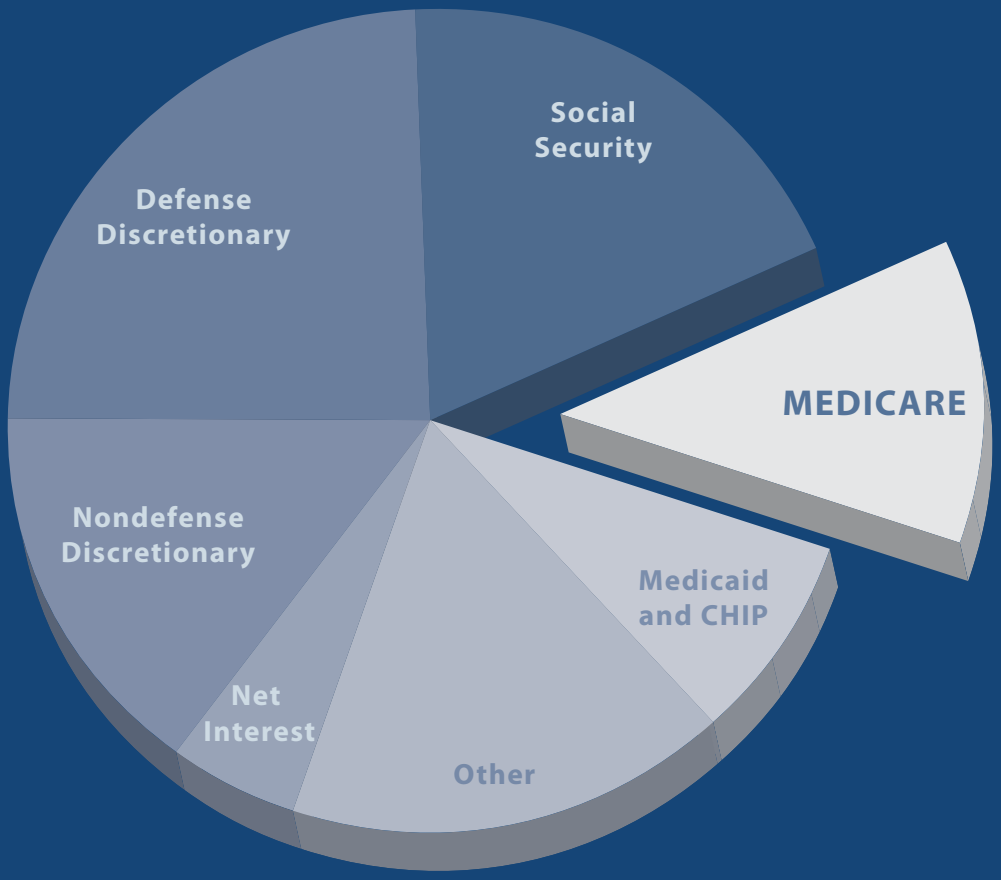
THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE



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CHARTBOOK

MEDICARE CHARTBOOK

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THE HENRY J. KAISER FAMILY FOUNDATION

OVERVIEW

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Medicare provides substantial health and financial security for 47 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 generally become eligible for Medicare when they reach age 65, although younger adults can also qualify if they have a permanent disability. Comprising approximately 15 percent of the federal budget and 20 percent of total national health spending in 2010 and a rising share of the nation's gross domestic product (GDP), Medicare is often a part of discussions related to the growth in federal spending and rising 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, the Medicare program is likely to remain at the forefront of national policy discussions in the coming years.

This chartbook provides basic information about Medicare today and the challenges facing the program in the future, and is organized in the following sections:

Section One: Medicare Beneficiaries

Medicare currently covers 47 million people, including 39 million people age 65 and older and 8 million nonelderly people with a permanent disability. Between 1966 and 2000, the number of people on Medicare more than doubled, and is projected to double yet again to 80 million by 2030. Medicare serves a population with diverse needs and circumstances. Nearly half of all Medicare beneficiaries live on an income below 200 percent of the federal poverty level, and those with lower incomes generally report being in poorer health than their higher income counterparts. Nearly half have three or more chronic conditions, roughly one-third has a cognitive or mental impairment, and more than one-fourth of all beneficiaries report their health status is fair or poor. More than two million Medicare beneficiaries live in nursing homes or other long-term care settings, most of whom are female and nearly half of whom are ages 85 and older.

Section Two: Medicare Benefits, Utilization, and Access to Care

Medicare covers a broad range of health care services, including inpatient and outpatient hospital care, post acute care such as home health and skilled nursing facility care, physician services, diagnostic testing including preventive services, prescription drug coverage, and hospice care. Medicare-covered benefits are typically subject to deductibles and coinsurance payments. Despite offering a relatively generous benefits package, Medicare provides limited long-term care benefits and does not cover eyeglasses, hearing aids, or dental care. Because health problems tend to rise with age, Medicare beneficiaries generally use more health care services than younger adults. In 2006, 82 percent of all beneficiaries had one or more physician visit, 21 percent were hospitalized, and 30 percent had one or more emergency room visit. A relatively small share of Medicare beneficiaries report access problems across a broad range of standard measures; however, rates of access problems tend to be higher among certain subgroups, such as those with low incomes, those in relatively poor health, the non-elderly disabled, and beneficiaries without supplemental coverage.

Section Three: Medicare and Prescription Drugs

Medicare beneficiaries are highly dependent on prescription drugs to manage their acute and chronic health conditions, with virtually all beneficiaries (88 percent) taking at least one medication in 2006. Since 2006, Medicare has offered access to an outpatient prescription drug benefit (Part D) through private plans, including stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans. Assistance with drug plan premiums and cost-sharing is available to beneficiaries with limited incomes and resources. As of 2010, 90 percent of Medicare beneficiaries have prescription drug coverage, the majority of whom are enrolled in a Part D plan. About 10 million people on Medicare receive low-income Part D subsidies; however, an estimated 2.3 million were eligible for these subsidies in 2009 but did not receive them.

Section Four: Medicare Advantage

Since the early 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly health maintenance organizations (HMOs), as an alternative to the fee-for-service (FFS) Medicare program. Over the past several decades, the role of private plans in Medicare has evolved. Even the name of the program (Part C) has changed, from Medicare+Choice, as it was called in 1997, to Medicare Advantage, as it was renamed in 2003. In 2010, about one in four people on Medicare (24 percent) are enrolled in a Medicare Advantage plan. Originally, Medicare payments to plans were set for each county to be lower than average payments for beneficiaries in the traditional fee-for-service program. Over time, however, Medicare payments to plans were increased above average costs for traditional Medicare to help attract more private plans to serve Medicare beneficiaries, particularly in rural areas, and to boost enrollment. The Affordable Care Act of 2010 modified Medicare's method for paying Medicare Advantage plans to phase down overpayments to plans, while providing bonuses to plans with high quality ratings.

Section Five: The Role of Medicaid for Medicare Beneficiaries

Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is also a source of supplemental coverage for roughly one in five Medicare beneficiaries. These beneficiaries are known as dual eligibles because they are eligible for both Medicare and Medicaid. Medicaid helps to make Medicare affordable for beneficiaries with low incomes and modest assets, by paying premiums and filling in Medicare's cost-sharing requirements and by paying for benefits that are not covered under traditional Medicare. Eligibility for Medicaid assistance is based on a beneficiary's income and resources, with some variation across states. Most dual eligibles qualify for full Medicaid benefits, including long-term care and dental services, which Medicare does not cover. Some dual eligibles do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements through the Medicare Savings Programs (MSP), administered under Medicaid. Beneficiaries eligible for Medicare and Medicaid tend to be in poorer health and have greater medical and long-term care needs than others on either program, and thus account for a disproportionate share of spending under both programs—36 percent of Medicare spending in 2006 and 40 percent of Medicaid spending in 2007.

Section Six: Supplemental Insurance Coverage

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 (90 percent) have some form of supplemental health insurance. Employer-sponsored coverage is the most common source of supplemental insurance in 2007, followed by Medicare Advantage plans, which typically provide some benefits beyond those covered under traditional Medicare, Medicare Supplemental Insurance policies (Medigap), and Medicaid for those with low incomes and modest assets. Supplemental coverage helps reduce access and cost-related burdens to care. A larger share of beneficiaries without supplemental insurance than those with it report delaying seeking medical care due to costs. While more than one-third of all Medicare beneficiaries have additional coverage from an employer, the share of employers offering retiree health benefits has declined, from 66 percent in 1988 to 28 percent in 2010.

Section Seven: Out-of-Pocket Spending

In 2006, Medicare covered just under half (48 percent) of fee-for-service beneficiaries' total medical and long-term care expenses. Beneficiaries paid, on average, 25 percent of total expenses out-of-pocket. Of the $4,241 in average out-of-pocket spending per beneficiary, 39 percent was for premiums, 19 percent for long-term care, 15 percent for medical providers and supplies, and 14 percent for prescription drugs. Out-of-pocket spending on health care increases with advancing age and varies by health status. With health costs rising more rapidly than income for people on Medicare, median out-of-pocket spending as a share of beneficiaries' income has increased from 11.9 percent in 1997 to 16.2 percent in 2006. Median out-of-pocket spending on premiums (both Medicare and private supplemental insurance) increased from 5.5 percent in 1997 to 8.0 percent in 2006.

Section Eight: Medicare Spending

In fiscal year 2010, Medicare spending is expected to total $524 billion, accounting for 20 percent of national health expenditures, 15 percent of the federal budget, and 3.6 percent of the gross domestic product (GDP). Medicare is responsible for 20 percent of the $2.6 trillion in total national health care expenditures in the U.S., but 40 percent of the nation's total home health care spending, 30 percent of hospital spending, and 24 percent of prescription drug costs. Inpatient hospital services continue to account for the largest share of Medicare benefit payments (27 percent), followed by Medicare Advantage plans (23 percent) and payments to physicians (13 percent). On an average per capita basis, annual Medicare spending has grown at a slightly smaller rate than annual private health insurance spending. In 2006, Medicare payments averaged $8,344 for beneficiaries enrolled in the traditional fee-for-service program, but spending is highly skewed, with 10 percent of the population accounting for 58 percent of Medicare spending, averaging $48,210 among those in the top decile of spending. Average annual growth in Medicare spending is projected to be 5.8 percent between 2012 and 2020, according to CBO, and 5.9 percent between 2010 and 2019, nearly one percentage point lower than projections for this period prior to the passage of the Affordable Care Act of 2010.

Section Nine: Medicare Financing

In fiscal year 2010, Medicare revenues come mainly from general revenue (43 percent), payroll taxes (37 percent), and beneficiary premiums (13 percent), with the remaining 7 percent of revenues from taxation of Social Security benefits, payments from states, and interest. Part A (the Hospital Insurance (HI) Trust Fund) is funded mainly by a 1.45 percent payroll tax paid by workers and employers (and as of 2011, a 2.35 percent payroll tax on earnings for taxpayers with incomes above $200,000/individual and $250,000/couple). The Part B Supplementary Medical Insurance (SMI) Trust Fund is financed by a combination of beneficiary premiums (25 percent) and general revenues (most of the remainder). Part D is similarly financed; general revenues make up 82 percent of revenues for Part D, beneficiary premiums comprise 10 percent of total revenues, and payments from states comprise 7 percent. According to the Medicare Board of Trustees' 2010 intermediate assumptions, the HI Trust Fund reserves are projected to be depleted in 2029—a 12-year extension from the previous year's projection of 2017, attributable mainly to Medicare spending reductions and additional revenues included in the Affordable Care Act of 2010.

About the Data in this Chartbook: The data presented in this chartbook come from a variety of sources. Data from the Centers for Medicare & Medicaid Services (CMS) Medicare Current Beneficiary Survey (MCBS) Cost and Use file and Access to Care file (various years) were analyzed to describe Medicare beneficiary characteristics, service use, access to care supplemental coverage, and spending. Other sources of data and analysis include: the Center for Studying Health System Change; Congressional Budget Office (CBO); Dartmouth Institute for Health Policy & Clinical Practice; Employee Benefit Research Institute (EBRI); Georgetown University Health Policy Institute; Health Research and Educational Trust; Kaiser Commission on Medicaid and the Uninsured (KCMU); Mathematica Policy Research; Medicare Board of Trustees; Medicare Payment Advisory Commission (MedPAC); NORC at the University of Chicago; Office of the Actuary (OACT) and Office of Research, Development, and Information (ORDI) within CMS, Department of Health and Human Services (HHS); Urban Institute; U.S. Census Bureau; and U.S. Office of Management and Budget (OMB). Specific sources of data include: Center for Studying Health Systems Change 2008 Health Tracking Physician Survey; CMS 2009 Data Compendium; CMS 2010 Guide to Health Insurance; CMS Medicare Advantage State/County Market Penetration file; CMS, Office of the Actuary, National Health Expenditure Projections; CMS Prescription Drug Plan and Medicare Advantage landscape files; Dartmouth Atlas of Health Care; EBRI Databook on Employee Benefits; Kaiser/HRET Survey of Employer-Sponsored Health Benefits; and OMB FY2011 Budget.

SECTION ONE:
MEDICARE BENEFICIARIES

MEDICARE BENEFICIARIES

Medicare is a federally sponsored health insurance program that provides benefits to 47 million people in the United States. Most individuals become eligible for Medicare when they reach age 65 and they or their spouse have made payroll tax contributions to Social Security for at least 40 quarters. Individuals 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) or amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease).

Medicare provides health insurance to 39 million people ages 65 and older and 8 million beneficiaries who are under age 65 and permanently disabled. Medicare beneficiaries account for 15 percent of the total U.S. population, with some variation across states, ranging from 9 percent of the total population living in Alaska to 21 percent of the population in West Virginia.

Medicare covers a diverse population. The Medicare population is predominantly non-Hispanic white (78 percent) and female (56 percent). Most beneficiaries are between the ages of 65 and 84, but those ages 85 and older account for 12 percent of the Medicare population, while the under age-65 disabled and ESRD populations represent 16 percent of all beneficiaries. Five percent of all Medicare beneficiaries live in a long-term care facility. A majority of the Medicare population lives in urban areas, and 24 percent live in rural areas. Beneficiaries in rural areas account for at least 60 percent of the Medicare populations in Mississippi, Montana, North Dakota, South Dakota, Vermont, and Wyoming.

While many people on Medicare enjoy good health, nearly half (46 percent) of all Medicare beneficiaries have three or more chronic conditions, nearly one-third (31 percent) have a cognitive or mental impairment, and more than one-fourth report being in fair or poor health (28 percent) or having a limitation in activities of daily living (ADLs), such as eating, dressing or bathing (29 percent). Among beneficiaries ages 85 and older, nearly half (48 percent) have a functional impairment and one-third (33 percent) have a cognitive impairment. Among the nonelderly disabled, 68 percent have a mental or cognitive limitation, and 42 percent have a functional impairment.

Most Medicare beneficiaries live on modest incomes and depend on Social Security as their primary source of income. Nearly half of all Medicare beneficiaries (47 percent) live on incomes below twice the federal poverty level ($21,660/individual and $29,140/couple in 2010)—with even higher rates among certain subgroups, such as the nonelderly disabled (67 percent) and those ages 85 and older (58 percent). More than two-thirds of black and Hispanic beneficiaries live on an income below twice the poverty level. Sixteen percent of the total Medicare population has an income below 100 percent of the federal poverty level—with significantly higher rates observed among black and Hispanic beneficiaries, and among those under age 65 with disabilities. Across the states, the share of beneficiaries living in poverty ranges from 7 percent in Alaska to 25 percent in Louisiana.

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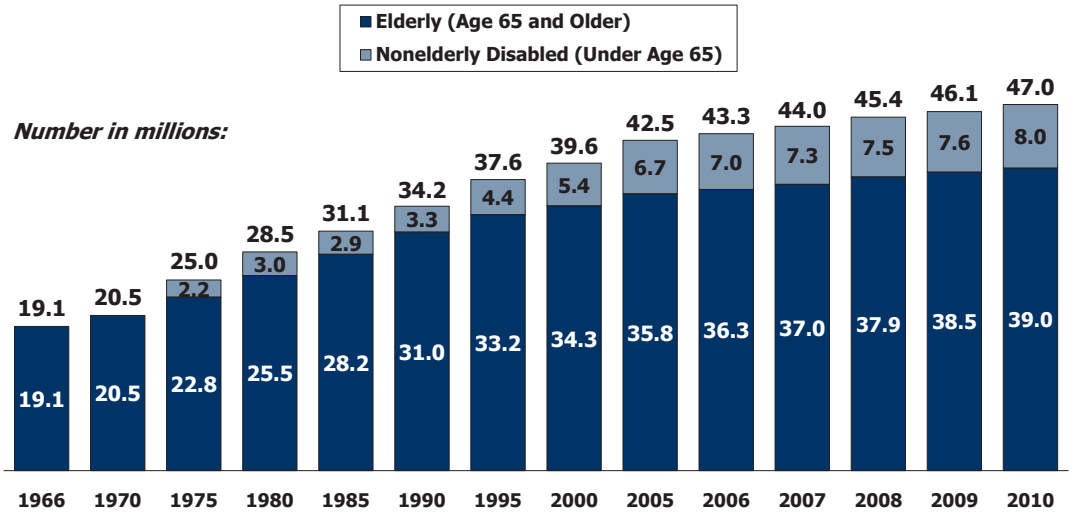
Figure 1.1

Medicare Enrollment, 1966-2010

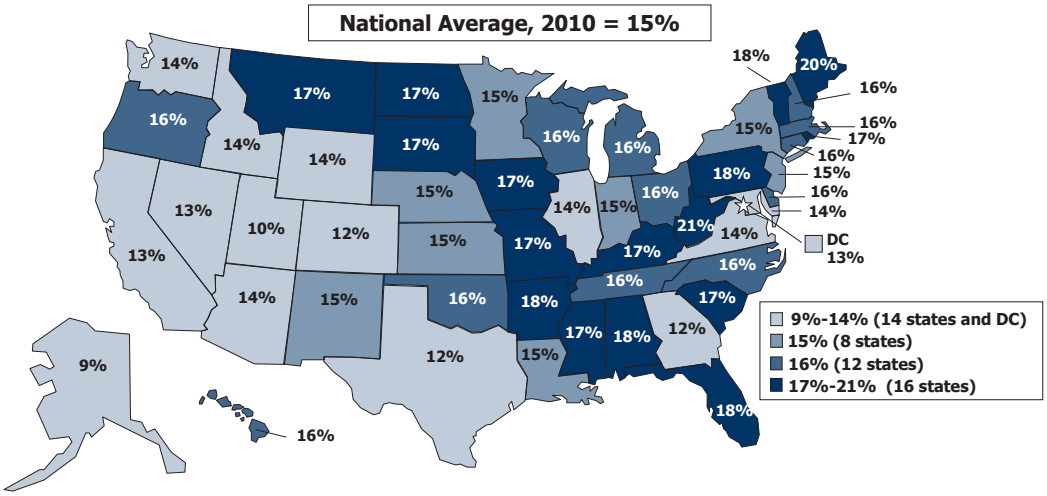


NOTES: Numbers may not sum to total due to rounding. People with disabilities under age 65 were not eligible for Medicare prior to 1972.
SOURCE: Centers for Medicare & Medicaid Services, Medicare Enrollment: Hospital Insurance and/or Supplemental Medical Insurance Programs for Total, Fee-for-Service and Managed Care Enrollees as of July 1, 2008: Selected Calendar Years 1966-2008; 2009-2010, HHS Budget in Brief, FY2011.

Medicare is a federal health insurance program covering an estimated 47 million people in 2010, including 39 million Americans ages 65 and older and 8 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 2000 and is projected to double yet again to 80 million by 2030, according to Medicare program actuaries.

