THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE AT A GLANCE

July 2006

OVERVIEW OF MEDICARE

Medicare is the federal health insurance program created in 1965 for all people age 65 and older regardless of their income or medical history. The program was expanded in 1972 to include people under age 65 with permanent disabilities. Medicare now covers nearly 43 million Americans. Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. People under age 65 who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those with End Stage Renal Disease and Lou Gehrig's disease become eligible for Medicare when they begin receiving SSDI payments.

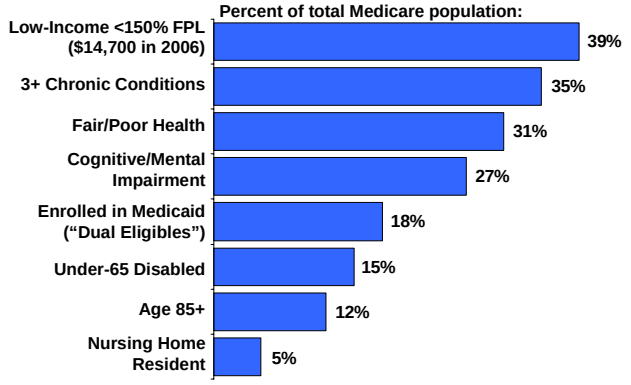
Medicare plays a vital role in ensuring the health of beneficiaries by covering many important health care services, including a new prescription drug benefit. However, there are also gaps in coverage, notably dental, vision, and long-term care. Medicare benefits are expected to total $374 billion in 2006, accounting for 14% of the federal budget (CBO, 2006).

CHARACTERISTICS OF PEOPLE ON MEDICARE

Medicare covers a diverse population: 35% have three or more chronic conditions, 17% are African American or Hispanic, 14% have limitations in three to six activities of daily living, and 12% are age 85 and older (Figure 1). Many people on Medicare have modest incomes and resources: 39% have incomes below 150% of poverty ($19,600/single and $26,400/couple in 2006). Fifteen percent – nearly 7 million in 2006 – are under age 65 and permanently disabled.

Figure 1

Selected Characteristics of the Medicare Population



SOURCE: Low-income, chronic conditions, and cognitive/mental impairment data from Medicare Current Beneficiary Survey 2002; all other data from Medicare Current Beneficiary Survey 2003.

MEDICARE'S STRUCTURE

Medicare is organized into four parts (Figure 2).

Part A pays for inpatient hospital, skilled nursing facility, home health, and hospice care. Accounting for 41% of benefit spending in 2006, Part A is funded mainly by a dedicated tax of 2.9% of earnings paid by employers and workers (1.45% each).

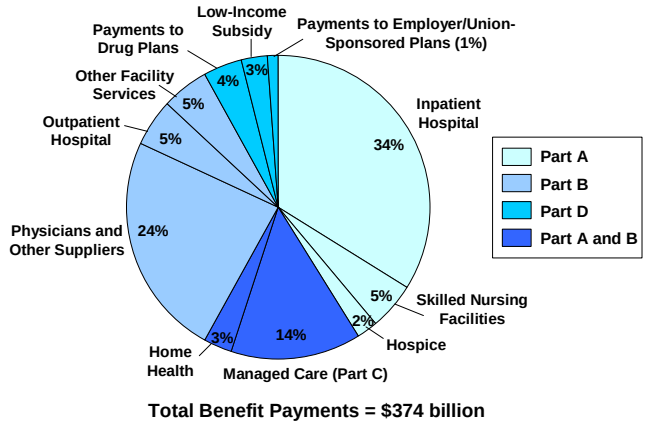
Part B pays for physician, outpatient, and home health visits and preventive services. Part B is funded by taxpayers through general revenues and beneficiary premiums and accounts for 35% of benefit spending in 2006. Medicare beneficiaries pay a monthly Part B premium of $88.50 in 2006 (estimated to increase to $98.40 in 2007). Starting in 2007, those with annual income over $80,000 ($160,000 per couple) will pay a higher, income-related monthly Part B premium.

Part C refers to the Medicare Advantage program, through which beneficiaries can enroll in a private managed care plan, such as an HMO, PPO, or private fee-for-service (PFFS) plan. These plans offer combined coverage of Part A, Part B, and in most cases, Part D (prescription drug) benefits. Part C accounts for 14% of benefit spending in 2006.

Part D is the new outpatient prescription drug benefit, delivered through private plans that contract with Medicare. The benefit includes additional assistance with plan premiums and cost-sharing amounts for low-income beneficiaries. Part D, which is funded by general revenues, beneficiary premiums, and state payments, accounts for 8% of benefit spending in 2006. Enrollees in Medicare drug plans pay a monthly premium that averages $25 across plans in 2006.

Figure 2

Medicare Benefit Payments by Type of Service, 2006



Note: Does not include administrative expenses such as spending for implementation of the Medicare drug benefit and the Medicare Advantage program. SOURCE: Congressional Budget Office, Medicare Baseline, March 2006.

