conditions, and nearly one fourth have a cognitive or mental impairment. The oldest beneficiaries, those ages 85 and older, are 13 percent of all people on Medicare, while the youngest, those under age 65 with disabilities, are 17 percent.

Many people with Medicare live on modest incomes primarily derived from Social Security. Half of beneficiaries had annual incomes less than $22,500 in 2012—around 200 percent of the federal poverty level for a single person—and one-fourth of beneficiaries had incomes below $14,000, while only a small share had relatively high incomes **(Exhibit 3)**.

Medicare Benefits

Under the traditional Medicare program, benefits for hospital services, physician services, and prescription drugs are divided into three parts: Part A, Part B, and Part D, respectively. Under Medicare Advantage (Part C), private health plans offer integrated coverage of all benefits covered under Part A and Part B, and typically also Part D. Today, the majority of people with Medicare (73 percent) receive benefits through the traditional Medicare program, while 27 percent of beneficiaries are enrolled in a Medicare Advantage plan.

- **Part A** is the Hospital Insurance program, which helps pay for hospital visits and skilled nursing facility stays, post-acute home health care, and hospice care. Most people become entitled to Part A after paying payroll taxes for 10 years and enrollment is automatic upon reaching age 65.
- **Part B** is the Supplementary Medical Insurance program, which helps pay for physician visits, outpatient hospital services, lab work, and preventive services such as mammograms and flu shots. Enrollment in Part B is voluntary, but the majority of people who are entitled to Part A also enroll in Part B.
- **Part D**, which started in 2006, is a voluntary, outpatient prescription drug benefit, delivered either through private stand-alone prescription drug plans to supplement traditional Medicare or through Medicare Advantage plans. Part D plans are required to provide a "standard" drug benefit, but plans can vary the design of the benefit as long as it is at least equal in value to the standard benefit, and in fact most plans offer an alternative benefit design. In 2013, beneficiaries who want to enroll in Part D have more than 20 stand-alone prescription drug plans to choose from in each state, along with many Medicare Advantage plans. Today, about 90 percent of people in Medicare have drug coverage, a majority of whom (32 million beneficiaries) are enrolled in a Part D plan.
- **Part C**, known as Medicare Advantage, offers an alternative to traditional Medicare, where beneficiaries can enroll in a private plan, such as a health maintenance organization or preferred provider organization. These plans receive payments from the government to provide enrollees with all Medicare-covered benefits, most often including the Part D drug benefit, and, often, extra benefits that Medicare does not cover such as vision and dental services. Today about 13 million Medicare beneficiaries, more than a quarter of all people with Medicare, are enrolled in Medicare Advantage plans **(Exhibit 4)**.

Despite the important benefits that Medicare covers, there are gaps in Medicare's benefit package. Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities. Notably, Medicare does not pay for most custodial long-term services and supports, such as extended nursing home stays. Traditional Medicare also does not cover vision exams or eyeglasses, dental services, or hearing aids.

Beneficiaries' Use of Medicare-Covered Services

A majority of Medicare beneficiaries enrolled in traditional Medicare reported using one or more Medicare-covered services in 2009 **(Exhibit 5)**. Nearly eight in ten beneficiaries (77 percent) visited a physician in 2009, with a median number of 4 visits per patient. Nearly one in five (19 percent) reported at least one inpatient hospital stay, and 20 percent of those who were hospitalized in the year were readmitted within 30 days of at least one of their initial hospital discharges. Among the 9 percent of beneficiaries who reported using home health services, the median number of visits was 17. Nearly three in ten beneficiaries (28 percent) had at least one visit to an emergency department in 2009; 12 percent had two or more visits. Five percent had a skilled nursing facility stay in 2009, and 2 percent had a hospice stay.

While most people with Medicare use some amount of medical care in any given year, a majority of spending is concentrated among the relatively small share of beneficiaries with significant needs and medical expenses. In 2009, 10 percent of beneficiaries in traditional Medicare accounted for nearly 60 percent of Medicare spending **(Exhibit 6)**.

How Much Do Beneficiaries Pay for Medicare?