Figure 1.2

Medicare Beneficiaries as a Percent of State Populations, 2010

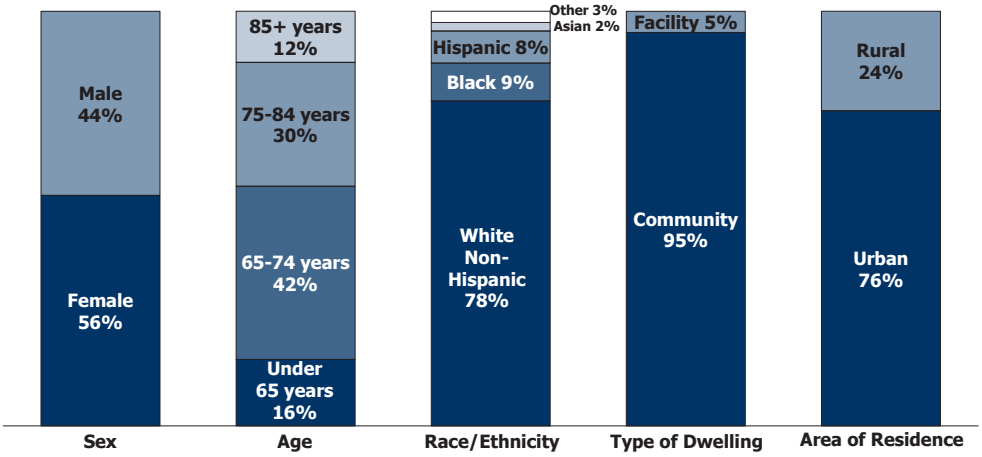


NOTES: Percent enrollment calculated using U.S. Census Bureau July 2009 population estimates.
SOURCE: Centers for Medicare & Medicaid Services (CMS) Management Information Integrated Repository (MIIR), February 16, 2010. Medicare beneficiaries as a share of state population estimates are based on July 1, 2009 state-level population estimates from the U.S. Census Bureau.

Medicare beneficiaries make up 15 percent of the total U.S. population in 2010, but within each state, their share of the total population varies. West Virginia has the largest proportion of state residents who are Medicare beneficiaries (21 percent), while Alaska has the smallest share (9 percent).

Figure 1.3

Demographic Characteristics of the Medicare Population, 2006



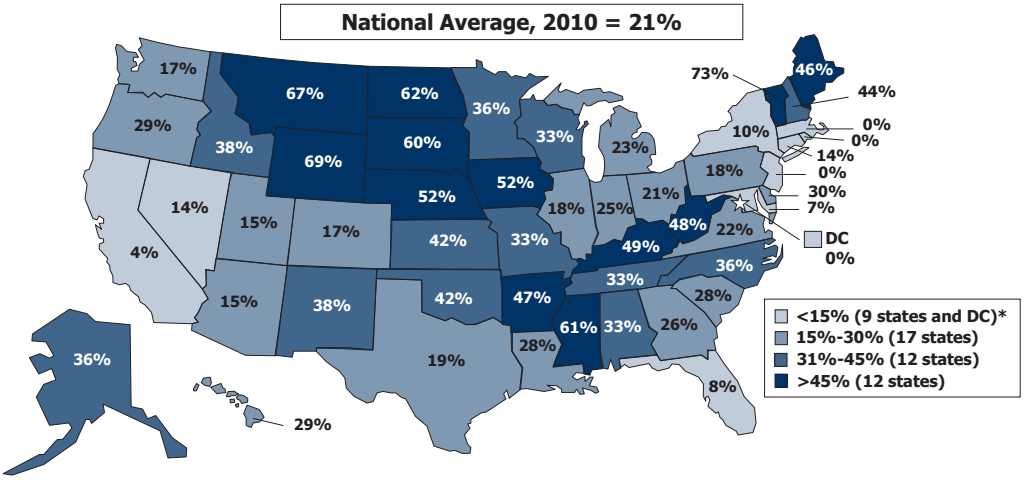
Total Medicare Beneficiaries, 2006 = 43.9 Million

NOTES: Numbers may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Medicare serves the health needs of a diverse population that is predominantly female (56 percent and non-Hispanic white (78 percent). Over seven in ten beneficiaries are between the ages of 65 and 84. Beneficiaries age 85 and over, as well as members of racial and ethnic minority groups, represent growing segments of the Medicare population. By 2050, the elderly population will be more racially and ethnically diverse, with minorities accounting for 42 percent of the population age 65 and over. Hispanics will account for nearly half (48 percent) of the elderly racial/ethnic minority population, followed by blacks (29 percent) and other races/ethnicities (24 percent).

Figure 1.4

Percent of Medicare Beneficiaries Residing in Rural Counties, by State, 2010

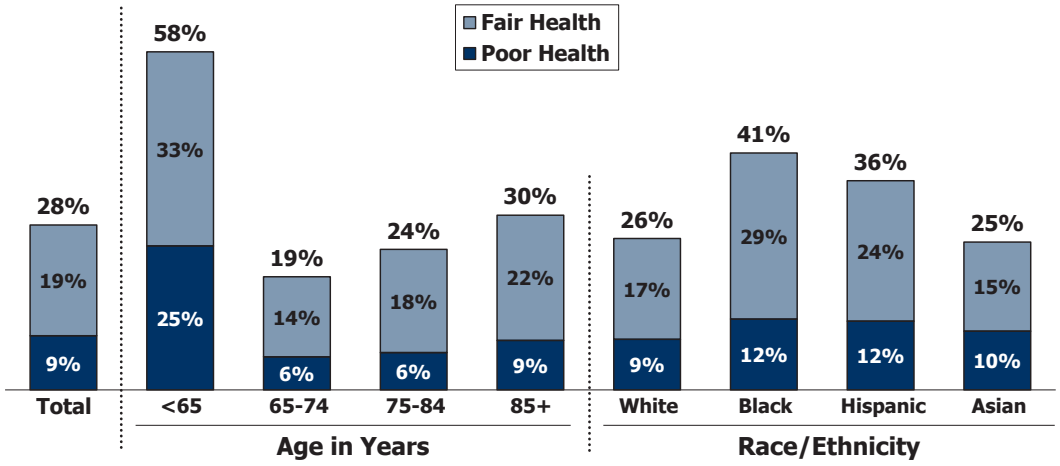


NOTES: Rural refers to counties that are outside of metropolitan areas (as defined by the Office of Management and Budget), according to the August 2004 release of the USDA Economic Research Service County Typology Codes. *There are no counties designated as rural in the District of Columbia, New Jersey, or Rhode Island.
SOURCE: Kaiser Family Foundation analysis of Centers for Medicare & Medicaid Services Medicare Advantage State/County Market Penetration File, May 2010.

On average nationwide, 21 percent of Medicare beneficiaries live in rural counties in 2010. In seven states, less than 15 percent of the Medicare population live in rural counties. (There are no counties designated as rural in New Jersey, Rhode Island, or the District of Columbia.) In contrast, nearly half or more of the Medicare population lives in rural counties in 12 states—with Vermont (73 percent), Wyoming (69 percent), and Montana (67 percent) having the largest share of beneficiaries living in rural areas in 2010.

Figure 1.5

Self-Reported Health Status of Medicare Beneficiaries, by Age and Race/Ethnicity, 2006

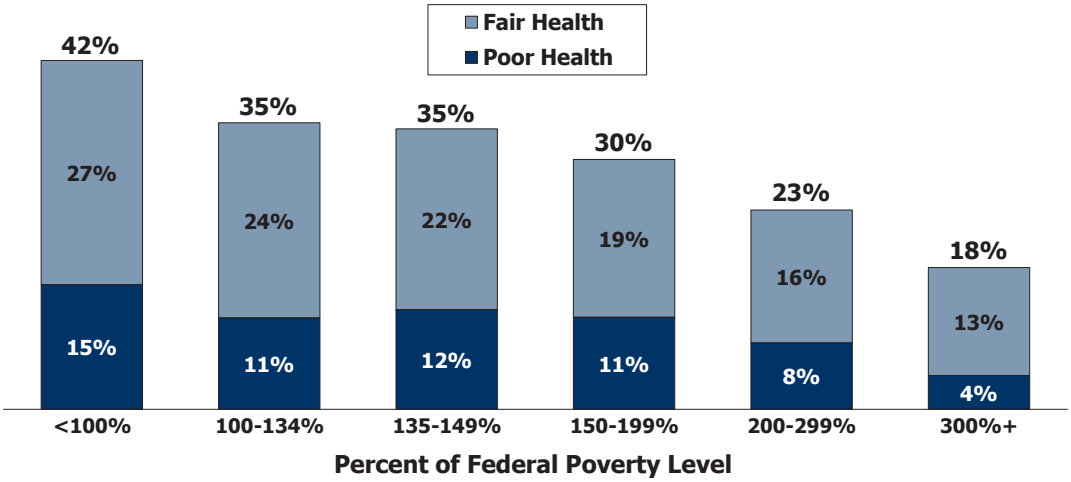


NOTES: Numbers may not sum to total due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Nearly three in ten Medicare beneficiaries (28 percent) report being in fair or poor health. A larger share of certain subgroups of the Medicare population report being in fair or poor health than others, including nonelderly beneficiaries with disabilities, and black and Hispanic beneficiaries.

Figure 1.6

Self-Reported Health Status of Medicare Beneficiaries, by Poverty Level, 2006

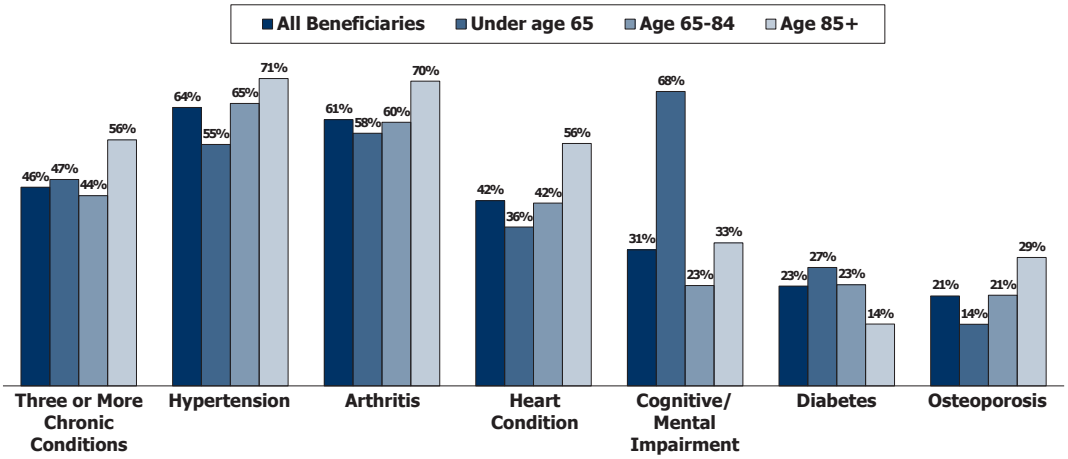


NOTES: In 2006, the federal poverty level was $9,800/individual and $13,200/couple. Numbers may not sum to total due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Medicare beneficiaries with lower incomes are generally in poorer health than those with higher incomes. While 42 percent of beneficiaries with incomes less than 100 percent of the federal poverty level ($9,800/individual, and $13,200/couple in 2006) describe their own health as either fair or poor, only 18 percent of those with incomes above 300 percent of poverty do so.

Figure 1.7

Prevalence of Chronic Conditions Among Non-Institutionalized Medicare Beneficiaries, 2006

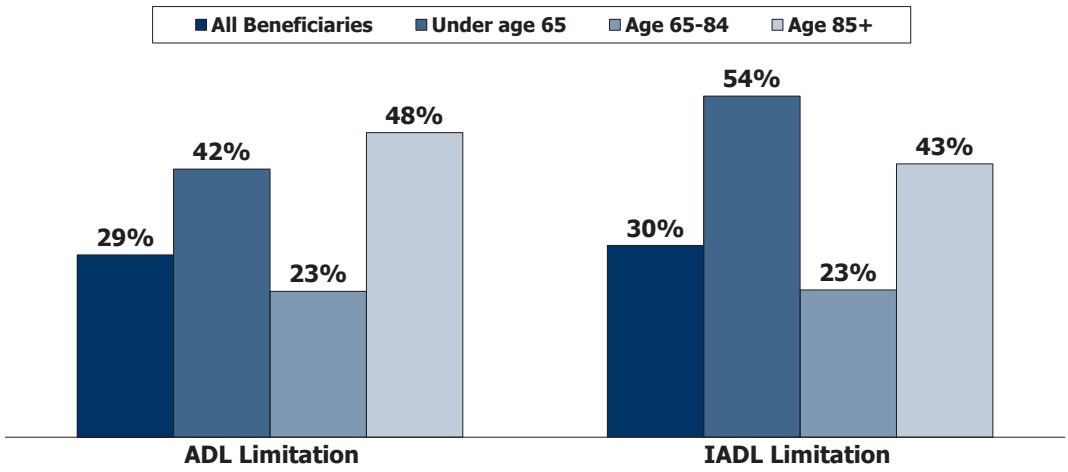


NOTES: Heart condition is defined as diagnosis with hardening of arteries, angina, myocardial infarction, congestive heart failure, or problem with heart valves or heart rhythm. Cognitive/mental impairment is defined as diagnosis with mental retardation, mental disorder, or Alzheimer's disease, or having memory loss that interferes with daily activity. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Overall, nine of every ten non-institutionalized Medicare beneficiaries report living with one or more chronic illnesses; nearly half (46 percent) have three or more chronic conditions. Hypertension and arthritis are the most common conditions, affecting 64 percent and 61 percent of beneficiaries, respectively. While the prevalence of many conditions increases with age, other conditions, such as diabetes and cognitive or mental impairments, are more prevalent among nonelderly Medicare beneficiaries with disabilities.

Figure 1.8

Functional Limitations Among Non-Institutionalized Medicare Beneficiaries, 2006

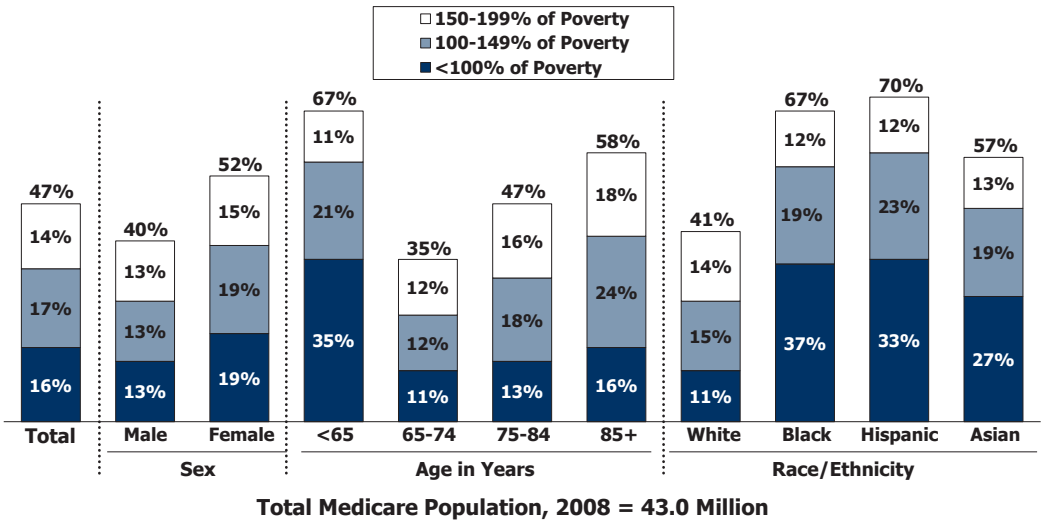


NOTES: ADL is activity of daily living, which includes eating, dressing, getting into and out of a bed or chair, taking a bath or shower, and using the toilet. IADL is instrumental activity of daily living, which includes preparing meals, managing money, shopping, doing housework, and using the telephone. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Nearly three in ten beneficiaries (29 percent) are limited in their ability to handle basic activities of daily living (ADLs), such as bathing and eating, with even higher shares among the nonelderly disabled population (42 percent) and those ages 85 and older (48 percent). A similar share of all beneficiaries (30 percent) are limited in their ability to do instrumental activities of daily living (IADLs), such as housework, preparing meals, and using the telephone. Such limitations affect a greater share of nonelderly disabled beneficiaries (54 percent) and those ages 85 and over (43 percent).

Figure 1.9

Poverty Among the Medicare Population, 2008

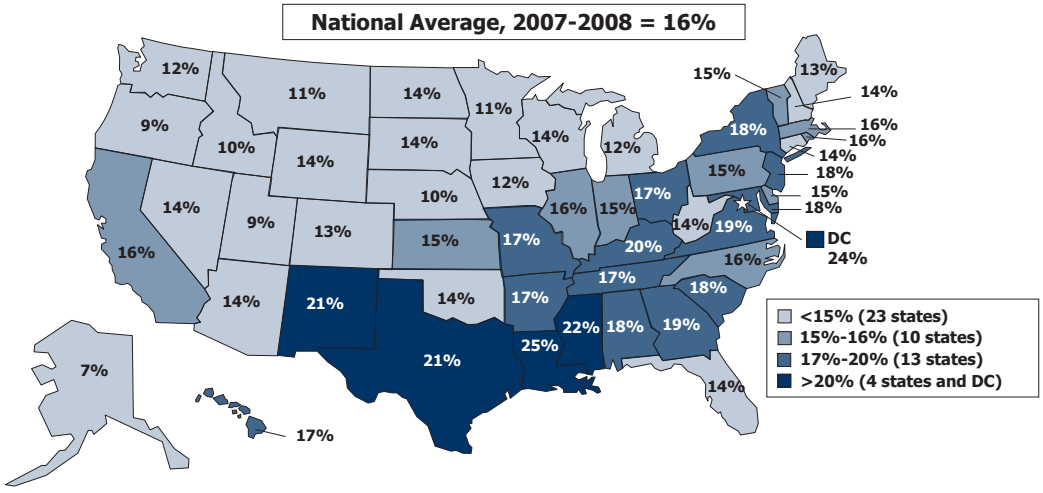


NOTES: Excludes the institutional population. Numbers may not sum to total due to rounding. In 2008, the federal poverty level was $10,400 for an individual and $14,000 for a couple.
SOURCE: Kaiser Family Foundation analysis of the U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.

Nearly half of all Medicare beneficiaries had incomes below twice the federal poverty level (FPL) in 2008 ($20,800 for an individual and $28,000 for a couple). Poverty rates vary greatly among different segments of the Medicare population, with higher rates for females, nonelderly beneficiaries with disabilities, those age 85 or older, and black and Hispanic beneficiaries. More than two-thirds of black and Hispanic beneficiaries live on incomes below twice the poverty level, compared to 41 percent of whites. More than half of all beneficiaries ages 85 and older, and more than two-thirds of the under 65 disabled, live on incomes below twice the poverty level.