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Beneficiary Cost Sharing and Out-of-Pocket Spending

Medicare has relatively high cost-sharing requirements and covers less than half (45%) of beneficiaries' total costs. Medicare premiums and cost-sharing requirements are indexed to rise annually; the monthly Part B premium has nearly doubled between 2000 and 2006. In 2006, the Parts A, B, and D (standard) deductibles are $952, $124, and $250, respectively. Unlike most employer-sponsored plans, Medicare has no cap on out-of-pocket spending.

A significant share of beneficiary out-of-pocket spending in 2002 was for long-term care (36%) and prescription drugs (22%). Even with the new drug benefit, beneficiaries are likely to face significant out-of-pocket costs in the future to meet their long-term care needs.

The Role of Private Plans in Medicare

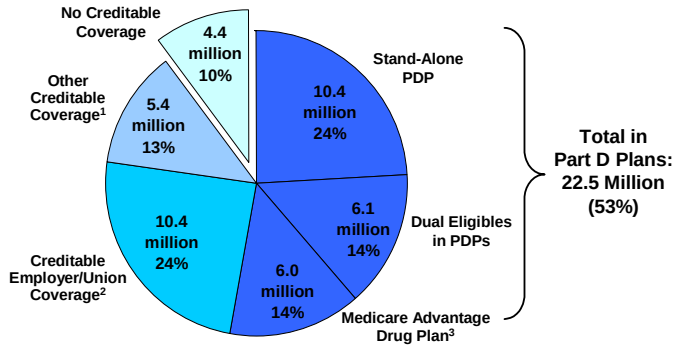
Private plans are playing a larger role in Medicare through a revitalization of the Medicare managed care program, now known as Medicare Advantage, as well as through the new Part D drug benefit.

Medicare Advantage. Medicare HMOs have been an option under Medicare since the 1970s, although the majority of beneficiaries have remained in the traditional fee-for-service program. The Medicare Modernization Act of 2003 (MMA) included several provisions to encourage private plan participation and beneficiary enrollment. In 2006, virtually all beneficiaries have a choice of one or more Medicare Advantage plans, with enrollment now at 16% of the total Medicare population. Medicare pays HMOs and other plans to provide all Medicare-covered benefits. The average Medicare payment to Medicare Advantage plans for Part A and B services is 111% of the cost of similar benefits in the fee-for-service program (MedPAC, 2006).

Medicare Prescription Drug Plans. Beneficiaries can obtain the new Medicare drug benefit through private stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs). Medicare pays plans to provide the standard drug benefit, or one that is actuarially equivalent.

Figure 3

HHS Estimates of Prescription Drug Coverage Among Medicare Beneficiaries, 2006



Total Number of Beneficiaries = 43 Million

Note: Numbers do not sum to 100% due to rounding. [1] Includes coverage from Veterans Administration, Indian Health Service, employer plans without retiree subsidies, and employer plans for active workers. [2] Includes employer/union, FEHB, and TRICARE coverage. [3] Approximately 0.5 million dual eligibles are enrolled in Medicare Advantage drug plans and are reported in this category. SOURCE: HHS, June 14, 2006. Data as of June 11, 2006.

As of June 2006, 22.5 million beneficiaries were enrolled in Medicare Part D plans, including 16.5 million in PDPs and another 6 million in MA-PDs (HHS, 2006) (Figure 3).

Additional Sources of Coverage

In addition to Medicare, most beneficiaries have some form of supplemental coverage.

Employer-sponsored plans. Employers are a key source of supplemental coverage, assisting about 11 million retirees on Medicare. However, retiree health benefits are on the decline; only 33% of large firms offered retiree benefits in 2005, down from 66% in 1988 (KFF/HRET, 2005). An additional 2.6 million Medicare beneficiaries are active workers (or spouses) for whom employer plans are the primary source of coverage.

Medicaid. More than 7 million low-income beneficiaries are dually eligible for Medicare and Medicaid. Most qualify for full Medicaid benefits, including long-term care and dental, and get help with Medicare's premiums and cost-sharing requirements. Some do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements under the Medicare Savings Programs, administered under Medicaid.

Medigap and other coverage. Many beneficiaries purchase private supplemental policies, known as Medigap (nearly 9 million in 2002). Another 3 million beneficiaries receive supplemental assistance through the Veterans Administration or some other government program, according to HHS.

Medicare Spending and Outlook

With the aging of the population and the new drug benefit, net federal spending on Medicare is estimated by CBO to grow from $331 billion in 2006 to $524 billion in 2011. Annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services and higher prices for health care services. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2004 was lower for Medicare (8.9%) than for private health insurance (9.9%) for common benefits (excluding prescription drugs) (CMS Office of the Actuary, 2006).

Looking to the future, Medicare faces many challenges, but none greater than financing care for an aging population with a declining ratio of workers to beneficiaries. Medicare spending as a share of GDP is expected to increase from 2.7 percent in 2005 to 4.7 percent in 2020. The Part A Trust Fund reserves are projected to be exhausted in 2018, and a "Medicare funding warning" is expected to be triggered next year by the Medicare Trustees, as required by law. Maintaining benefits for future beneficiaries will require more resources over time. In addition to these fiscal challenges, others include: ensuring the successful implementation of the drug benefit; setting fair payments to providers and plans; improving care for those with multiple chronic conditions; and providing adequate financial protections for those with low incomes and health security for an aging U.S. population.

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