While Medicare covers a wide array of medical services, Medicare coverage is not free to beneficiaries. In addition to paying into Medicare during their working years through payroll taxes, people with Medicare face premiums, deductibles, and cost-sharing amounts for Medicare coverage. Unlike typical private insurance plans, traditional Medicare does not place a limit on how much beneficiaries have to spend out of pocket for inpatient and outpatient services each year.

- **Part A:** Most beneficiaries do not pay a monthly premium for Part A services, but are subject to a deductible before Medicare Part A coverage begins. In 2013, the Part A deductible for each "spell of illness" is $1,184 for an inpatient hospital stay. Beneficiaries are generally subject to coinsurance for benefits covered under Part A, including extended stays in a hospital ($296 per day for days 61-90 and $592 for days 91-150 in 2013) or skilled nursing facility ($148 per day for days 21-100 in 2013). There is no copayment for home health visits.

- **Part B:** Beneficiaries enrolled in Part B are generally required to pay a monthly premium ($104.90 in 2013). Beneficiaries with annual incomes greater than $85,000

for an individual or $170,000 for a couple pay a higher, income-related monthly Part B premium, ranging from $146.90 to $335.70 in 2013. Approximately 5 percent of all Medicare beneficiaries are required to pay the Part B income-related premium in 2013, but because the income thresholds are frozen at their current levels through 2019, a larger share of beneficiaries will be required to pay the income-related Part B premium over the next several years. Part B benefits are subject to an annual deductible ($147 in 2013), and most Part B services are subject to coinsurance of 20 percent. No coinsurance and deductibles are charged for preventive services that are rated A or B by the U.S. Preventive Services Task Force.

- **Part C:** Medicare Advantage plan premiums and cost sharing vary widely across plans. Medicare Advantage enrollees generally pay the monthly Part B premium and often pay an additional premium directly to their plan. In 2013, the average monthly premium for Medicare Advantage drug plans (weighted by 2012 enrollment) is $39; premiums vary by plan type and are lower for HMOs ($30 per month) than for PPOs ($64 per month) (Gold et al. 2012). Medicare Advantage plans are required to limit beneficiaries' total out-of-pocket spending each year (the maximum is $6,700 in 2013), but cost-sharing requirements vary widely across plans in 2013.

- **Part D:** In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. These amounts vary by plan. In 2013, the average monthly premium for stand-alone prescription drug plans is $40 (weighted by 2012 enrollment) (Hoadley et al. 2012). Higher-income Part D enrollees are required to pay an income-related premium surcharge in addition to their monthly Part D premium, ranging from $11.60 to $66.60 in 2013. The standard Part D benefit in 2013 requires enrollees to pay a deductible of $325 and 25 percent coinsurance for prescriptions, up to an initial coverage limit of $2,970 in total drug costs, followed by a coverage gap, where enrollees pay 47.5 percent of the cost of brand-name drugs and 79 percent of the cost of generic drugs until they have spent $4,750 out of pocket (excluding premiums) **(Exhibit 7)**.

Taken altogether, Medicare's fairly high cost-sharing requirements could be a burden for beneficiaries with fixed incomes or extensive medical needs, while the absence of an annual out-of-pocket spending limit places beneficiaries at risk of having potentially catastrophic medical expenses. As a result, a majority of beneficiaries in traditional Medicare have some form of additional insurance to help with out-of-pocket costs and provide benefits that

Medicare does not cover **(Exhibit 8)**. Sources of supplemental coverage include: employer-sponsored retiree health benefits (41 percent); private insurance policies known as Medigap, which cover some or all of Medicare's deductibles and coinsurance (21 percent); and Medicaid, which pays Medicare premiums and cost sharing and provides additional benefits, such as long-term services and supports and dental services, for most of the nine million low-income Medicare beneficiaries who are currently also covered by Medicaid. Beneficiaries with both Medicare and Medicaid are referred to as "dual eligibles."

Beneficiaries who have some type of private supplemental insurance (i.e., retiree health benefits or Medigap) to help cover their Medicare-related expenses typically pay premiums for this coverage. The 17 percent of beneficiaries in traditional Medicare who have no supplemental coverage do not face these premium costs, but they are responsible for paying the full amount of their Medicare cost-sharing obligations out of their own pockets.