Figure 1.10

Medicare Beneficiaries Under 100 Percent of Poverty as a Percent of State Medicare Populations, 2007-2008

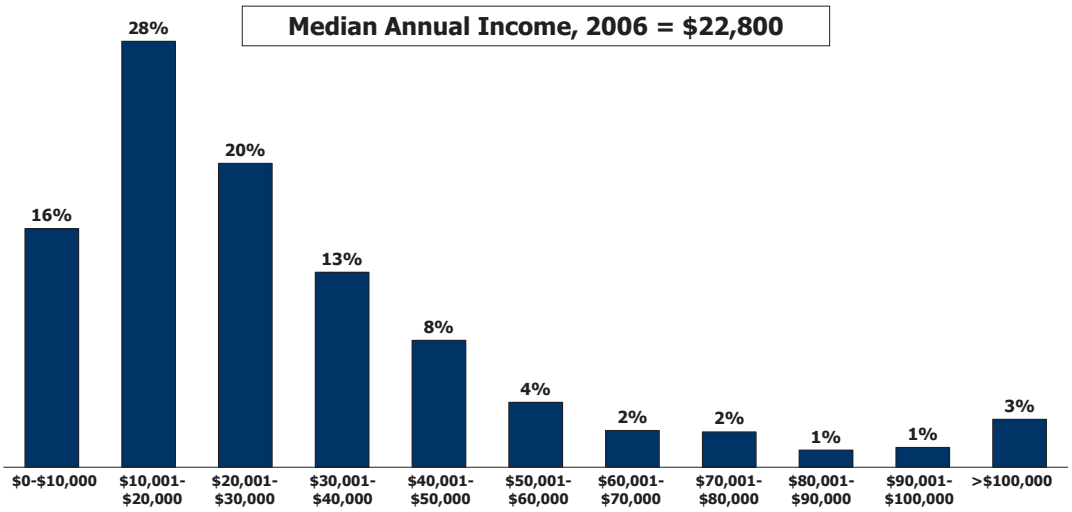


NOTES: In 2008, the federal poverty level was $10,400 for an individual and $14,000 for a couple.
SOURCE: Kaiser Family Foundation analysis of pooled estimates from the U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplements, 2007 and 2008.

On average nationwide, 16 percent of Medicare beneficiaries had incomes less than 100 percent of poverty in 2008, but the share living in poverty varied by state. Alaska, Oregon and Utah had the lowest share of beneficiaries living in poverty (7 percent, 9 percent, and 9 percent respectively), while more than 20 percent of beneficiaries in four states (Louisiana, Mississippi, New Mexico, and Texas) and the District of Columbia had incomes below the poverty level in 2008.

Figure 1.11

Annual Income of Medicare Beneficiaries, 2006

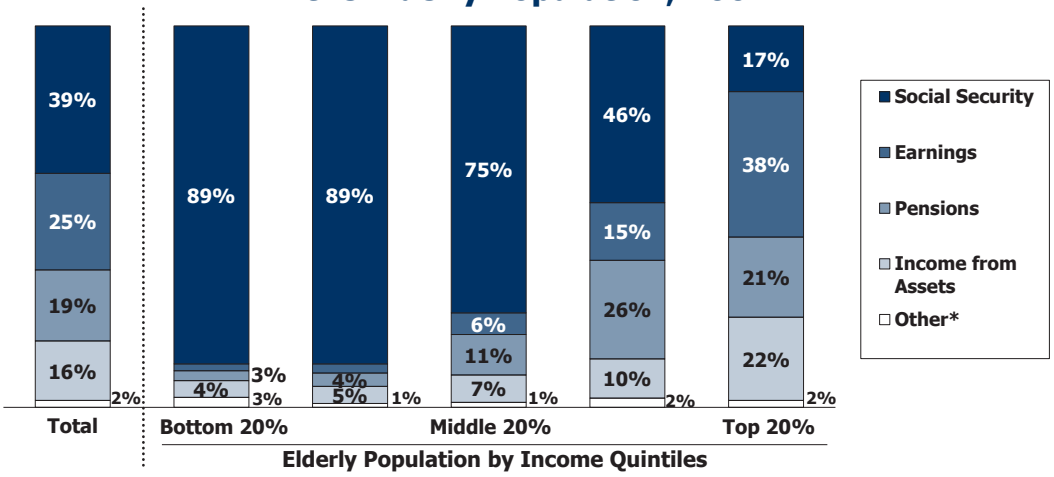


NOTES: Annual income includes that of individual respondents and their spouses, if applicable. Estimates do not sum to totals in text due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Most Medicare beneficiaries live on modest incomes. In 2006, the annual median income among Medicare beneficiaries was $22,800. Nearly half of all beneficiaries (44 percent) have annual family incomes of $20,000 or less, 15 percent have annual incomes greater than $50,000, and 6 percent have incomes that exceed $80,000.

Figure 1.12

Distribution and Sources of Income Among the Elderly Population, 2007

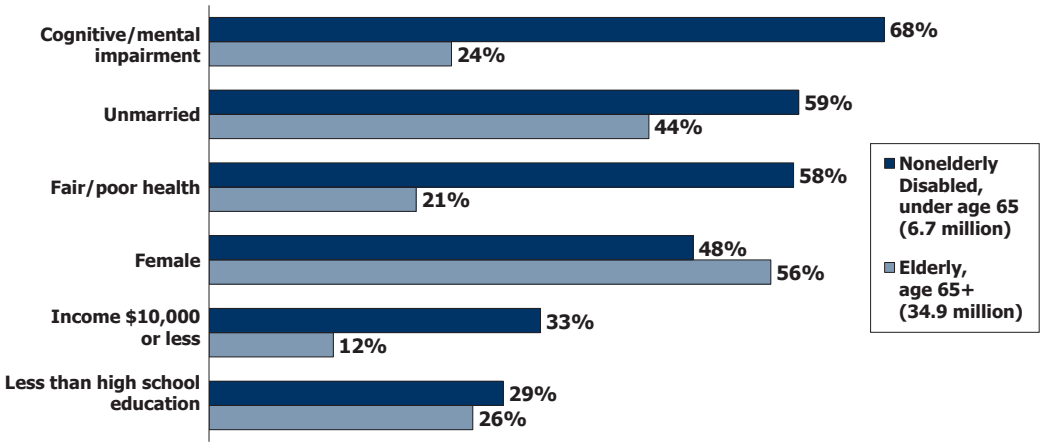


NOTES: * 'Other' includes public assistance, Supplemental Security Income, unemployment compensation, workers' compensation, veterans' benefits, non-pension survivors' benefits, non-pension disability benefits, educational assistance, child support, alimony, regular financial assistance from friends or relatives not living in the individual's household, and other sources of income. Numbers may not sum to 100 percent due to rounding.
SOURCE: Employee Benefits Research Institute Databook on Employee Benefits, July 2009; analysis of data from the 2008 Current Population Survey March Supplement.

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 roughly half of their annual income or more, but among those with the lowest incomes, Social Security comprises the vast majority (89 percent) of their annual income. In contrast, earnings and pensions account for 59 percent of annual incomes for the 20 percent of elderly people in the highest-income group, while Social Security comprises just 17 percent of their annual income.

Figure 1.13

Comparison of Nonelderly Disabled and Elderly Medicare Beneficiaries, 2006

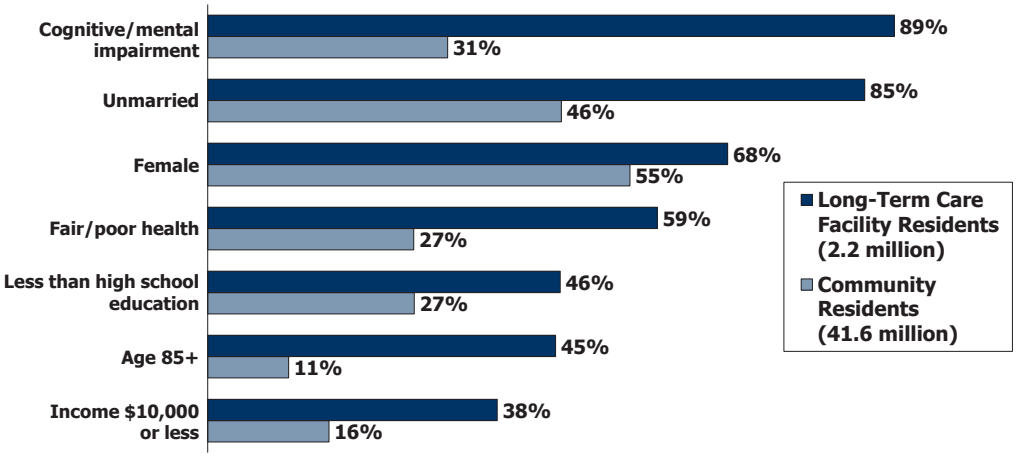


NOTES: Disabled beneficiaries includes those with end stage renal disease (ESRD). Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Younger (under age 65) Medicare beneficiaries with disabilities report higher rates of health and cognitive problems than beneficiaries ages 65 and older, and a larger share live on an income of less than $10,000 as compared with the elderly. In 2006, there were 6.7 million noninstitutionalized 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). Nearly seven in ten nonelderly disabled beneficiaries have a cognitive or mental impairment, about six in ten report their health as fair or poor, and one in three lives on an annual income of $10,000 or less.

Figure 1.14

Comparison of Medicare Beneficiaries Residing in Long-Term Care Facilities and the Community, 2006

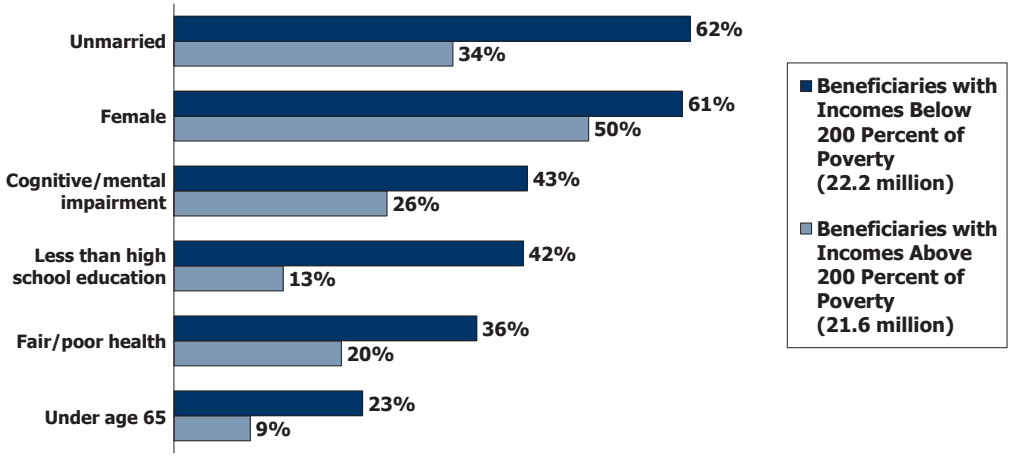


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Medicare beneficiaries living in long-term care settings differ considerably than those living in the community. While most Medicare beneficiaries reside in their own homes or other community-based settings, 2.2 million beneficiaries live in a nursing home or other long-term care facility. A larger share of facility residents are cognitively or mentally impaired (89 percent), female (68 percent), in fair or poor health (59 percent), over age 85 (45 percent), and have annual incomes of $10,000 or less (38 percent), compared to beneficiaries living in the community.

Figure 1.15

Comparison of Medicare Beneficiaries with Incomes Below and Above 200 Percent of Poverty, 2006



NOTES: In 2006, the federal poverty level was $9,800/individual and $13,200/couple.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

About one half of Medicare beneficiaries lived on annual family incomes below 200 percent of the federal poverty level (FPL) in 2006. Compared with beneficiaries at higher income levels, those with incomes below 200 percent of the federal poverty level (FPL) are disproportionately female (61 percent), have cognitive or mental impairments (43 percent), and report their health as fair or poor (36 percent).

SECTION TWO:
MEDICARE BENEFITS, UTILIZATION, AND ACCESS TO CARE

MEDICARE BENEFITS, UTILIZATION, AND ACCESS TO CARE

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 care plans), and Part D for prescription drugs. Medicare covers a wide range of medical services, but has relatively high cost-sharing requirements, provides limited coverage of long-term care and does not cover eyeglasses, hearing aids, or dental care.

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 and coinsurance for a skilled nursing facility stay lasting between 21 and 100 days. 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, an annual Part B deductible, and other cost-sharing requirements. Beneficiaries enrolled in Medicare Advantage (Part C) plans generally pay a monthly premium to their plan, in addition to the Medicare Part B monthly premium, and generally must pay various cost-sharing requirements for benefits and services covered by their plan. Beneficiaries enrolled in Part D plans generally pay a monthly premium for drug coverage, in addition to various cost-sharing requirements for their prescriptions. *(See Appendix B for Medicare Beneficiary Premiums, Deductibles, and Coinsurance, 1966–2019.)*

Most beneficiaries use at least one Medicare-covered service in a given year. Physician office visits are the most frequent, with 82 percent of beneficiaries reporting at least one visit in 2006. In that year, 30 percent of all beneficiaries had one or more emergency room visits, 21 percent of beneficiaries had at least one hospital stay, 8 percent received a Medicare-covered home health visit, 5 percent were admitted to a skilled nursing facility, and 2 percent received some hospice care.

Medicare covers a number of preventive services such as flu shots, pneumococcal vaccines, prostate cancer screenings, mammograms, and Pap smears. Three-fourths of male beneficiaries age 50 and older (76 percent) report being screened for prostate cancer in 2008, while over half of female Medicare beneficiaries age 40 and older (57 percent) said they received a mammogram in 2008, with lower rates of receiving mammograms among low-income beneficiaries and those reporting poor health.

Beneficiaries generally enjoy broad access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures. While the vast majority of Medicare beneficiaries do not report problems with access to medical care, experiences vary by demographic subgroup, such as health status, age, and income, with a larger share of beneficiaries in poor health, the nonelderly disabled, and those with low incomes reporting access problems than their counterparts. *(For variations in access to care by supplemental coverage, see Section 6.)*

The vast majority of physicians and other medical practitioners in the U.S. (an average of 96 percent nationwide) participate in Medicare, meaning they agree to accept Medicare's allowed charge as payment in full for services they provide to Medicare beneficiaries (in addition to applicable beneficiary coinsurance amounts). Participation rates vary by physician specialty, however. In 2008, three-quarters of physicians were accepting all or most new patients with Medicare.

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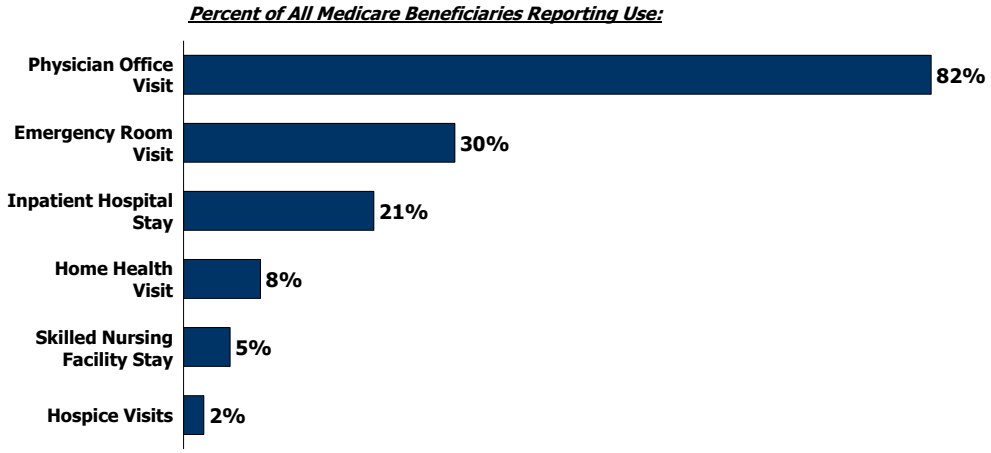
Figure 2.1
Medicare Benefits* and Cost-Sharing Requirements, 2010

PART A	
Deductible	$1,100 per benefit period
Inpatient hospital	
Days 1-60	No coinsurance
Days 61-90	$275 per day
Days 91-150	$550 per day (for up to 60 lifetime reserve days)
After 150 Days	Not covered
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$137.50 per day
After 100 Days	Not covered
Home Health	No coinsurance; no limit on number of visits
Hospice	No coinsurance for hospice care; copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	Up to 190 days in a lifetime
PART B	
Deductible	$155
Premium	$110.50/month; higher for those with incomes above $85,000/single or $170,000/couple; $96.40/month for those held harmless from the premium increase
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance; certain limits may apply
Clinical laboratory services	No coinsurance
Home health care	No coinsurance; no limit on number of visits
Outpatient mental health services	45% coinsurance (phasing down to 20% in 2014)
One-time "Welcome to Medicare" physical exam	20% coinsurance; covered within first 12 months of Part B enrollment; Part B deductible does not apply
Preventive services*	
Flu shot, Pneumococcal shot	No coinsurance; limit of one flu shot per flu season
Hepatitis B shot, colorectal and prostate cancer screening, pap smear, mammogram, cardiovascular screening, abdominal aortic aneurysm (AAA) screening, bone mass measurement, diabetes screening and monitoring, glaucoma screening, smoking cessation	20% coinsurance after annual Part B deductible is met; however, Part B deductible and coinsurance are waived for some preventive services
PART D	
Information below applies to the standard Part D benefit; benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.	
Deductible	$310
Premium	$31.94 national average monthly premium *(unweighted PDP and MA-PD plan average)*
Initial coverage *(up to $2,830 in total drug costs)*	25% coinsurance
Coverage gap *(between $2,830 and $6,440 in total drug costs)*	100% coinsurance (not covered) after $250 rebate (phasing down to 25% in 2020)
Catastrophic coverage *(above $4,550 in out-of-pocket spending)*	Minimum of $2.50/generic, $6.30/brand; or 5% coinsurance

NOTES: *This table does not include all Medicare-covered benefits or preventive services; for a complete listing, see http://www.medicare.gov/Coverage/Home.asp and http://www.medicare.gov/Health/Overview.asp.
SOURCES: CMS, www.medicare.gov, Medicare & You 2010, Your Guide to Medicare's Preventive Services.

Figure 2.2

Medicare Beneficiaries' Utilization of Selected Medical and Long-Term Care Services, 2006

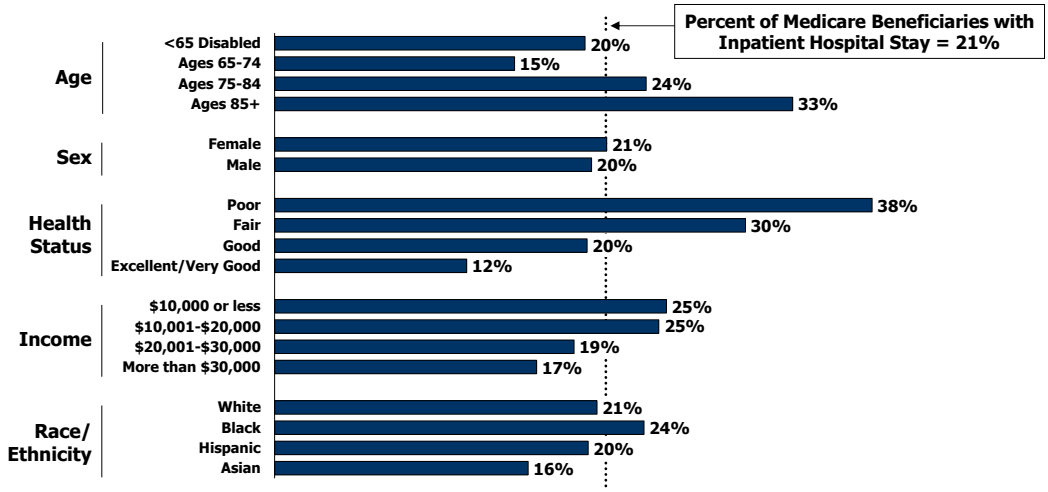


NOTES: Analysis excludes beneficiaries enrolled in Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

A majority of Medicare beneficiaries enrolled in traditional fee-for-service Medicare reported using one or more Medicare-covered services in 2006. More than eight in ten beneficiaries (82 percent) visited a physician in 2006, with a median number of six visits per patient. One in five (21 percent) reported at least one inpatient hospital stay, and 19 percent of those who were hospitalized in the year were readmitted within 30 days of their initial hospital discharge. Among the 8 percent of beneficiaries who reported using home health services, the median number of visits was 17. Three in ten beneficiaries (30 percent) had at least one visit to the ER; 12 percent had two or more visits.