As a result, many beneficiaries face significant out-of-pocket costs for both premiums and non-premium expenses to meet their medical and long-term care needs. Spending on Part B and Part D premiums and cost sharing as a share of annual average Social Security benefit payments has increased from 6 percent in 1970 to 26 percent in 2010 **(Exhibit 9)**. Overall, beneficiaries' out-of-pocket health spending has risen faster than their incomes in recent years, from around 12 percent in 1997 to more than 15 percent in 2009, and Medicare households spend three times as much of their household budgets on health care compared with non-Medicare households (15 percent versus 5 percent) **(Exhibit 10)**. Altogether, these facts could warrant focusing greater attention on the adequacy of Medicare coverage and on ways to improve the Medicare program and the financial protection it provides to beneficiaries.

Future Outlook

Looking to the future, Medicare is expected to face significant financing challenges due to rising health care costs, the aging of the U.S. population, and the declining ratio of workers to beneficiaries. Medicare also is playing a major role in policy discussions about reducing the federal budget deficit. As part of these discussions, a number of Medicare proposals have been made, including: restructuring Medicare benefits and cost sharing; eliminating "first-dollar" Medigap coverage; increasing Medicare premiums for all beneficiaries or those with relatively high incomes; raising the Medicare eligibility age; changing Medicare

from its current defined benefit structure to a “premium support” system; and accelerating the implementation of delivery system reforms (Kaiser Family Foundation 2013a).

While policymakers weigh potential Medicare savings options to reduce the deficit, the public does not perceive a need for significant cuts. The Foundation’s recent polling shows that a majority of the public (75 percent) believes that deficit reduction can occur without major reductions in Medicare spending (Kaiser Family Foundation 2013b). In fact, 58 percent of Americans say they would not be willing to see any reductions to Medicare as part of deficit reduction discussions. When asked about specific proposals to reduce Medicare spending in the context of deficit reduction, a majority of Americans expressed support for two proposals: 1) requiring drug companies to give the federal government a better deal on medications for low-income people on Medicare; and 2) requiring high-income seniors to pay higher Medicare premiums; these proposals were supported by 85 percent and 59 percent of Americans, respectively **(Exhibit 11)**. Notably, the survey also shows that relatively few Americans (roughly two in ten) are aware that wealthier Medicare beneficiaries already pay higher premiums for their Medicare coverage.

Other proposals are opposed by a majority of Americans, including: 1) requiring all seniors to pay higher Medicare premiums; 2) increasing the payroll taxes workers and employers pay to help fund Medicare; 3) reducing payments to hospitals and other health care providers for treating people covered by Medicare; and 4) gradually raising the age of Medicare eligibility from 65 to 67 for future retirees. These proposals were opposed by 85 percent, 55 percent, 51 percent, and 51 percent of Americans, respectively.

A challenge facing policymakers is finding ways to control Medicare spending growth and sustain Medicare for future generations, while setting fair payments to providers and plans, and without negatively affecting patient care, imposing an undue financial burden on seniors and people with disabilities in Medicare, or shifting costs onto other payers. While Medicare faces long-term financial challenges, it is also important to remember that Medicare is a vital source of financial and health security for 50 million people today, and the vast majority of seniors say that Medicare is working well for them. Therefore, moving forward it will be important to assess the implications of proposed changes to the Medicare program for current and future beneficiaries.

Again, I appreciate this opportunity to testify, and I will be happy to take your questions.

REFERENCES

Nancy De Lew. 2000. “Medicare: 35 Years of Service,” *Health Care Financing Review*, 2000.

Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman. 2012. *Medicare Advantage 2013 Data Spotlight: Plan Availability and Premiums,* Kaiser Family Foundation, December 2012. http://www.kff.org/medicare/8388.cfm

Jack Hoadley, Juliette Cubanski, Elizabeth Hargrave, Laura Summer, and Jennifer Huang. 2012. *Medicare Part D: A First Look at Plan Offerings in 2013,* Kaiser Family Foundation, November 2012. http://www.kff.org/medicare/8375.cfm

Kaiser Family Foundation. 2013a. *Policy Options to Sustain Medicare for the Future,* January 2013. http://www.kff.org/medicare/8402.cfm

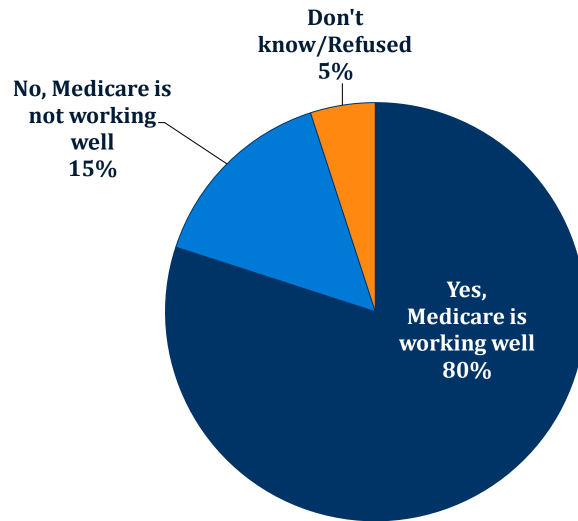
Kaiser Family Foundation. 2013b. *The Public's Health Care Agenda for the 113th Congress*, January 2013. http://www.kff.org/kaiserpolls/8405.cfm

Medicare Payment Advisory Commission (MedPAC). 2012. *Report to the Congress: Medicare Payment Policy*, March 2012.

U.S. Bureau of the Census. 2012. Current Population Survey, Annual Social and Economic Supplements, Historical Poverty Tables, Table 3. Poverty Status of People, by Age, Race, and Hispanic Origin: 1959 to 2011, 2012.

Exhibit 1

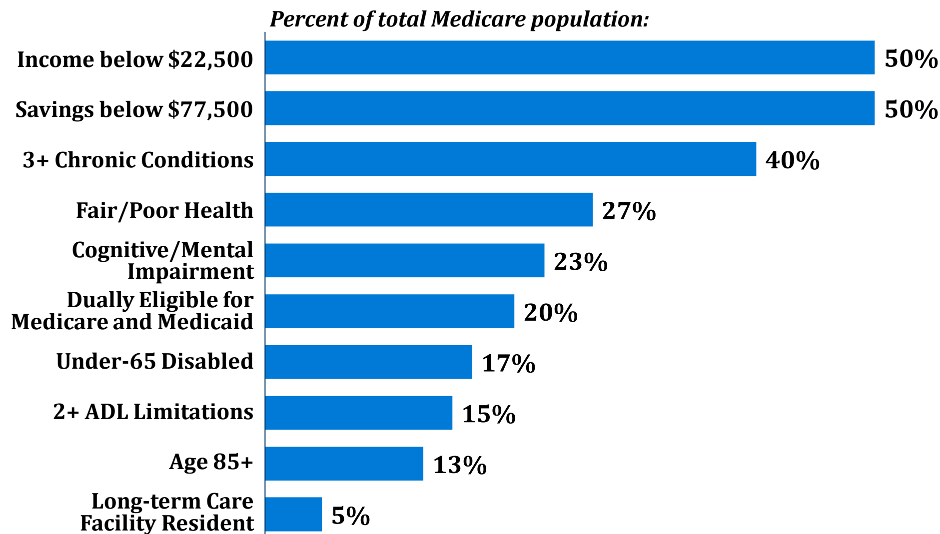
Vast majority of seniors say Medicare is working well for them



SOURCE: Kaiser Family Foundation/Robert Wood Johnson Foundation/Harvard School of Public Health, The Public's Health Care Agenda for the 113th Congress (conducted January 3-9, 2013)