Figure 2.3

Inpatient Hospital Utilization by Medicare Beneficiaries, by Demographic Characteristics, 2006

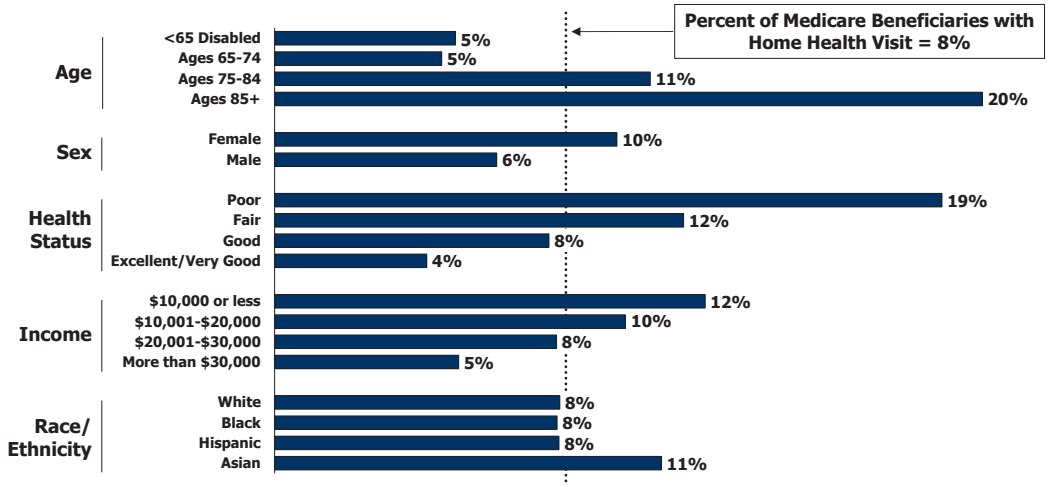


NOTES: Analysis excludes beneficiaries enrolled in Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

In 2006, 21 percent of beneficiaries in traditional fee-for-service Medicare reported at least one inpatient hospital stay, but hospitalization rates varied by individual characteristics, such as health status, age, and income. Hospitalization rates were higher among those in poor or fair health (38 percent and 30 percent, respectively), among those ages 85 and older (33 percent), and among those with incomes less than $20,000 (25 percent).

Figure 2.4

Home Health Care Utilization by Medicare Beneficiaries, by Demographic Characteristics, 2006



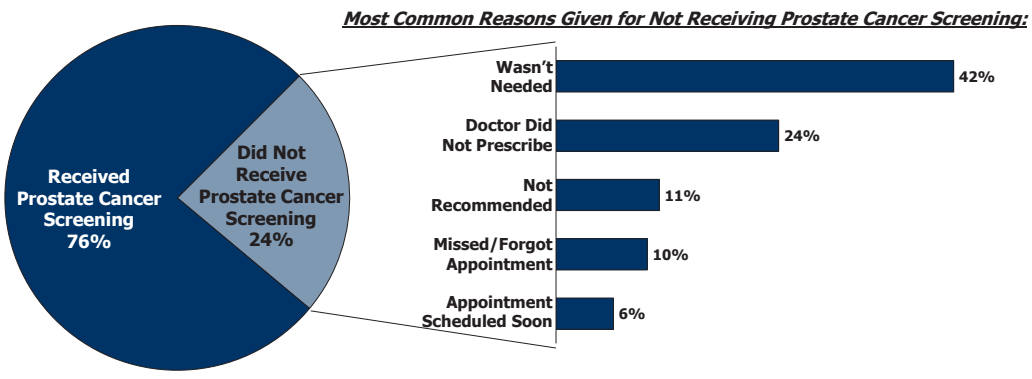
NOTES: Analysis excludes beneficiaries enrolled in Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

In 2006, 8 percent of beneficiaries in traditional fee-for-service Medicare used home health care services, but the rate of use varied substantially depending on beneficiaries' health status, age, and other circumstances. Home health care utilization rates were highest among those in poor health (19 percent) and those ages 85 and older (20 percent). Home health care use was higher among females than males and among those with lower incomes than higher incomes. Among home health users, the median number of visits received was 17.

Figure 2.5

Preventive Service Utilization by Male Medicare Beneficiaries, 2008

Prostate Cancer Screening



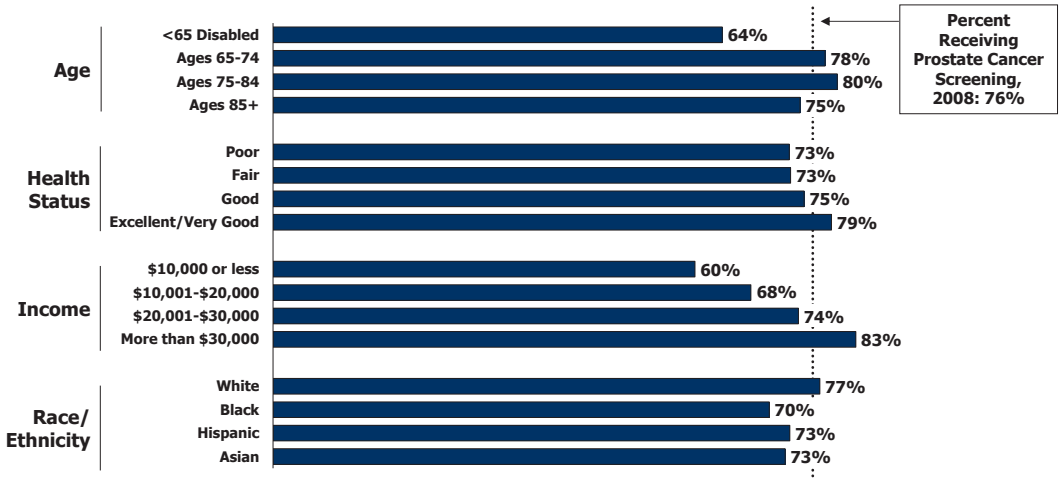
Total Male Medicare Beneficiaries, age 50+, 2008 = 16.6 Million

NOTES: Includes only male beneficiaries who did/did not receive a blood test to screen for prostate cancer. Respondents could give multiple reasons for not receiving prostate cancer screening; response categories are not mutually exclusive. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Medicare covers annual prostate cancer screenings for all male beneficiaries with Medicare ages 50 and older. More than three in four male Medicare beneficiaries (76 percent) received a prostate cancer screening test in 2008. For the 24 percent of males who did not receive screening, the most common reasons cited were that it was not needed (42 percent) or that their doctor did not prescribe it (24 percent).

Figure 2.6

Percent of Male Medicare Beneficiaries that Received Prostate Cancer Screening, by Demographic Characteristics, 2008



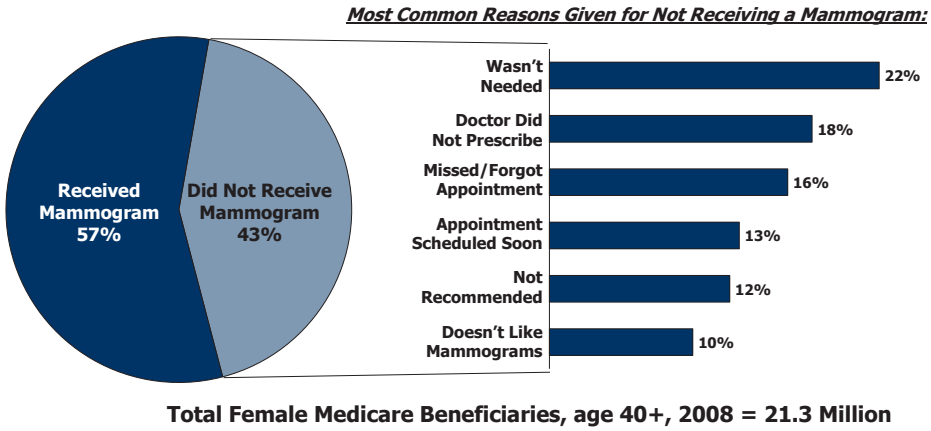
NOTES: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

In 2008, three quarters (76 percent) of male beneficiaries age 50 and over received a prostate cancer screening, but the rate of receipt of screening varied substantially depending on beneficiaries demographic characteristics. The share of male Medicare beneficiaries receiving prostate cancer screening was lower among nonelderly beneficiaries, those reporting fair or poor health, those with low incomes, and black beneficiaries.

Figure 2.7

Preventive Service Utilization by Female Medicare Beneficiaries, 2008

Mammogram



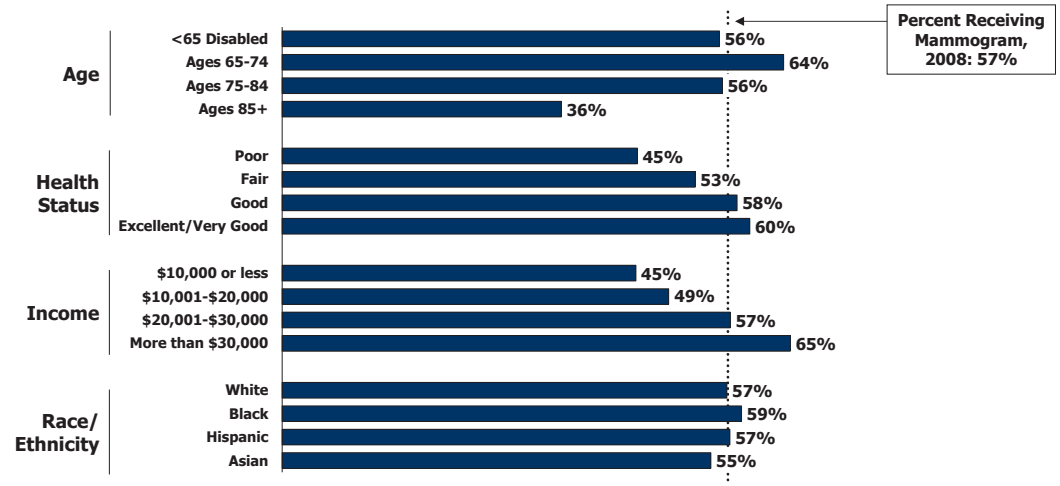
Total Female Medicare Beneficiaries, age 40+, 2008 = 21.3 Million

NOTES: Respondents could give multiple reasons for not receiving a mammogram; response categories are not mutually exclusive. Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

All females with Medicare ages 40 and older are eligible for a mammogram once every 12 months, but only about half of female beneficiaries (57 percent) reported receiving a mammogram in 2008. Among those who did not receive a mammogram, commonly cited reasons were that the test was not needed (22 percent), their doctor did not prescribe it (18 percent), or the patient missed or forgot the appointment (16 percent).

Figure 2.8

Percent of Female Medicare Beneficiaries that Received a Mammogram, by Demographic Characteristics, 2008

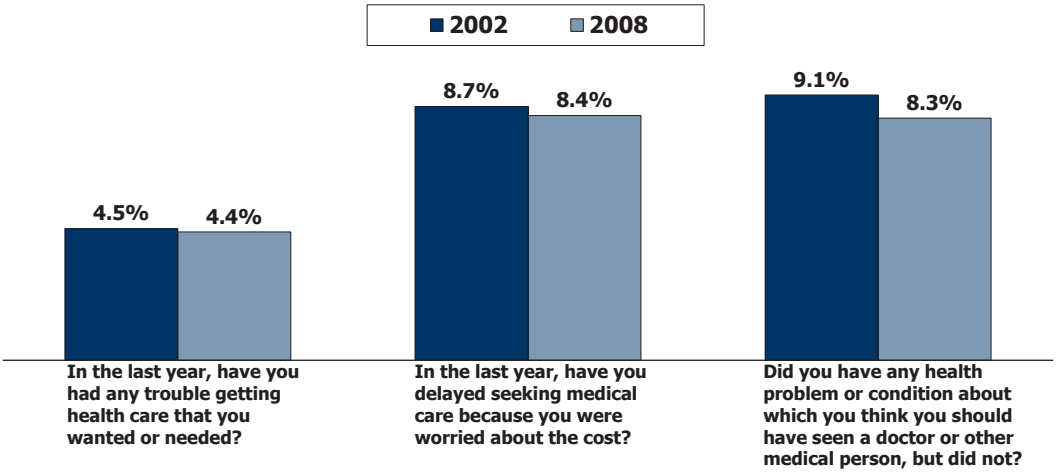


NOTES: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

In 2008, more than half (57 percent) of female beneficiaries age 40 and over received a mammogram, but the rate of receipt of screening varied substantially depending on beneficiaries demographic characteristics. The share of female Medicare beneficiaries receiving a mammogram was lower among nonelderly beneficiaries, beneficiaries over age 75, those reporting poor health, and those with low incomes.

Figure 2.9

Measures of Access to Care Among Medicare Beneficiaries, 2002 and 2008

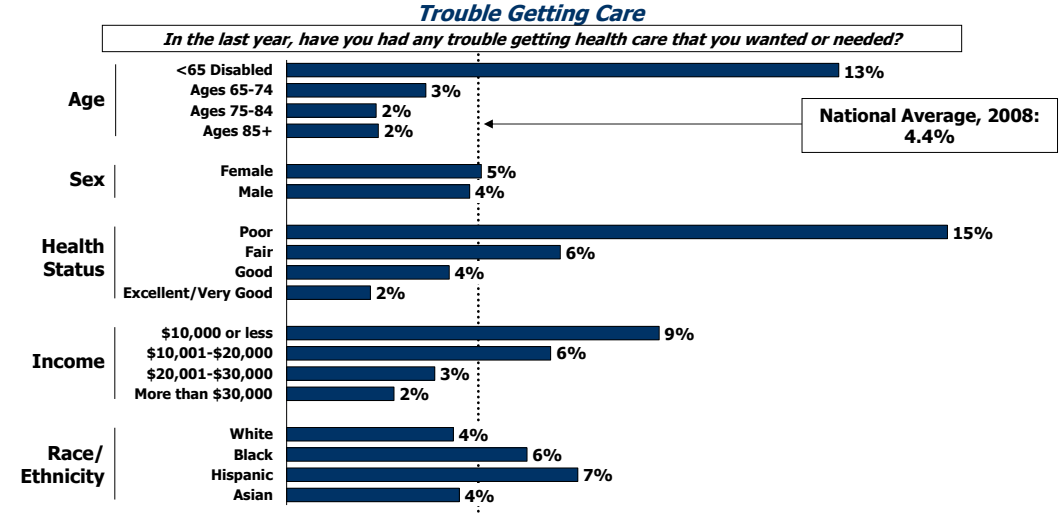


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2002 and 2008.

A relatively small share of Medicare beneficiaries report experiencing problems accessing needed medical care, with no significant change in two of three measures of access difficulties between 2002 and 2008. Roughly 4 percent of all beneficiaries reported trouble getting health care in 2008, while 8 percent said they delayed seeking medical care due to cost, and 8 percent said they had a serious medical problem for about which they should have seen a doctor but did not (a significant decrease of one percentage point since 2002).

Figure 2.10

Measures of Access to Care Among Medicare Beneficiaries, by Demographic Characteristics, 2008

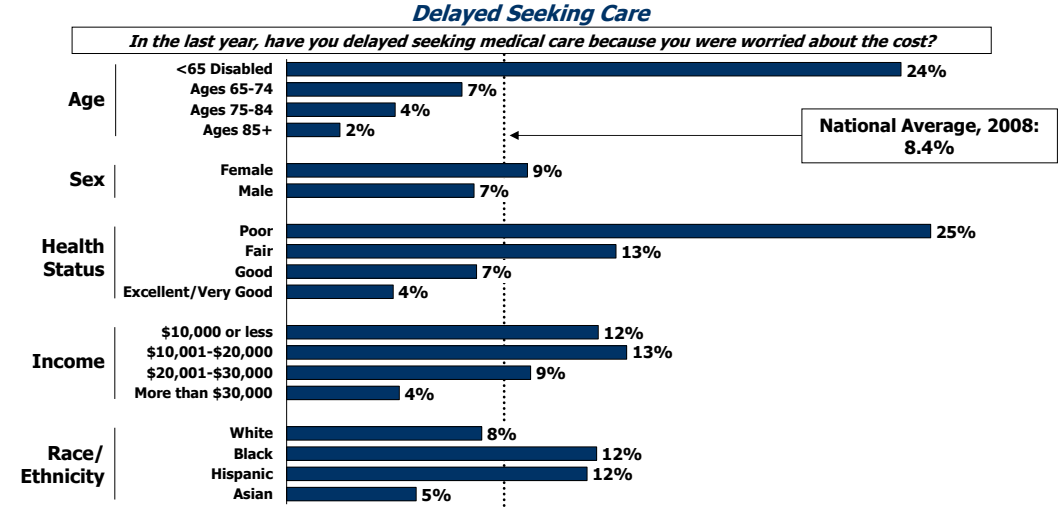


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

While the vast majority of Medicare beneficiaries do not report experiencing problems with access to medical care, experiences vary by individual characteristics, such as health status, age, and income. For example, in 2008, 15 percent of beneficiaries in poor health reported that they had trouble getting health care they wanted or needed, compared to 4 percent or less among those in good health or better. A larger share of nonelderly disabled beneficiaries than those age 65 or older reported trouble getting needed care, along with a larger share of those with income of $20,000 or less compared to those with higher incomes.

Figure 2.11

Measures of Access to Care Among Medicare Beneficiaries, by Demographic Characteristics, 2008



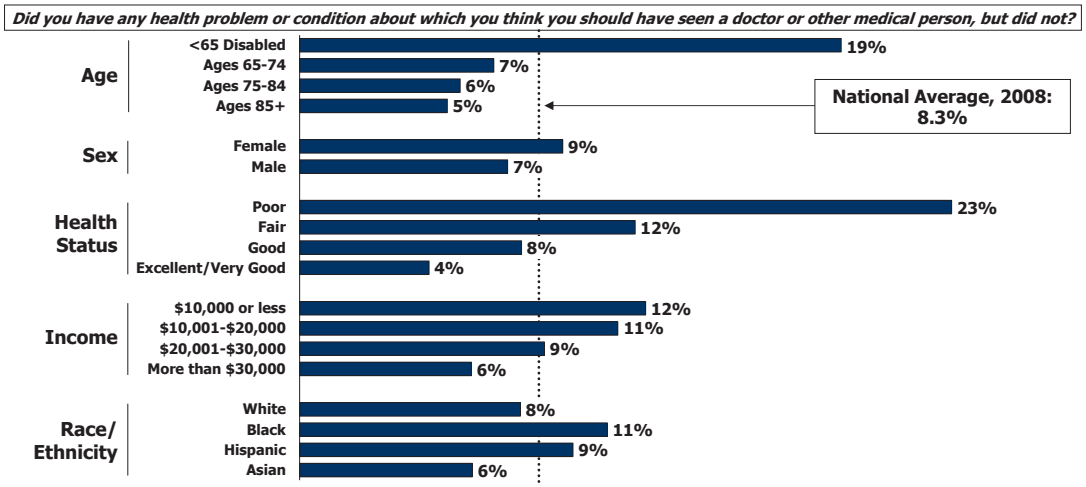
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

In 2008, one quarter of Medicare beneficiaries in poor health and a similar share of nonelderly disabled beneficiaries reported that they delayed seeking medical care because they were worried about the cost, compared to 7 percent or less among those in good health and better and those ages 65 and older. A larger share of beneficiaries with low or moderate incomes ($30,000 or less) reported delaying seeking medical care because of cost than those with higher incomes.