Exhibit 2

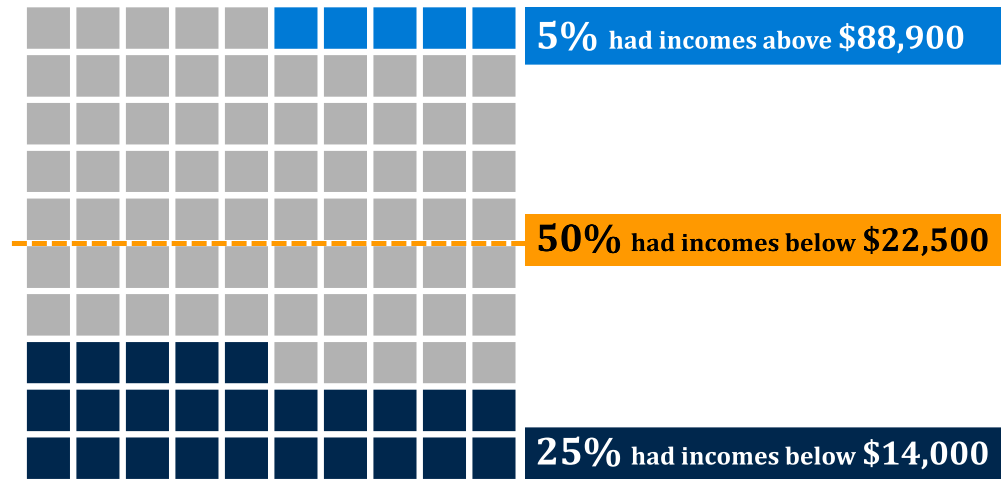
Many Medicare beneficiaries have significant health needs and modest financial resources



NOTE: ADL is activity of daily living.
SOURCE: Income and savings data for 2012 from Urban Institute analysis for the Kaiser Family Foundation.
All other data from Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 3

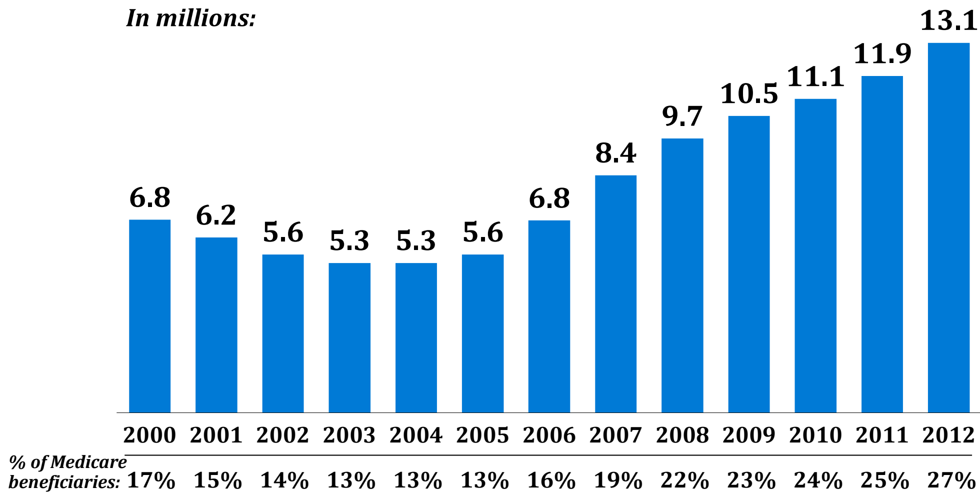
Most Medicare beneficiaries have modest incomes



NOTE: Estimates are for 2012.
SOURCE: Urban Institute analysis of DYNASIM for the Kaiser Family Foundation.

Exhibit 4

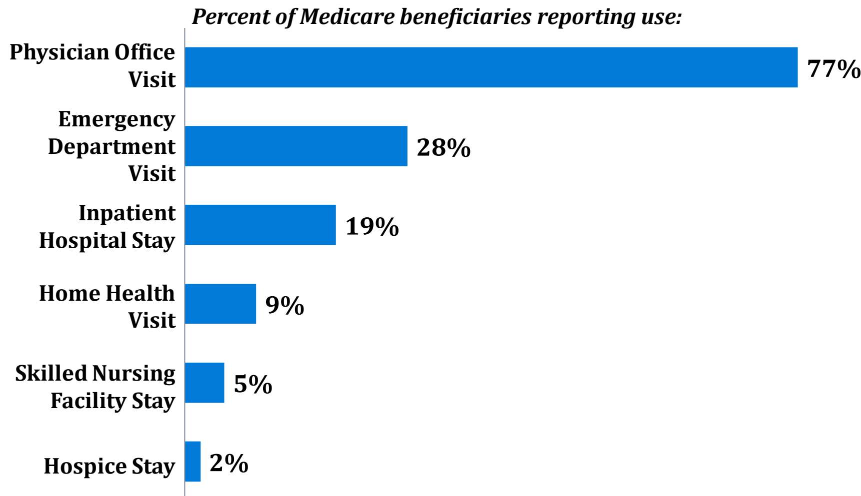
Enrollment in Medicare private health plans has grown significantly in recent years



SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files.

Exhibit 5

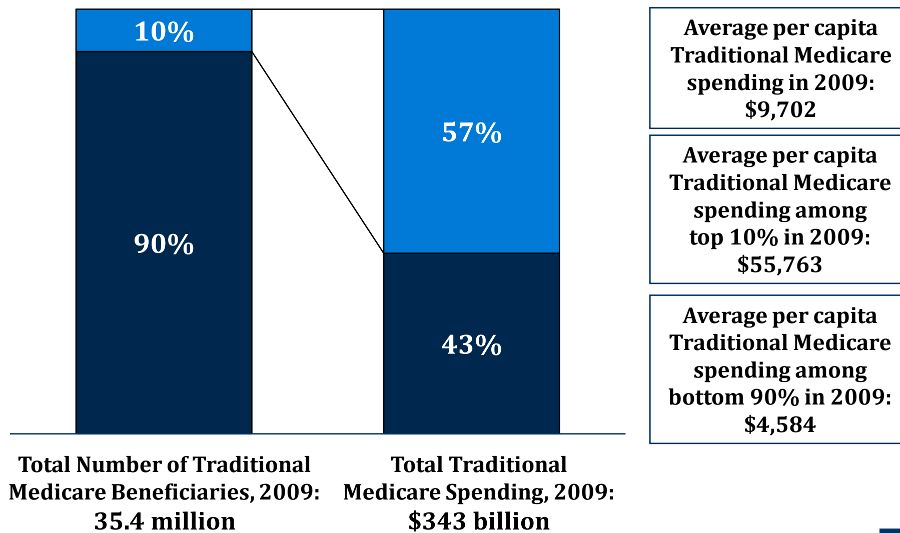
Most Medicare beneficiaries use at least one Medicare-covered service in any given year



NOTE: Excludes beneficiaries enrolled in Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey 2009 Cost and Use file.

Exhibit 6

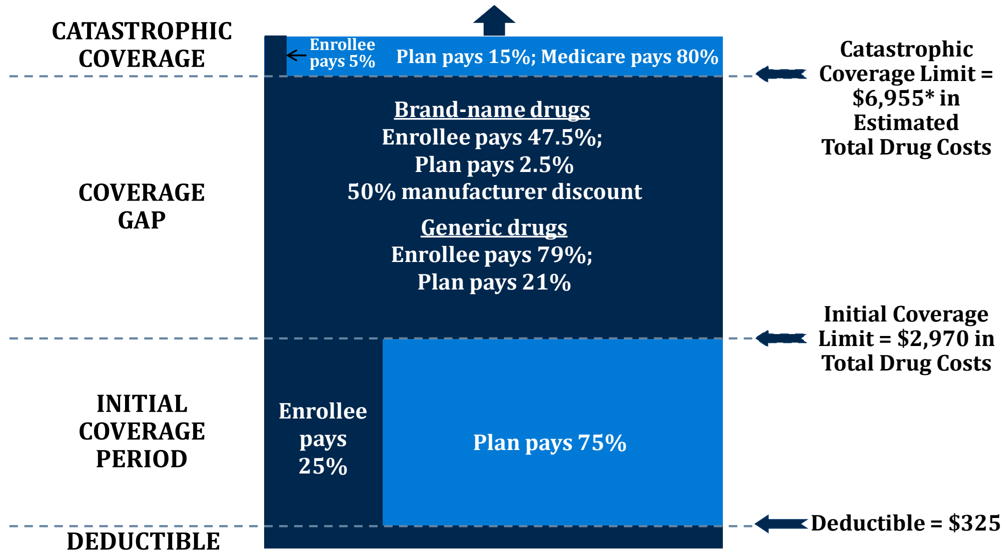
A relatively small share of Medicare beneficiaries accounts for a relatively large share of spending



NOTE: Excludes beneficiaries enrolled in Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2009.