Figure 2.12

Measures of Access to Care Among Medicare Beneficiaries, by Demographic Characteristics, 2008

Did Not See Doctor for Problem

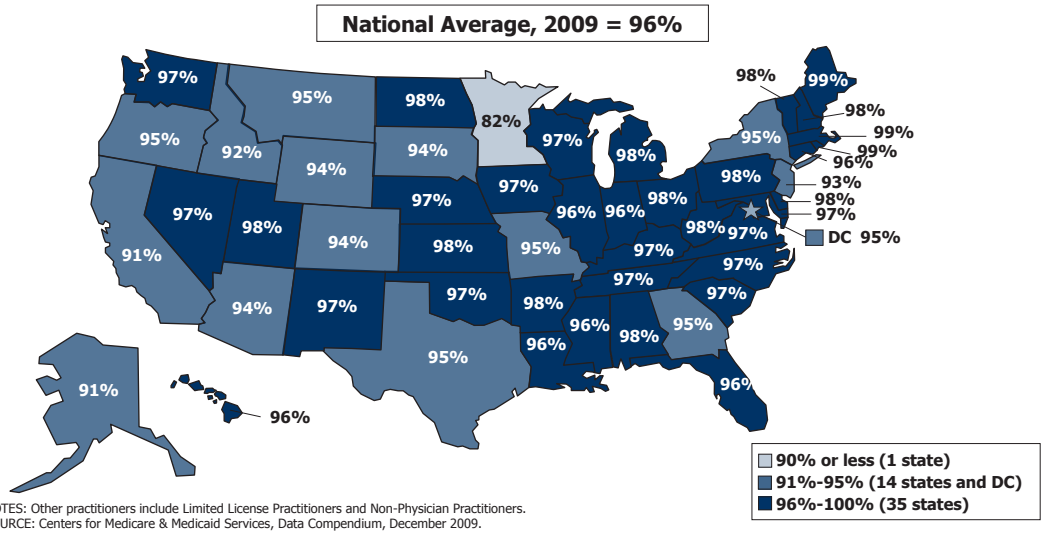


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

In 2008, nearly a quarter (23 percent) of Medicare beneficiaries in poor health and nearly one in five (19 percent) nonelderly disabled beneficiaries reported that they had a health problem or condition that they thought they should have seen a doctor or other medical provider about but did not, compared to 8 percent or less of those in good health or better and those ages 65 and older. A larger share of beneficiaries with incomes below $20,000 reported not seeing a doctor for a health problem than those with higher incomes.

Figure 2.13

Percent of Physicians and Other Practitioners Participating in Medicare Part B, by State, 2009

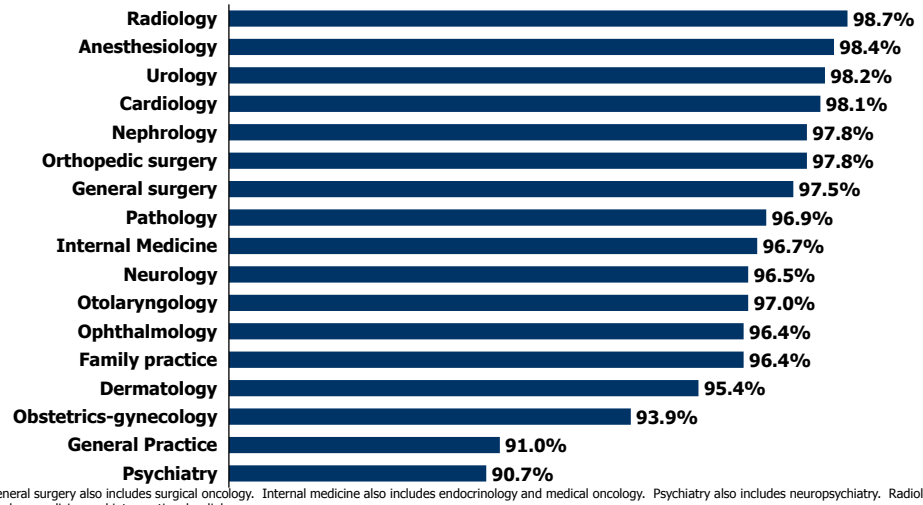


NOTES: Other practitioners include Limited License Practitioners and Non-Physician Practitioners.
SOURCE: Centers for Medicare & Medicaid Services, Data Compendium, December 2009.

The vast majority of physicians and other medical practitioners in the U.S. participate in Medicare, meaning they agree to accept Medicare's allowed charge as payment in full for services they provide to Medicare beneficiaries (in addition to applicable beneficiary coinsurance amounts). Averaged across all states, 96 percent of physicians and other practitioners participate in Medicare Part B, ranging from a low of 82 percent in Minnesota to 99 percent in Maine, Massachusetts, and Rhode Island.

Figure 2.14

Medicare Participation Rates as a Percent of Physicians, by Specialty, 2009

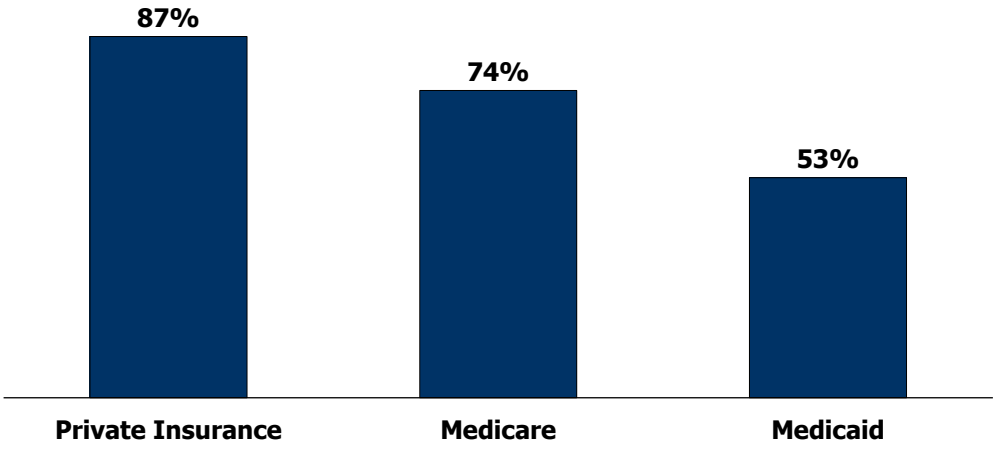


NOTES: General surgery also includes surgical oncology. Internal medicine also includes endocrinology and medical oncology. Psychiatry also includes neuropsychiatry. Radiology also includes nuclear medicine and interventional radiology.
SOURCE: Centers for Medicare & Medicaid Services, Data Compendium, December 2009.

While the majority of physicians nationwide participate in Medicare, the share varies by type of physician specialty. In 2009, more than 98 percent of physicians specializing in radiology, anesthesiology, urology, and cardiology participated in Medicare, while fewer than 95 percent of physicians in obstetrics-gynecology, general practice, and psychiatry participated in Medicare.

Figure 2.15

Percent of Physicians Accepting All or Most New Patients, by Type of Insurance Coverage, 2008



SOURCE: Center for Studying Health Systems Change, *HSC 2008 Health Tracking Physician Survey*, September 2009.

Physician acceptance of new patients varies widely by patient insurance type, with a smaller share of physicians accepting all or most new Medicaid patients than Medicare or privately-insured patients. In 2008, nearly nine in ten physicians (87 percent) reported that their practices accept all or most new privately-insured patients and three-quarters of physicians (74 percent) accept new Medicare patients, while just over half (53 percent) of physicians accept new Medicaid patients.

SECTION THREE:
MEDICARE AND PRESCRIPTION DRUGS

MEDICARE AND PRESCRIPTION DRUGS

Approximately 90 percent of all Medicare beneficiaries currently have some source of prescription drug coverage. The Medicare prescription drug benefit (Part D), which took effect in 2006, is the primary source of drug coverage, with six in ten beneficiaries enrolled in a Medicare drug plan. About one-third of beneficiaries have coverage from another source, such as an employer-sponsored retiree health benefits plan or the Veterans Administration (VA). Ten percent of all beneficiaries currently lack a known source of prescription drug coverage.

The Part D prescription drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs, that cover all Medicare benefits including drugs. In 2010, 1,576 PDPs are offered nationwide. Beneficiaries in all states have a choice of at least 41 stand-alone PDPs, in addition to multiple MA-PD plans, and enrollment in Part D plans varies by state. Monthly premiums for many of the most popular plans have increased significantly since 2006; overall, the weighted average monthly premium has increased from $25.93 in 2006 to $37.25 in 2010 (a 44 percent increase).

Enrollment in Medicare prescription drug plans is voluntary, with the exception of certain low-income beneficiaries who are automatically enrolled in a PDP if they do not choose a plan on their own. Beneficiaries with low incomes and modest assets are eligible for assistance with premiums and cost sharing for the Medicare Part D benefit. In 2009, 12.5 million Medicare beneficiaries were eligible for the low-income subsidy; of this total, most received subsidies, but 2.3 million beneficiaries were eligible for these subsidies but not receiving them.

Part D plans offer either a defined standard benefit or an actuarially equivalent benefit, and they can also offer enhanced benefits. The standard benefit has a deductible and 25 percent coinsurance up to an initial coverage limit, followed by a coverage gap (the so-called “doughnut hole”) where enrollees pay 100 percent of their total drug costs until they reach the catastrophic coverage limit. Thereafter, enrollees pay 5 percent of total drug costs. The Affordable Care Act of 2010 provides a $250 rebate to Part D enrollees with any spending in the coverage gap in 2010, and gradually phases in coverage in the gap between 2011 and 2020. The standard benefit amounts increase annually by the rate of per capita Part D spending growth.

Most Part D plans have a coverage gap. In 2010, 80 percent of all PDPs and nearly half of all MA-PD plans offer no gap coverage, and those that do offer some gap coverage generally limit their gap coverage to generic drugs only. An estimated 3.4 million Medicare beneficiaries (14 percent of all Part D enrollees) reached the coverage gap in 2007 and faced the full cost of their prescriptions. Of those who reached the gap, 20 percent stopped taking their medication, reduced their medication use, or switched medications.

While the majority of all Medicare beneficiaries now have prescription drug coverage, a larger share of certain subgroups of beneficiaries lack coverage than others. Larger shares of male beneficiaries, beneficiaries living in rural areas, and the nonelderly disabled had no drug coverage in 2008.

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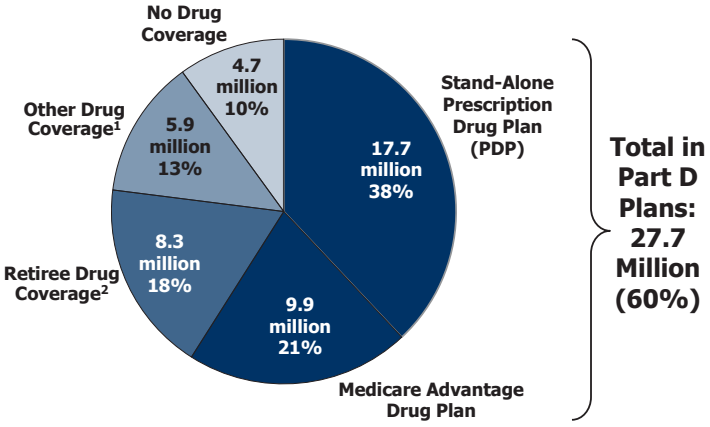
Figure 3.1

Prescription Drug Coverage Among Medicare Beneficiaries, 2010



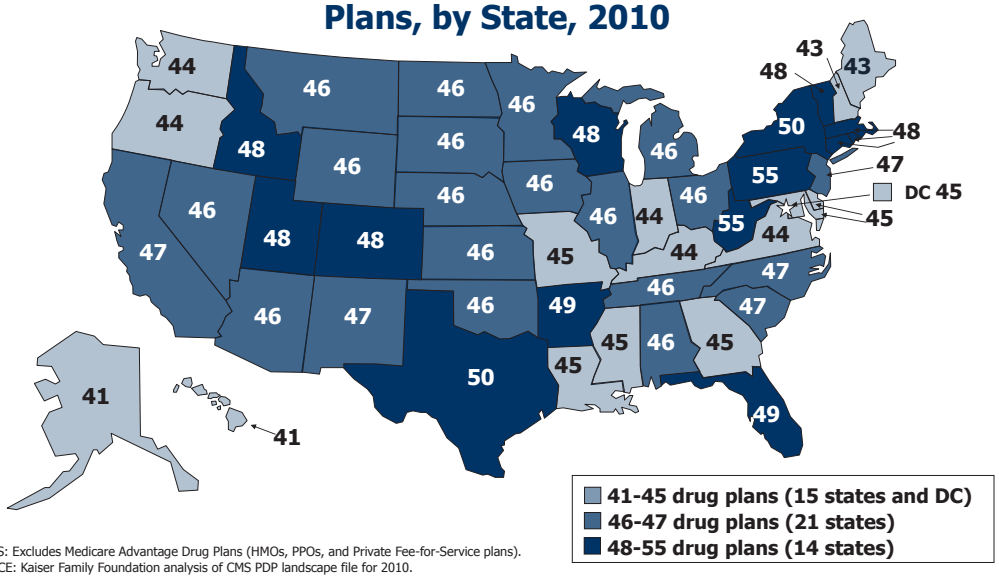
Total Number of Medicare Beneficiaries = 46.5 Million

NOTES: Numbers do not sum to 100 percent due to rounding. [1]Includes Veterans Affairs, retiree coverage without RDS, Indian Health Service, state pharmacy assistance programs, employer plans for active workers, Medigap, multiple sources, and other sources. [2]Includes Retiree Drug Subsidy (RDS) and FEHBP and TRICARE retiree coverage.
SOURCE: Centers for Medicare & Medicaid Services, 2010 Enrollment Information (as of February 16, 2010).

In 2010, 90 percent of Medicare beneficiaries have prescription drug coverage. Beneficiaries obtain drug coverage from a variety of sources, but most (60 percent) have coverage through a Medicare Part D plan, including the 14 percent of beneficiaries who are dually eligible for Medicare and Medicaid. Eighteen percent of beneficiaries have retiree coverage from their employers and 13 percent have coverage from other sources. One in ten Medicare beneficiaries (10 percent) has no coverage for prescription drugs.

Figure 3.2

Number of Medicare Part D Stand-Alone Prescription Drug Plans, by State, 2010

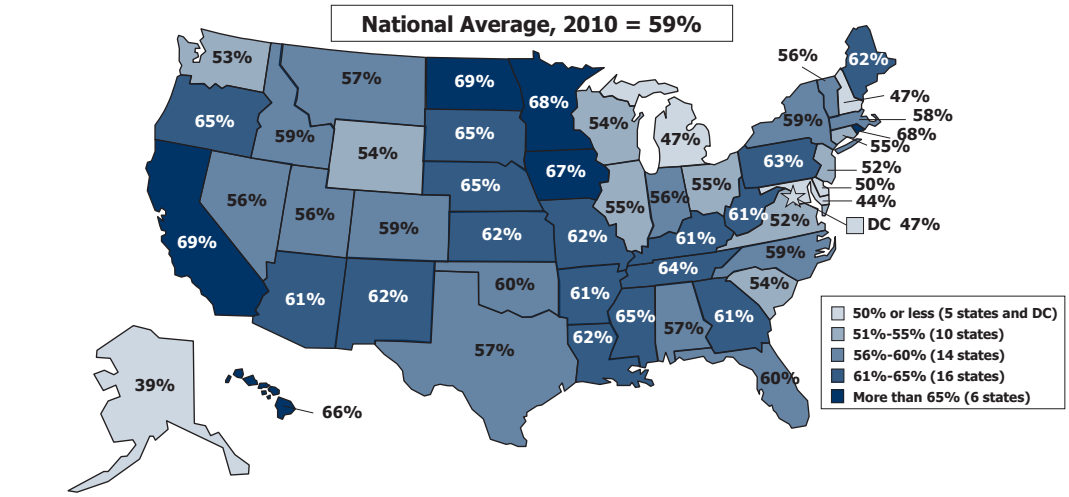


NOTES: Excludes Medicare Advantage Drug Plans (HMOs, PPOs, and Private Fee-for-Service plans).
SOURCE: Kaiser Family Foundation analysis of CMS PDP landscape file for 2010.

The Medicare drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs, that cover all Medicare benefits including drugs. In 2010, a total of 1,576 PDPs are offered across 34 PDP regions nationwide (excluding the territories). Beneficiaries in all states have a choice of at least 41 stand-alone PDPs, in addition to multiple MA-PD plans.

Figure 3.3

Medicare Part D Enrollees as a Percent of Medicare Beneficiaries, by State, 2010



NOTES: National average excludes data for the territories.
SOURCE: Centers for Medicare & Medicaid Services (CMS) Management Information Integrated Repository (MIIR), February 16, 2010.

On average nationwide (excluding the territories), 59 percent of Medicare beneficiaries are enrolled in Medicare Part D plans in 2010. The share of beneficiaries enrolled in Part D plans varies by state, from 50 percent of beneficiaries or less in five states (Alaska, Delaware, Maryland, Michigan, and New Hampshire) and the District of Columbia to more than 65 percent in six states (California, Hawaii, Iowa, Minnesota, North Dakota, and Rhode Island).

Figure 3.4

Medicare Part D Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2010

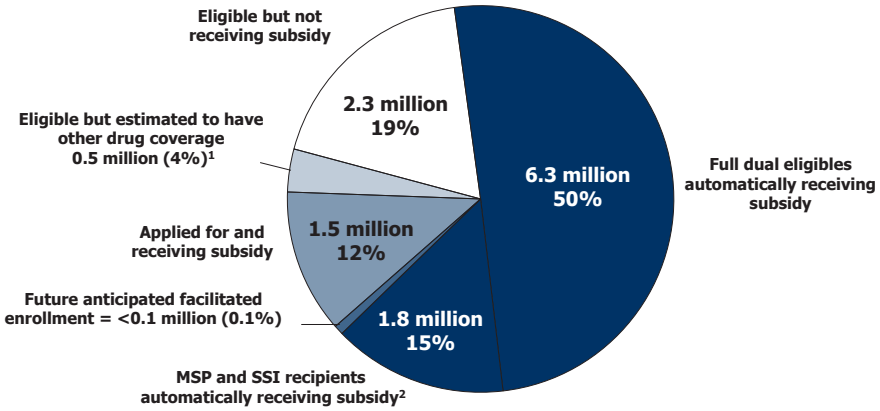
Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Individuals with Medicare and Medicaid	$0	$0	$1.10-$2.50/generic $3.20-$6.30/brand-name; no copayments after total drug spending reaches $6,440
Individuals with Medicare and Medicaid in nursing homes	$0	$0	No copayments
Individuals with income <135% of poverty and resources <$8,100/individual; $12,910/couple	$0	$0	$2.50/generic $6.30/brand-name; no copayments after total drug spending reaches $6,440
Individuals with income 135%-150% of poverty and resources <$12,510/individual; $25,010/couple	sliding scale up to $31.94*	$60	15% of total costs up to $6,440; $2.50/generic $6.30/brand-name thereafter

NOTES: The 2010 poverty level is $10,800/individual and $14,600/couple. Resources include $1,500/individual and $3,000/couple for funeral or burial expenses. *$31.94 is the national monthly Part D base beneficiary premium for 2010.
SOURCE: Kaiser Family Foundation summary of Medicare drug benefit low-income subsidies in 2010.

Medicare beneficiaries with low incomes and limited resources are eligible for premium and cost-sharing subsidies for the prescription drug benefit through the Part D low-income subsidy (LIS) program. Medicare beneficiaries with Medicaid coverage (dual eligibles) and those enrolled in Medicare Savings Programs are automatically deemed eligible for these subsidies. Other low-income beneficiaries are required to meet both an income and asset test and apply separately for the LIS program and Part D plan enrollment.