Exhibit 7

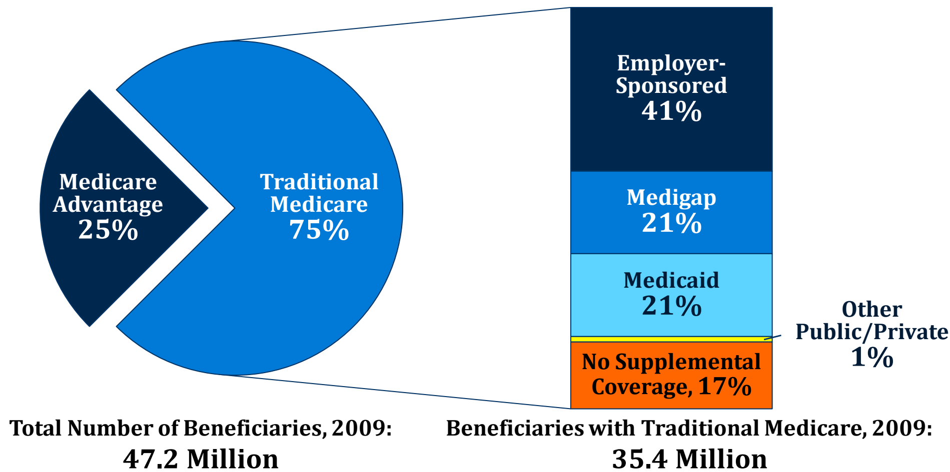
Standard Medicare Prescription Drug Benefit, 2013



NOTE: *Amount shown is the estimated catastrophic coverage limit for non-low income subsidy enrollees, which corresponds to true out-of-pocket spending of $4,750.
SOURCE: Kaiser Family Foundation illustration based on CMS standard benefit parameter update for 2013. Amounts rounded to nearest dollar.

Exhibit 8

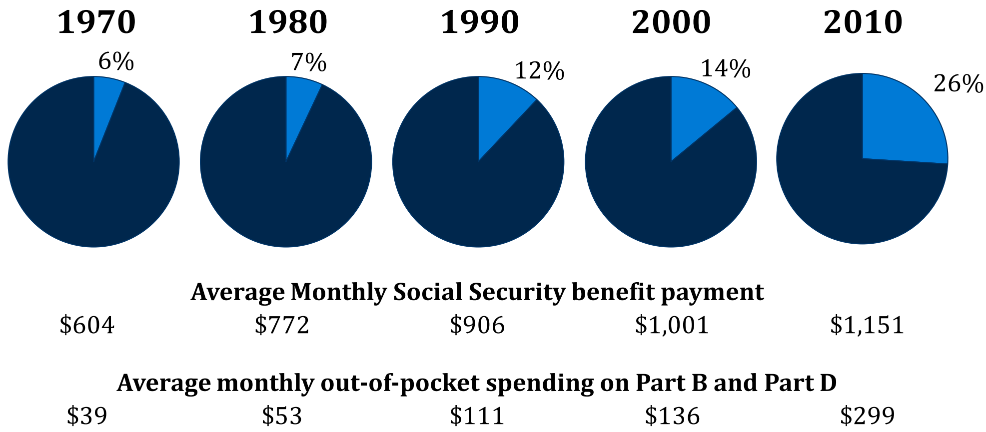
Most beneficiaries in traditional Medicare have some form of supplemental coverage; others are enrolled in Medicare Advantage plans



NOTE: Numbers do not sum due to rounding. Some Medicare beneficiaries have more than once source of coverage during the year; for example, 2% of all Medicare beneficiaries had both Medicare Advantage and Medigap in 2009. Supplemental Coverage was assigned in the following order: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage; individuals with more than one source of coverage were assigned to the category that appears highest in the ordering.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 9

Part B and Part D premiums and cost sharing increased as a share of average Social Security benefits between 1970 and 2010