Figure 3.5

Eligibility and Participation in Medicare Part D Low-Income Subsidies, 2009



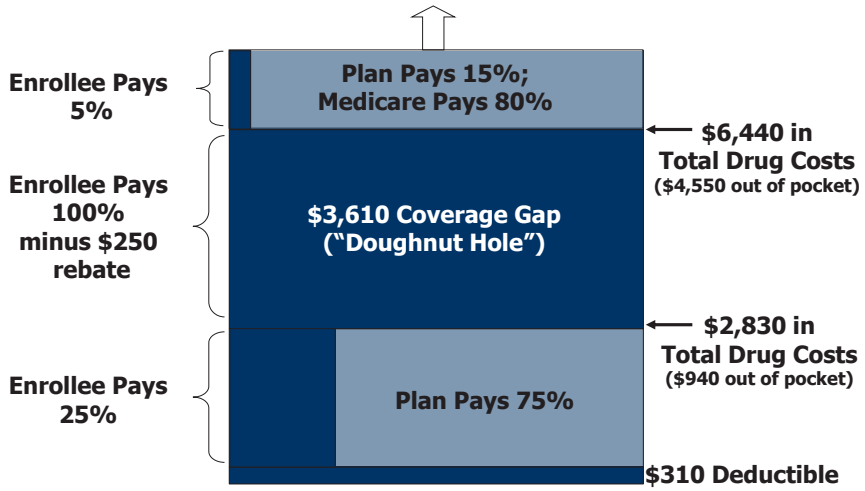
Medicare Beneficiaries Eligible for Low-Income Subsidies, 2009 = 12.5 million

NOTES: [1]Includes Veterans Affairs, Indian Health Service, and Retiree Drug Subsidy (RDS) coverage. [2]MSP is Medicare Savings Program; SSI is Supplemental Security Income.
SOURCE: Centers for Medicare and Medicaid Services, 2009 Enrollment Information (as of February 1, 2009)

In 2009, 9.6 million Part D enrollees received low-income subsidies. The majority (65 percent) of beneficiaries who were eligible for low-income subsidies under the Medicare drug benefit in 2009 were deemed eligible and automatically received the subsidy because they were either covered by Medicaid, enrolled in a Medicare Savings Program, or received Supplemental Security Income. However, 2.3 million Medicare beneficiaries were eligible for low-income subsidies but not receiving them, accounting for 19 percent of all beneficiaries eligible for the subsidies in 2009.

Figure 3.6

Medicare Part D Standard Prescription Drug Benefit, 2010

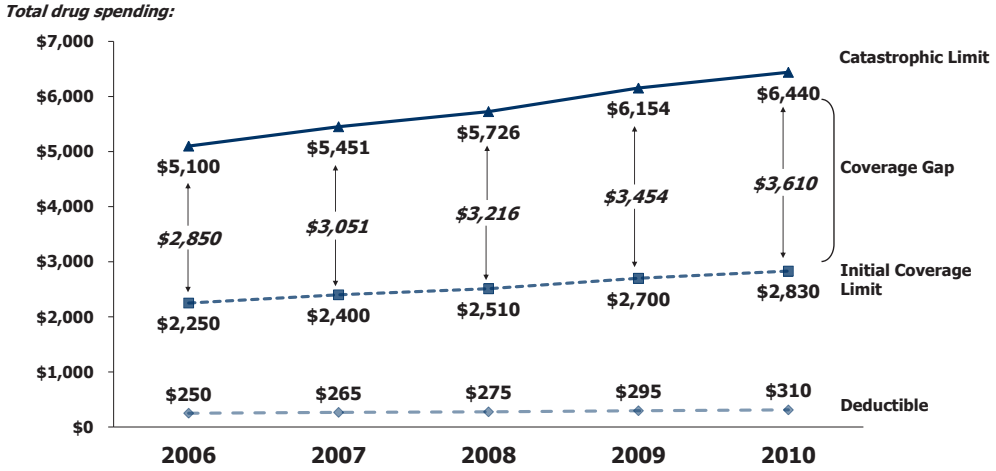


NOTES: Amounts rounded to nearest whole dollar.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2010 (standard benefit parameter update from CMS, April 2009).

Under the Medicare Part D standard drug benefit design, beneficiaries who enroll in a drug plan pay an annual deductible ($310 in 2010) and 25 percent coinsurance for their prescription drugs. In addition, the standard benefit includes a coverage gap ("doughnut hole"), where beneficiaries are responsible for 100 percent of the total cost of their prescriptions until they reach catastrophic coverage (minus a $250 rebate in 2010 for those who reach the gap). The Affordable Care Act of 2010 gradually phases in coverage in the gap and eliminates the coverage gap entirely by 2020, so that enrollees who reach the gap will pay 25 percent of the cost of their medications until they qualify for catastrophic coverage.

Figure 3.7

Medicare Part D Standard Benefit Parameters, 2006-2010

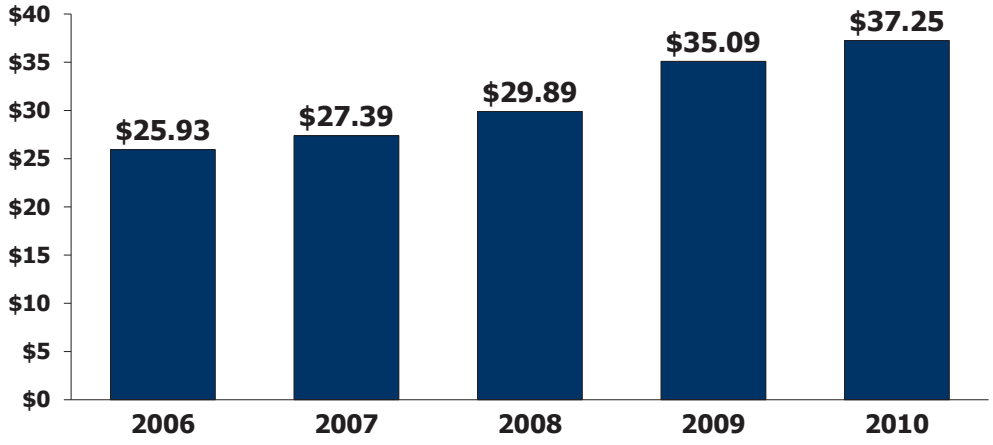


NOTE: Estimates rounded to nearest whole dollar. Enrollees in non-standard benefit plans may face different thresholds depending on the design of their Part D plan benefits and cost-sharing amounts.
SOURCE: Centers for Medicare & Medicaid Services.

Since 2006, the standard benefit parameters (deductible, initial coverage limit, and catastrophic limit) have increased by about 25 percent, reflecting growth in Medicare per capita drug costs. These parameter amounts increase each year, automatically increasing Part D enrollees' out-of-pocket liability.

Figure 3.8

Weighted Average Monthly Premium for Medicare Part D Stand-Alone Prescription Drug Plans, 2006-2010

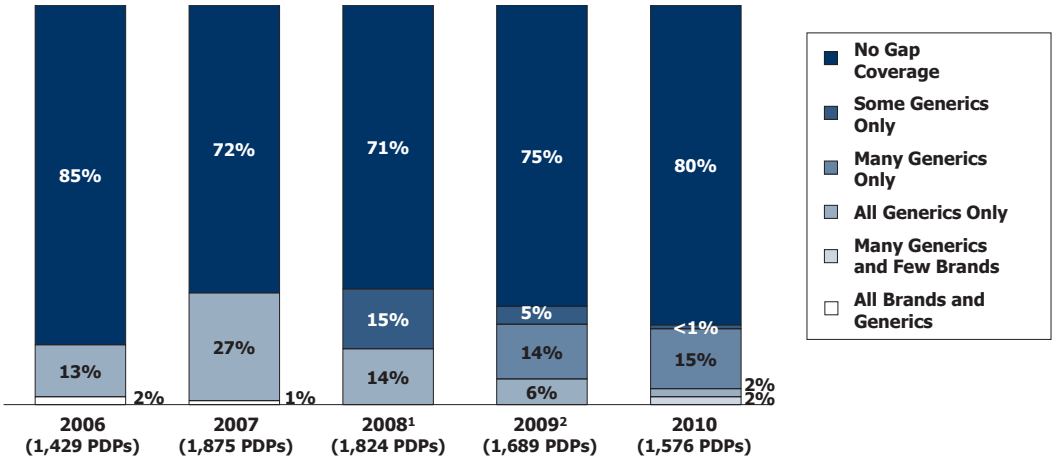


SOURCE: Georgetown University/NORC analysis of CMS PDP landscape files, 2006-2010, for the Kaiser Family Foundation.

The majority of Part D enrollees pay a monthly premium for Medicare drug coverage. Part D enrollees have faced relatively steep drug plan premium increases over time, including those in the most popular plans. Between 2006 and 2010, average PDP premiums increased 44 percent, weighted by each year's enrollment—from $25.93 in 2006 to $37.25 in 2010.

Figure 3.9

Percent of Medicare Part D Stand-Alone Prescription Drug Plans, by Type of Gap Coverage, 2006-2010

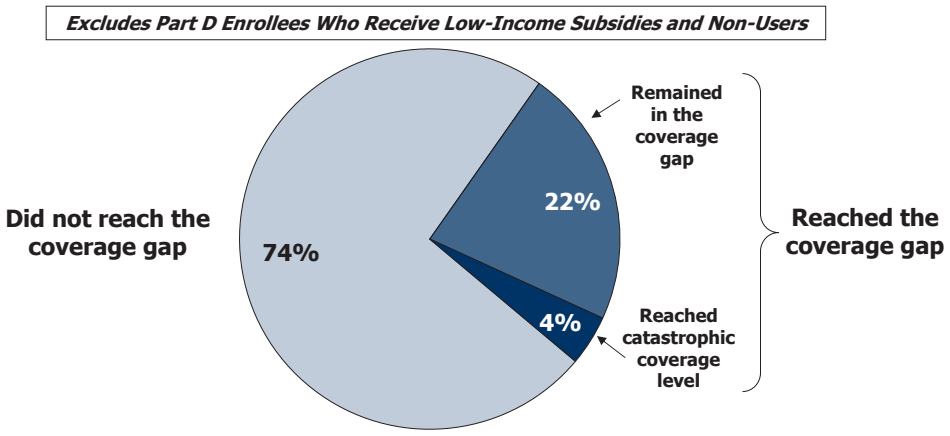


NOTES: PDP is prescription drug plan. [1] In 2008, one PDP offered gap coverage for brand-name drugs (rounds to 0 percent).[2] In 2009, three PDPs offered gap coverage for brand-name drugs (rounds to 0 percent).
SOURCE: Georgetown University/NORC analysis of CMS PDP landscape files, 2006-2010, for the Kaiser Family Foundation.

Since 2006, most Part D plans have had a coverage gap and most Part D enrollees are in plans with a coverage gap. More MA-PD plans than PDPs offer gap coverage; however, most plans that offer gap coverage cover primarily generic drugs only.

Figure 3.10

Percent of Medicare Part D Enrollees Who Reached the Coverage Gap and Catastrophic Coverage in 2007



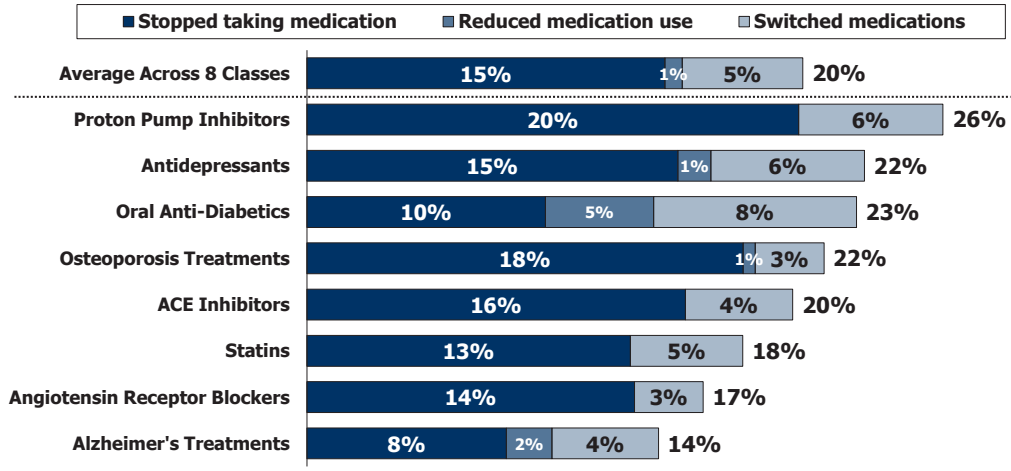
NOTES: Estimates based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007.
SOURCE: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRx database, 2007.

Among Part D enrollees who filled one or more prescriptions but did not receive low-income subsidies in 2007, one quarter (26 percent) had spending high enough to reach the coverage gap—an estimated 3.4 million beneficiaries or 14 percent of all Part D enrollees in 2007.

Figure 3.11

Changes in Drug Use By Medicare Part D Enrollees Who Reached the Coverage Gap in 2007

Among Part D enrollees who reached the coverage gap, percent who:

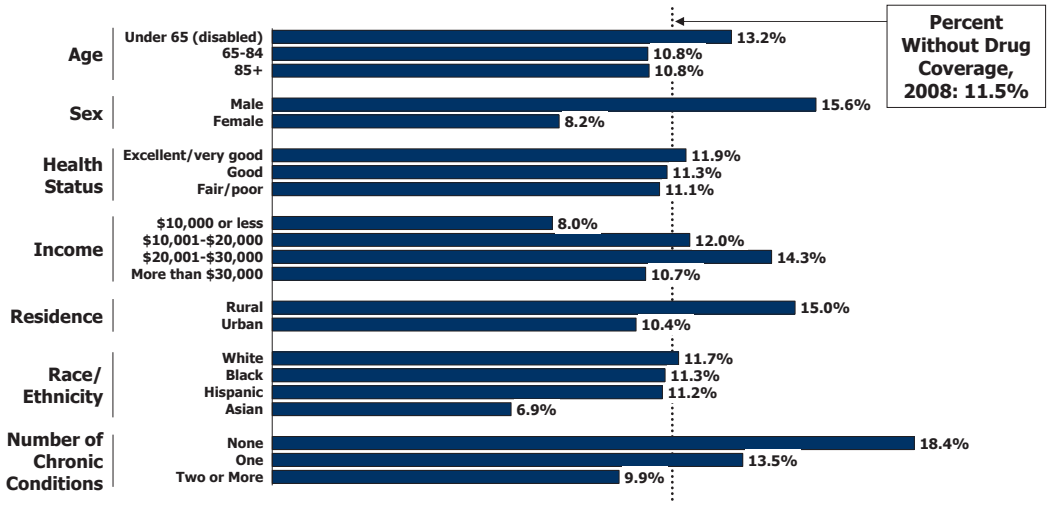


NOTES: Estimates based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007. Percentages may not sum to total due to rounding.
SOURCE: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRx database, 2007.

Among Part D enrollees using drugs in one or more of eight drug classes, 20 percent of enrollees who reached the coverage gap in 2007 either stopped taking a medication in that drug class (15 percent), reduced their medication use (e.g., skipped doses) (1 percent), or switched to a different medication in that class (5 percent) when they reached the gap. Part D enrollees' response to the coverage gap varied by drug class.

Figure 3.12

Percent of Medicare Beneficiaries Without Prescription Drug Coverage, by Demographic Characteristics, 2008



SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

In 2008, roughly 12 percent of all Medicare beneficiaries had no prescription drug coverage, with a larger share lacking coverage among male than female beneficiaries (16 percent versus 8 percent), nonelderly disabled than elderly beneficiaries (13 percent versus 11 percent), and for beneficiaries with no chronic conditions than those with one (18 percent versus 14 percent) or two or more chronic conditions (10 percent).

SECTION FOUR:
MEDICARE ADVANTAGE

MEDICARE ADVANTAGE

Since the early 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly health maintenance organizations (HMOs), as an alternative to the fee-for-service (FFS) Medicare program. Over the past several decades, the role of private plans in Medicare has evolved. Even the name of the program (Part C) has changed, from Medicare+Choice, as it was called in 1997, to Medicare Advantage, as it was renamed in 2003.

In 2010, about one in four people on Medicare (24 percent) are enrolled in a Medicare Advantage plan. The majority of these 11 million enrollees are in HMOs (65 percent), followed by local and regional preferred provider organizations (19 percent), private fee-for service plans (13 percent), and other types of plans, such as cost-based plans and Medicare medical savings accounts (4 percent). The share of all Medicare beneficiaries enrolled in Medicare Advantage plans varies across states, ranging from less than 10 percent (10 states and the District of Columbia) to at least 20 percent (22 states), from a low of 1 percent of beneficiaries in Alaska to 40 percent of beneficiaries in Oregon and Hawaii.

Medicare Advantage plans are required to provide all Medicare-covered benefits, but are permitted to vary the benefit design as long as the core benefit package is actuarially equivalent to traditional Medicare. Plans are also required to provide extra benefits to people covered in their plan, if the payment from Medicare exceeds the plan's bid, after adjustments for health status. The most common extra benefit provided by Medicare Advantage plans is reduced cost sharing for Medicare-covered benefits. Others include benefits beyond those covered by Medicare (such as dental or eyeglasses) and reduced premiums (for Part B and Part D). Benefits and premiums vary widely across plans, and have increased from year to year. Between 2009 and 2010, for example, the weighted average Medicare Advantage monthly premium increased by 32 percent.

Originally, Medicare payments to plans were set at the county level to be lower than average payments for beneficiaries in the traditional fee-for-service program. Over time, however, Medicare payments to plans were increased above average costs for traditional Medicare to help attract more private plans to serve Medicare beneficiaries, particularly in rural areas, and to boost enrollment. The Affordable Care Act of 2010 modified Medicare's method for paying Medicare Advantage plans to phase down overpayments to plans, while providing bonuses to plans with high quality ratings. Medicare rates Medicare Advantage plan quality on a one-star to five-star scale, with five stars representing the highest quality. Enrollment in highly-rated Medicare Advantage plans varies by state: 28 percent of Medicare Advantage enrollees nationwide are in plans that received four or more stars in 2010, ranging from none of the Medicare Advantage enrollees in five states (where there were no plans receiving four or more stars) to 89 percent of Medicare Advantage enrollees in Massachusetts.

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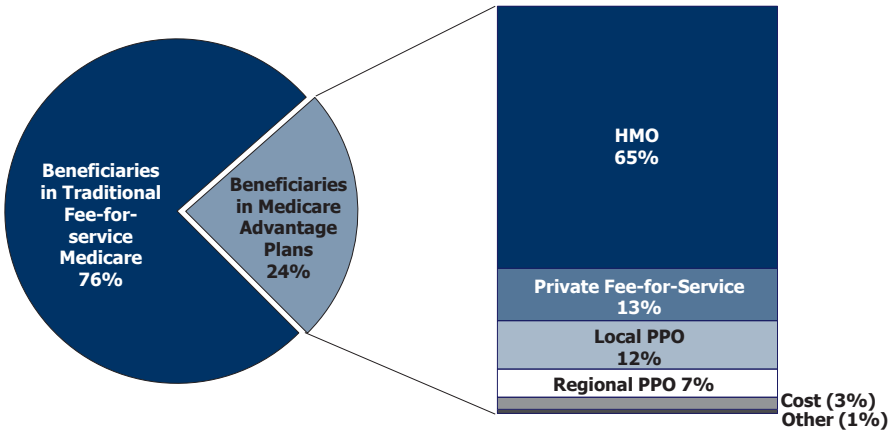
Figure 4.1

Distribution of Medicare Advantage Enrollment, by Plan Type, 2010



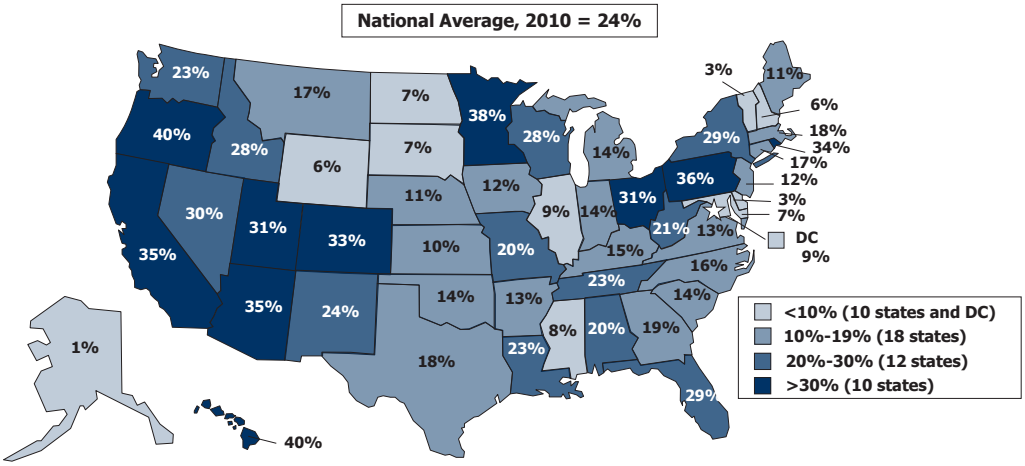
Total Medicare Beneficiaries in Medicare Advantage, 2010 = 11 Million

NOTES: HMO is health maintenance organization. PPO is preferred provider organization.
SOURCE: Mathematica Policy Research (MPR) and Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2010.

Approximately 11 million Medicare beneficiaries are enrolled in Medicare Advantage plans in 2010 (24 percent). The majority of enrollees (65 percent) are in Medicare HMOs, which have been an option under Medicare since the 1970s. Fewer beneficiaries are enrolled in other types of private plans, including private fee-for-service (PFFS) plans (13 percent of enrollment), local preferred provider organizations (PPOs) (12 percent), regional PPOs (7 percent), and other plans, such as cost-based plans and Medicare medical savings account plans.

Figure 4.2

Medicare Advantage Enrollees as a Percent of Medicare Beneficiaries, by State, 2010

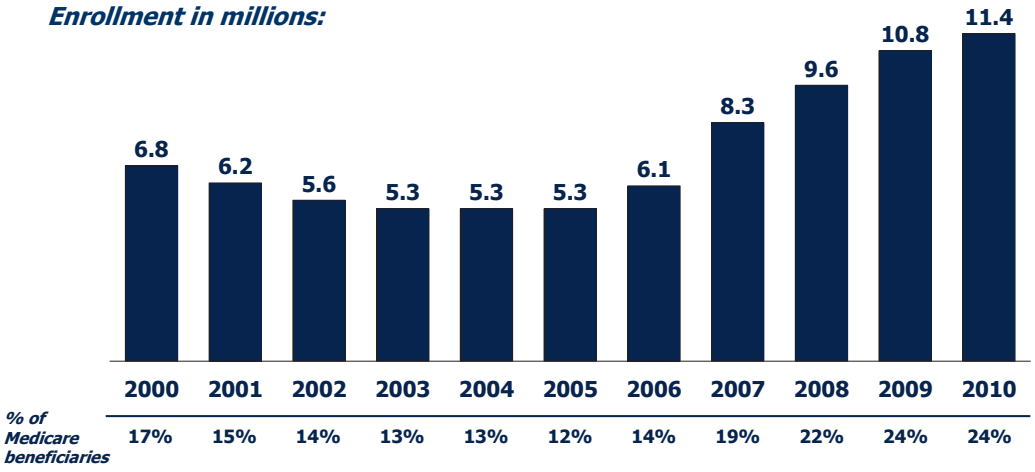


NOTES: Share of Medicare Advantage enrollees includes beneficiaries in Medicare HMOs, PPOs, PSOs, MSAs, PFFS, demonstrations, PACE, employer direct PFFS, and cost plans.
SOURCE: Kaiser Family Foundation analysis of data from CMS, Medicare Advantage State/County Penetration Data, February 2010.

Medicare Advantage enrollment varies widely across states. As of February 2010, less than 10 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans in 10 states and the District of Columbia, while at least 20 percent are enrolled in these plans in 22 states. Nationwide, 24 percent of Medicare beneficiaries are in a Medicare Advantage plan, ranging from 1 percent in Alaska to 40 percent in Oregon and Hawaii.

Figure 4.3

Total Medicare Private Health Plan Enrollment, 2000-2010

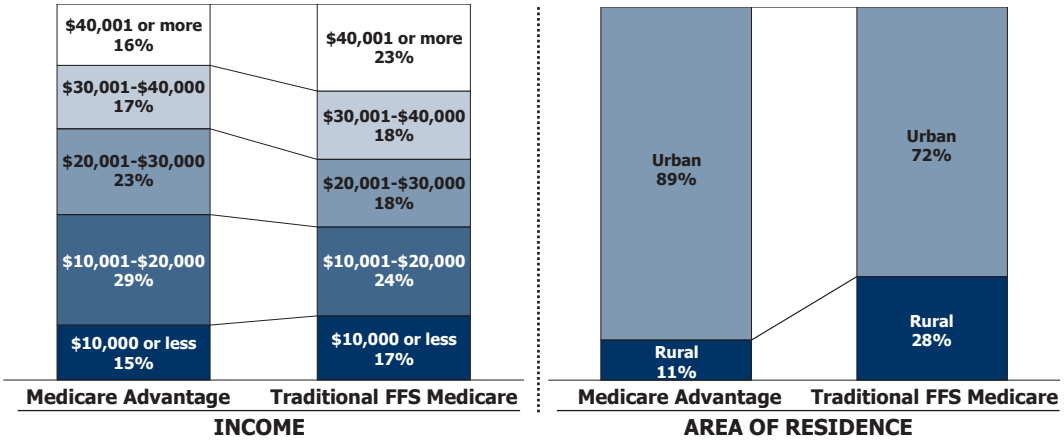


NOTE: Includes local HMOs, PSOs, PPOs; regional PPOs; PFFS plans; 1876 cost plans; demos; HCPP; and PACE plans.
SOURCE: MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," February 2000-2010.

Enrollment in private Medicare Advantage plans as a share of all Medicare beneficiaries decreased from 17 percent in 2000 to approximately 12 percent in 2005 before rising to 24 percent in 2010. Private plans are expected to maintain a prominent role in Medicare in the years to come, although changes to Medicare Advantage plan payments are expected to affect enrollment in these plans.

Figure 4.4

Characteristics of Beneficiaries in Medicare Advantage and Traditional Fee-for-Service Medicare, by Income and Area of Residence, 2008

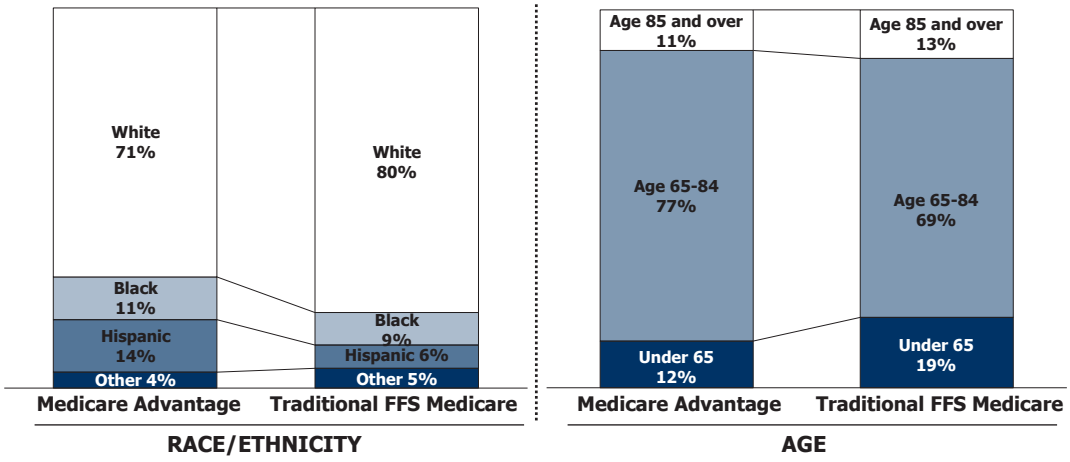


NOTES: FFS is fee-for-service. Numbers may not sum to 100 percent due to rounding. Urban counties are defined as those in a metropolitan statistical area (MSA); all other counties are classified as rural.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Beneficiaries with incomes between $10,000 and $30,000 accounted for a somewhat larger share of beneficiaries in Medicare Advantage plans than in traditional fee-for-service Medicare in 2008 (52 percent versus 42 percent, respectively). Beneficiaries living in rural areas accounted for a substantially smaller share of the Medicare Advantage population than they did of the traditional Medicare population (11 percent versus 28 percent, respectively).

Figure 4.5

Characteristics of Beneficiaries in Medicare Advantage and Traditional Fee-for-Service Medicare, by Race/Ethnicity and Age, 2008

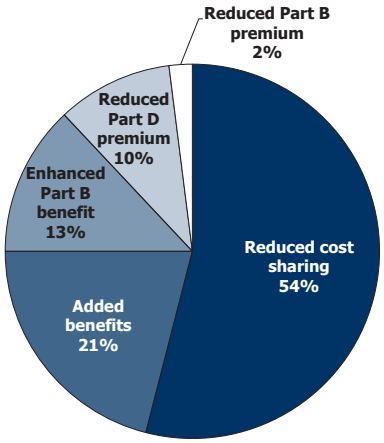


NOTES: FFS is fee-for-service. Numbers may not sum to 100 percent due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Hispanic beneficiaries accounted for a larger share of the Medicare Advantage population than they did of the traditional fee-for-service Medicare population in 2008, while no significant difference was observed among black beneficiaries. The share of beneficiaries ages 65 to 84 was slightly higher among Medicare Advantage enrollees than among beneficiaries in the traditional Medicare program, while the share of nonelderly beneficiaries with disabilities accounted for a smaller share of all Medicare Advantage enrollees than of those in traditional Medicare.

Figure 4.6

Distribution of the Dollar Amount of Benefit Improvements Financed from Medicare Advantage Plan Rebate Dollars, 2010

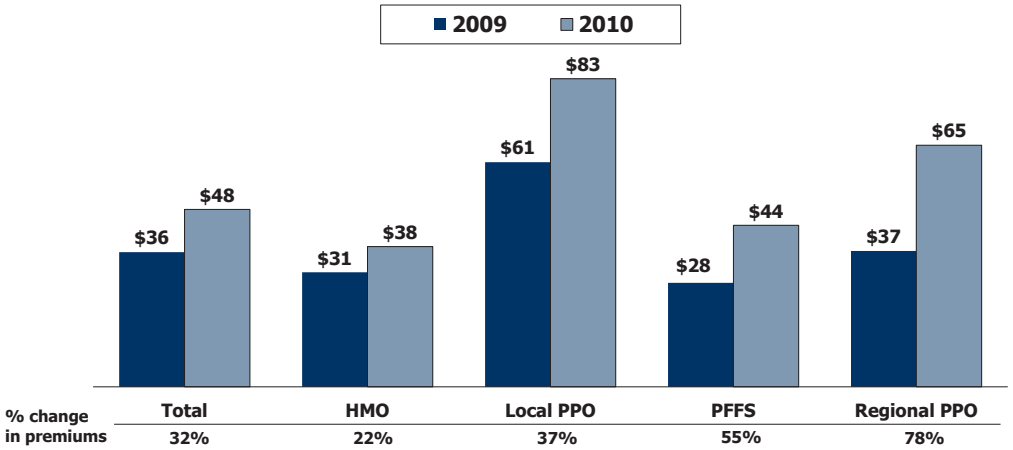


NOTES: Rebates are the extra payments Medicare pays plans with bids below the county benchmark. Dollars weighted by projected enrollment in 2010. Part B-only plans excluded.
SOURCE: Medicare Payment Advisory Commission analysis of Medicare Advantage plan bids for 2010.

In addition to Medicare-covered benefits, many Medicare Advantage plans provide supplemental benefits to enrollees. Plans with bids below the county benchmark (which is the maximum amount Medicare will pay plans) receive additional payments from Medicare (called "rebates") to fund these benefits. In 2010, more than half (54 percent) of these rebate dollars were used by plans to lower cost sharing, 21 percent was used for added benefits, such as vision exams, hearing tests, or preventive dental exams, and the remainder was used to provide enhanced Part B benefits or reduce Part B and Part D premiums.

Figure 4.7

Weighted Average Monthly Premium for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2009-2010

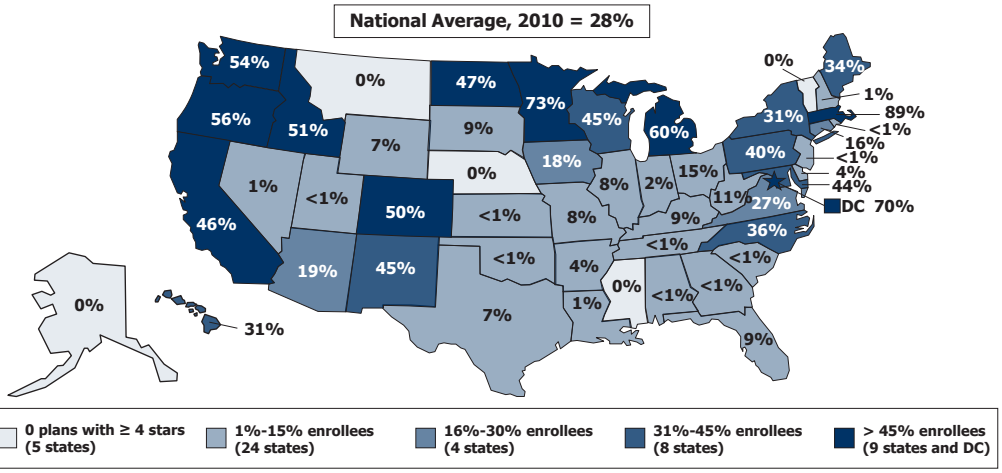


NOTES: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, plans for special populations (e.g. Mennonites) and plans that do not offer Part D benefits. The total includes cost plans, which are not shown separately. Weighted average monthly premiums are based on MA-PDs available in 2009 and 2010, weighted for the respective year of enrollment.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Landscape Files for 2009 and 2010 and CMS 2010 Part C and D Crosswalk file.

Between 2009 and 2010, the average enrollment-weighted premium for Medicare Advantage Prescription Drug (MA-PD) plans increased 32 percent, from $36 per month to $48 per month. The average increase was lower for HMOs (22 percent) than for local PPOs (37 percent) and for regional PPOs (78 percent). Almost half of all Medicare Advantage drug plan enrollees in 2010 (46 percent) are in plans that charge no additional premium for coverage. Typically, Medicare Advantage enrollees pay the monthly Part B premium, which is $110.50 in 2010.

Figure 4.8

Percent of Medicare Advantage Enrollees in Plans that Received Four or More Stars in 2010, by State



NOTES: The term "plan" is used in this analysis to mean the Medicare contracting entity because plan ratings are aggregated at the contract level. All states had at least 1 plan that received star ratings.
SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings.

Medicare rates the quality of Medicare Advantage plans on a scale of one star to five stars, with five stars representing the highest quality. Enrollment in highly-rated Medicare Advantage plans varies by state. In 2010, 28 percent of beneficiaries in Medicare Advantage plans nationwide are enrolled in plans that received four or more stars, ranging from none of the Medicare Advantage enrollees in five states (where there were no plans receiving four or more stars) to 89 percent of Medicare Advantage enrollees in Massachusetts.

SECTION FIVE:
THE ROLE OF MEDICAID FOR MEDICARE BENEFICIARIES

THE ROLE OF MEDICAID FOR MEDICARE BENEFICIARIES

Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is a source of supplemental coverage for roughly one in five Medicare beneficiaries. These beneficiaries are known as dual eligibles because they are eligible for both Medicare and Medicaid.

Medicaid helps to make Medicare affordable for beneficiaries with low incomes and modest assets, by paying premiums and filling in Medicare's cost-sharing requirements and by paying for benefits that are not covered under traditional Medicare. Eligibility for Medicaid assistance is based on a beneficiary's income and assets, with some variation across states.

Most dual eligibles qualify for full Medicaid benefits, including long-term care and dental services, which Medicare does not cover. Prior to 2006, Medicaid provided prescription drug coverage to full-benefit dual eligibles. When the Medicare Part D drug benefit took effect in 2006, dual eligibles were shifted to Medicare Part D plans, and became automatically eligible for premium and cost-sharing assistance through the Medicare Part D Low-Income Subsidy (LIS) program. Some dual eligibles do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements through the Medicare Savings Programs (MSP) administered under Medicaid.

Dual eligibles have a different demographic profile than other Medicare beneficiaries, with a larger share being female, nonelderly disabled, and black or Hispanic. Compared to other people with Medicare, a higher share of dual eligible beneficiaries have a cognitive or mental impairment (61 percent versus 27 percent), are in fair or poor health (51 percent versus 23 percent), are under age 65 and permanently disabled (38 percent versus 10 percent), and live in long-term care facilities (16 percent versus 2 percent). Dual eligibles represent a varying share of state Medicare populations, ranging from a low of 8 percent of beneficiaries in North Dakota to a high of 31 percent of beneficiaries in Maine.

While dual eligibles are a relatively 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 care than their non-dual eligible counterparts. Medicare spending on dual eligibles was 36 percent of total Medicare spending in 2006, while Medicaid spending on dual eligibles was 40 percent of total Medicaid spending in 2007. More than one-third (35 percent) of Medicare spending on dual eligibles was for inpatient hospital services, while 70 percent of Medicaid spending on dual eligibles was for long-term care services.