Average Monthly Social Security benefit payment

1970	1980	1990	2000	2010
$604	$772	$906	$1,001	$1,151

Average monthly out-of-pocket spending on Part B and Part D

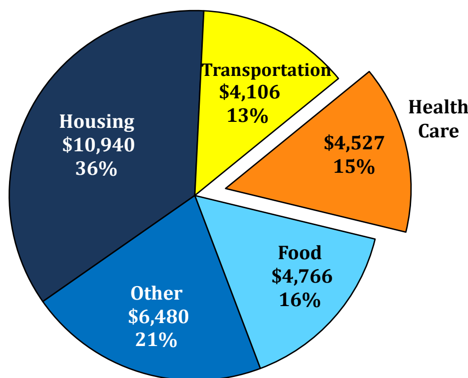
1970	1980	1990	2000	2010
$39	$53	$111	$136	$299

NOTE: Out-of-pocket spending includes Part B and Part D premiums and cost-sharing expenses for Part B and Part D covered services.
SOURCE: Kaiser Family Foundation analysis based on data from 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Exhibit 10

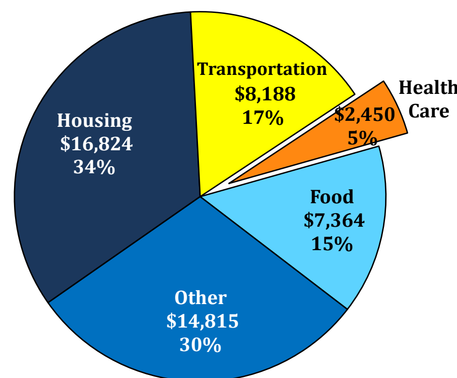
Medicare households spend a relatively large share of their household budgets on health care

Medicare Household Spending



Average Household Spending, 2010: $30,818

Non-Medicare Household Spending



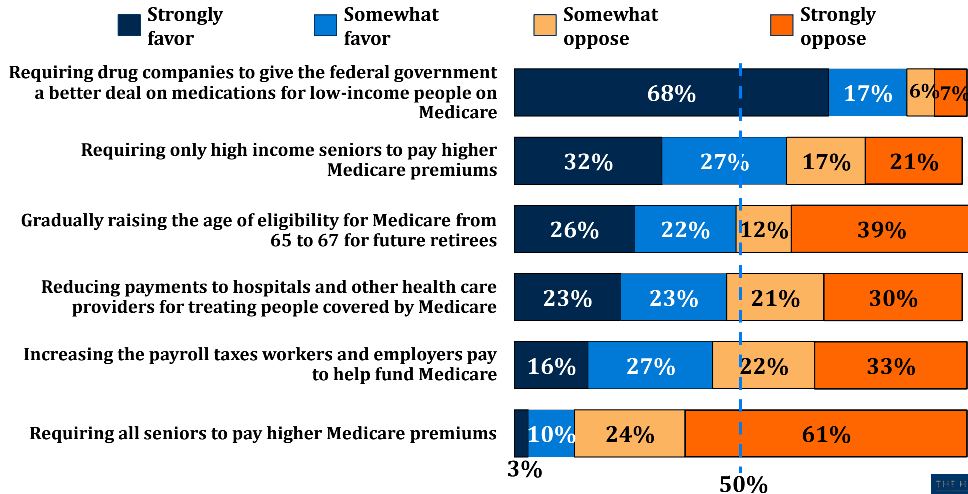
Average Household Spending, 2010: $49,641

SOURCE: Kaiser Family Foundation analysis of the Bureau of Labor Statistics 2010 Consumer Expenditure Survey Interview and Expense files.

Exhibit 11

Majority of the public expresses opposition to most deficit-reducing changes to Medicare

I'm going to read you some changes to the Medicare program that have been discussed as ways to reduce the federal budget deficit. Please tell me whether you would generally favor or oppose each one.



NOTE: Don't know/Refused answers not shown.
SOURCE: Kaiser Family Foundation/Robert Wood Johnson Foundation/Harvard School of Public Health, *The Public's Health Care Agenda for the 113th Congress* (conducted January 3-9, 2013)