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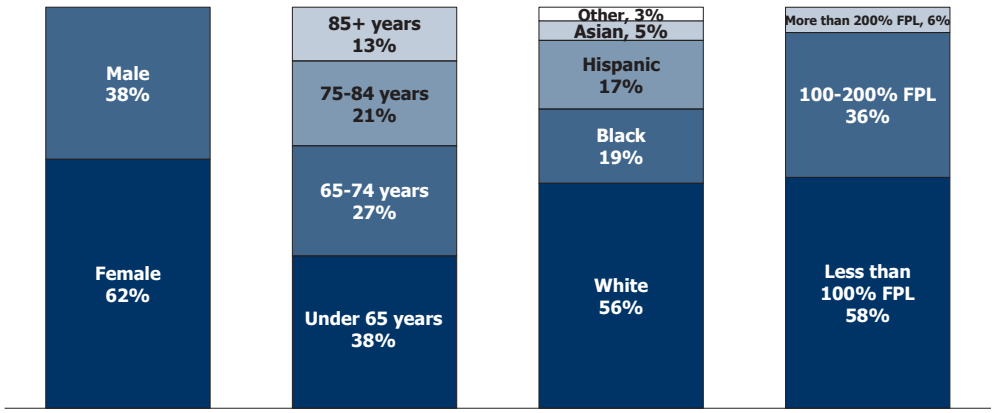
Figure 5.1
Medicaid and Medicare Savings Programs Eligibility Pathways and Benefits for Medicare Beneficiaries, 2010

Pathway to Eligibility	Income Eligibility Level[1] (individual/couple)	Asset Limit[2] (individual/couple)	Covered Costs and Benefits[3]
Full Medicaid	<74% of poverty (SSI income eligibility; varies by state)	$2,000/$3,000 (varies by state)	Medicaid benefits, Medicare Part A and Part B premiums and cost sharing
Qualified Medicare Beneficiary (QMB)	<100% of poverty ($10,830/$14,570)	$8,100/$12,910	Medicare Part A and Part B premiums and cost sharing
Specified Low-Income Medicare Beneficiary (SLMB)	100%-120% of poverty ($12,996/$17,484)	$8,100/$12,910	Medicare Part B premiums
Qualified Individual (QI)	120%-135% of poverty ($14,621/$19,670)	$8,100/$12,910	Medicare Part B premiums
Qualified Disabled and Working Individual (QDWI)	<200% of poverty ($21,660/$29,140)	$5,500/$9,000	Medicare Part A premiums
Optional Coverage			
Medically Needy[4]	Must spend income down to a specified level to qualify	$2,000/$3,000	Medicaid benefits, Medicare Part A and Part B premiums and cost sharing
Poverty Level	≤100% of poverty		
Special Income Rule for Nursing Home Residents	Institutionalized individuals with income <300% of the SSI level		
HCBS Waiver	Must be eligible for institutional care		

NOTES: SSI is Supplemental Security Income. HCBS is home and community based services. [1]Applicants are allowed a $20 disregard from any income before their income is measured against the poverty levels. [2]States have flexibility to modify asset limits; some have no asset limits. Asset limits for QMB, SLMB, QI, and QDWI include $1,500 per person for burial expenses. [3]Cost sharing is covered up to the amount Medicaid pays, at states' discretion. [4]Medicaid benefits may be more limited than for SSI eligibility.

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 long-term care and dental services. Those with incomes or resources just above the federal poverty level receive more limited assistance from Medicaid, primarily coverage of Medicare Part B premiums.

Figure 5.2
Demographic Characteristics of Dual Eligibles, 2006



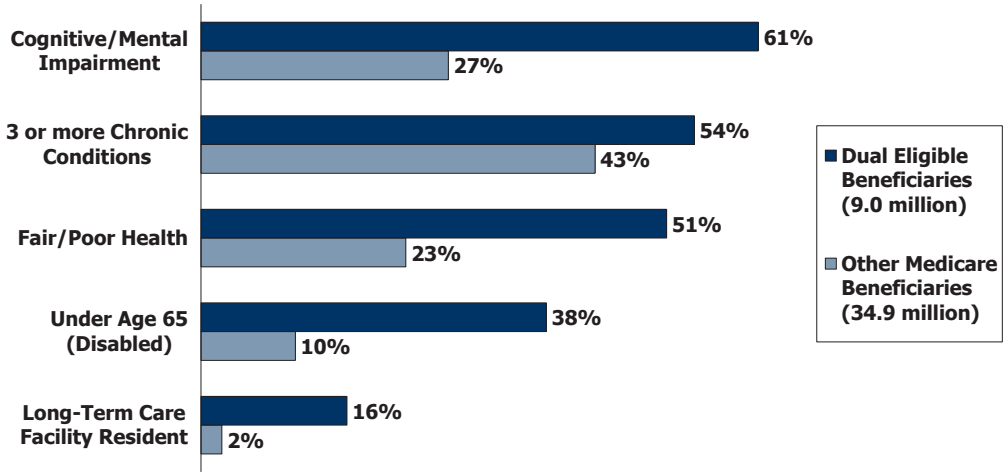
Total Dual Eligible Beneficiaries, 2006 = 9.0 Million

NOTES: 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). In 2006, the federal poverty level was $9,800/individual and $13,200/couple. Numbers may not sum to total due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Dual eligibles have a different demographic profile than other Medicare beneficiaries. Nearly two-thirds (62 percent) of dual eligibles are female, and roughly four in ten are under 65 years of age with permanent disabilities. A larger share of dual eligibles than other Medicare beneficiaries are of racial/ethnic minority groups—19 percent are black and 17 percent are Hispanic. In keeping with the income eligibility criteria, dual eligibles are predominantly low income, with 94 percent having incomes less than 200 percent of the federal poverty level.

Figure 5.3

Comparison of Dual Eligibles and Other Medicare Beneficiaries, 2006

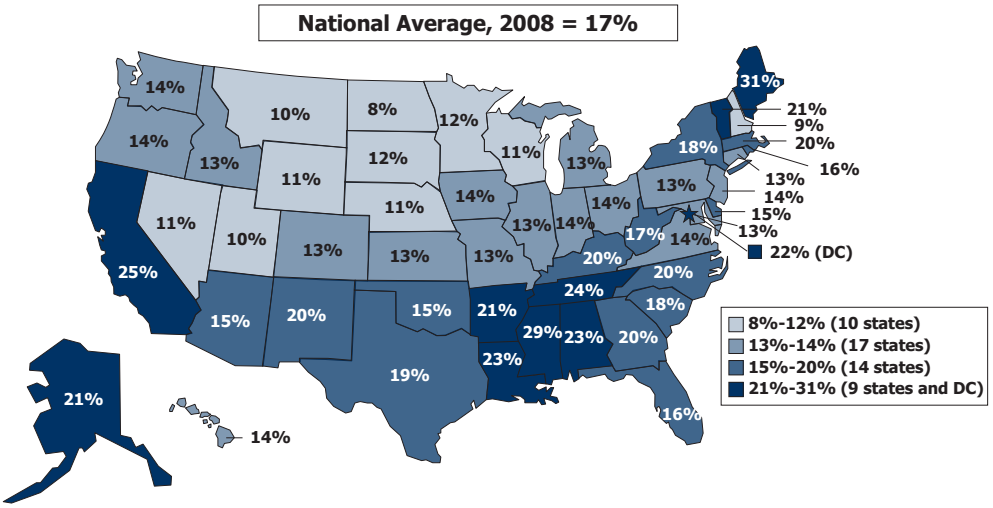


NOTES: Total number of dual eligibles includes beneficiaries eligible for full Medicaid benefits, along with other low-income beneficiaries eligible for assistance with Medicare premiums and cost-sharing requirements (the Medicare Savings Programs).
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Compared to other people with Medicare, dual eligible beneficiaries are generally in poorer health and have higher rates of certain chronic conditions. More than half (54 percent) of dual eligible beneficiaries have three or more chronic conditions, compared to 43 percent of other Medicare beneficiaries. A larger share of beneficiaries with both Medicare and Medicaid are in fair or poor health (51 percent versus 23 percent), are under age 65 and permanently disabled (38 percent versus 10 percent), and live in long-term care facilities (16 percent versus 2 percent).

Figure 5.4

Dual Eligibles as a Percent of State Medicare Populations, 2008

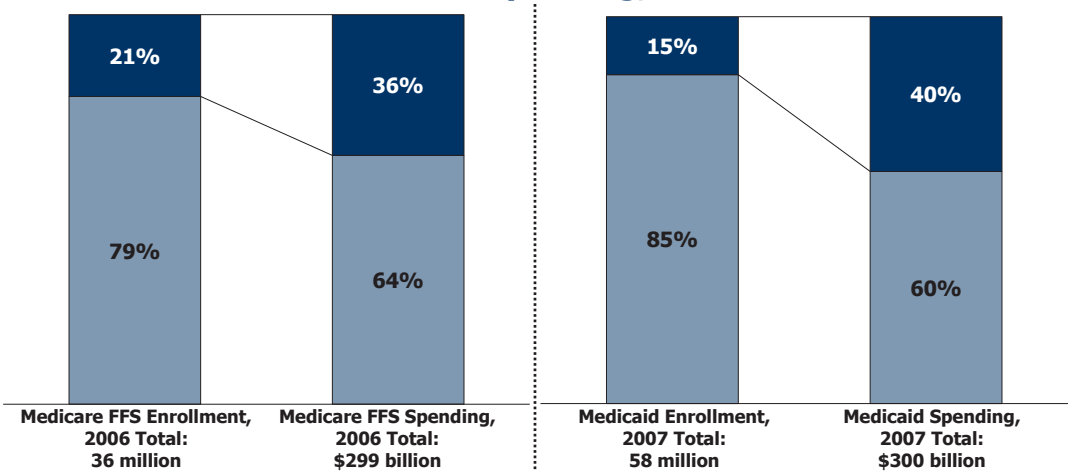


SOURCE: Centers for Medicare & Medicaid Services, Medicare Enrollment: Hospital Insurance and/or Supplemental Medical Insurance Enrollees by Area of Residence, Buy-in Status, and Residence, as of July 1, 2008.

Nationwide, 17 percent of Medicare beneficiaries are dual eligibles. As a share of state Medicare populations in 2008, dual eligibles range from less than 13 percent of beneficiaries in 10 states to 21 percent or more of beneficiaries in 9 states and the District of Columbia.

Figure 5.5

Dual Eligibles as a Percent of Medicare and Medicaid Enrollment and Spending, 2006/2007

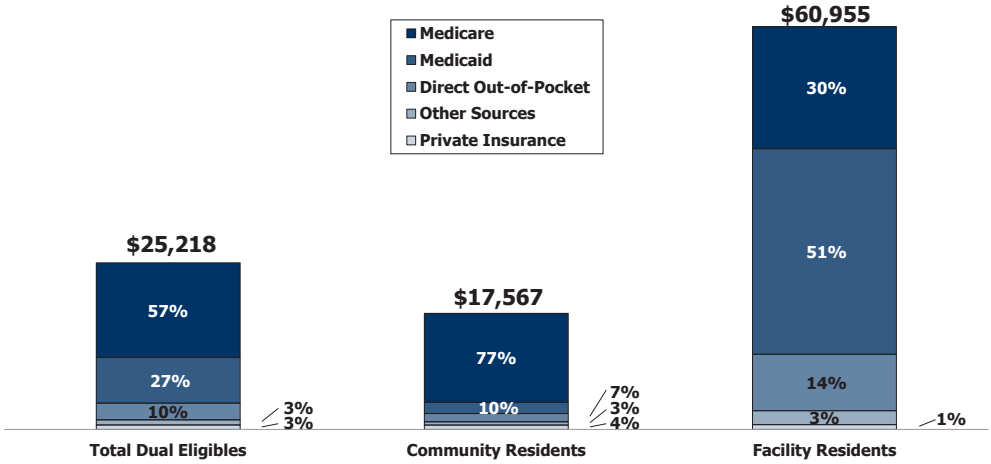


NOTES: FFS is fee-for-service. Estimates for Medicare include non-institutionalized and institutionalized beneficiaries, excluding Medicare Advantage enrollees.
SOURCE: Medicare spending and enrollment estimates from Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006; Medicaid spending and enrollment estimates from Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Dual eligibles comprise a relatively small share of the Medicare and Medicaid populations, but account for a disproportionate share of spending by both programs. Dual eligibles were 21 percent of the Medicare fee-for-service population in 2006, and accounted for 36 percent of total Medicare spending. In 2007, 15 percent of the 58 million people with Medicaid coverage were dual eligibles, accounting for 40 percent of total Medicaid benefit spending.

Figure 5.6

Average Total Per Capita Medical and Long-Term Care Spending for Dual Eligibles, by Source of Payment, 2006

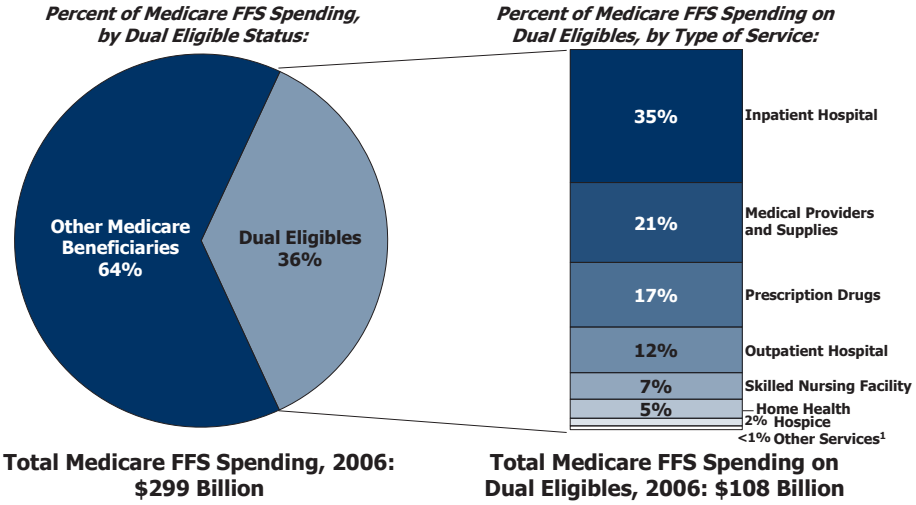


NOTES: Figure shows average total spending for non-institutionalized and institutionalized beneficiaries in fee-for-service Medicare only (excluding Medicare Advantage enrollees). Total excludes out-of-pocket spending on premiums for Medicare Parts A, B, and C and private health insurance. Numbers may not sum to 100 percent due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

In 2006, total average per capita medical and long-term care spending for dual eligibles was $25,218, with substantially higher total average per capita spending among dual eligibles living in long-term care facilities than among those living in the community. Medicare paid more than half (57 percent) of total spending for all dual eligibles, while Medicaid paid 27 percent. Medicaid paid a larger share of total spending for dual eligibles who are facility residents than those in the community, because Medicare does not pay for long-term care facility stays. Nonetheless, Medicare paid 30 percent of total spending—roughly $19,000—for dual eligibles living in long-term care facilities in 2006.

Figure 5.7

Medicare Expenditures for Dual Eligibles, 2006

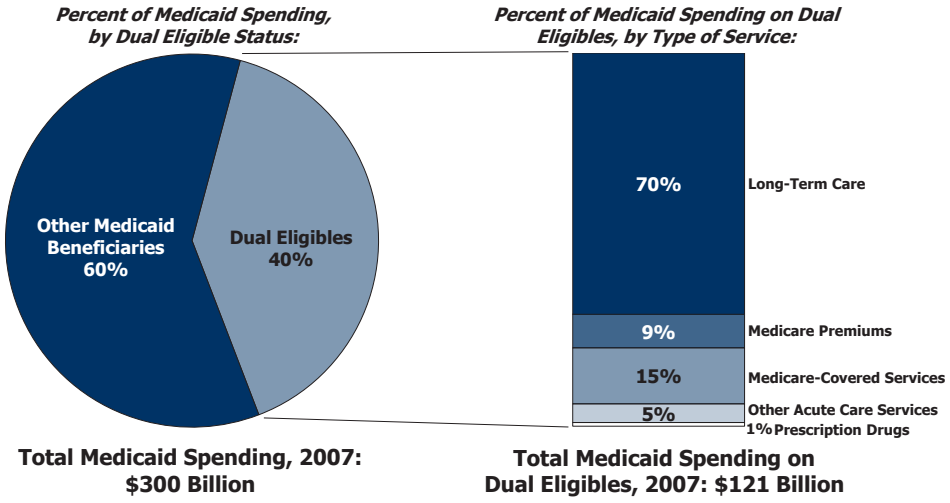


NOTES: FFS is fee-for-service. Figure shows average total spending for non-institutionalized and institutionalized beneficiaries, excluding Medicare Advantage enrollees. [1]Other services include dental and long-term care facility stays.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Medicare spending for dual eligibles in the traditional fee-for-service Medicare program totaled $108 billion in 2006. The largest component of Medicare expenditures for dual eligibles was for inpatient hospital events and services (35 percent), followed by medical provider services and supplies (21 percent), prescription drugs (17 percent), outpatient hospital services (12 percent), and short-term skilled nursing facility stays (7 percent).

Figure 5.8

Medicaid Expenditures for Dual Eligibles, 2007



SOURCE: Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Medicaid spending for dual eligibles totaled $121 billion in 2007. The majority of Medicaid expenditures for dual eligibles was for long-term care services (70 percent). A substantially smaller share was for payment of Medicare premiums for dual eligibles (9 percent), acute care services (5 percent), and prescription drugs (1 percent) (formerly covered by Medicaid for dual eligibles, but now covered under Medicare Part D).

SECTION SIX:
SUPPLEMENTAL INSURANCE COVERAGE

SUPPLEMENTAL INSURANCE COVERAGE

Most Medicare beneficiaries (90 percent) have some form of supplemental insurance that helps cover Medicare's relatively high cost-sharing expenses and often provides benefits currently not covered by Medicare. As of 2008, employer-sponsored coverage was the primary source of supplemental insurance, followed by Medicare Advantage, Medigap policies, and Medicaid. Medicaid is the federal-state program that provides health and long-term care coverage to low-income Americans, including an estimated 9 million Medicare beneficiaries with low incomes and modest assets *(See Section 5, "The Role of Medicaid for Medicare Beneficiaries.")*

Sources of supplemental coverage vary by demographic factors such as income, health status, age, race/ethnicity, and area of residence. For example, in 2008, when one-third of all Medicare beneficiaries had an employer-sponsored supplemental policy, only 7 percent of beneficiaries with incomes of $10,000 or less had supplemental coverage from an employer compared to more than half of those with incomes above $40,000. Conversely, Medicaid provided coverage to more than half (53 percent) of those with incomes below $10,000. Medicaid was also a critical source of supplemental coverage for more than one-third of the nonelderly disabled (39 percent), one-third of those in poor self-reported health (33 percent), and relatively large percentages of black and Hispanic beneficiaries (30 percent and 22 percent, respectively). Because Medicaid, unlike Medicare, pays for long-term care in nursing homes and other facilities, a large share of Medicare beneficiaries living in long-term care facilities relied on Medicaid to supplement Medicare (61 percent).

Overall, 10 percent of Medicare beneficiaries lacked supplemental coverage from any source—with higher rates reported among the nonelderly disabled (20 percent), the near-poor with incomes between $10,000 and $20,000 (15 percent), and among beneficiaries in poor self-reported health (15 percent). A larger share of Medicare beneficiaries without supplemental coverage than beneficiaries with any type of supplemental coverage report delays in seeking medical care because of cost concerns.

In recent years, employer-sponsored retiree health coverage has eroded as health care costs have risen. Since the late 1980s, the share of large employers offering retiree health benefits has declined from 66 percent in 1988 to 28 percent in 2010. At the same time, the share of Medicare beneficiaries enrolled in an HMO or other Medicare Advantage plan increased in recent years, from 14 percent in 2005 to 24 percent in 2010. *(See Section 4, "Medicare Advantage.")*

Medicare beneficiaries can purchase a Medigap policy to supplement Medicare's traditional fee-for-service benefits. Medigap policies—also called Medicare Supplement Insurance—are sold by private insurance companies and help cover Medicare's cost-sharing requirements and fill gaps in the benefit package. About one-sixth of all Medicare beneficiaries had an individually purchased Medigap policy in 2008.

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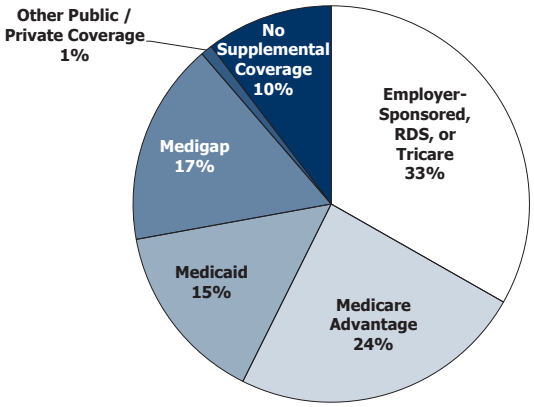
Figure 6.1

Sources of Supplemental Coverage Among Medicare Beneficiaries, 2008



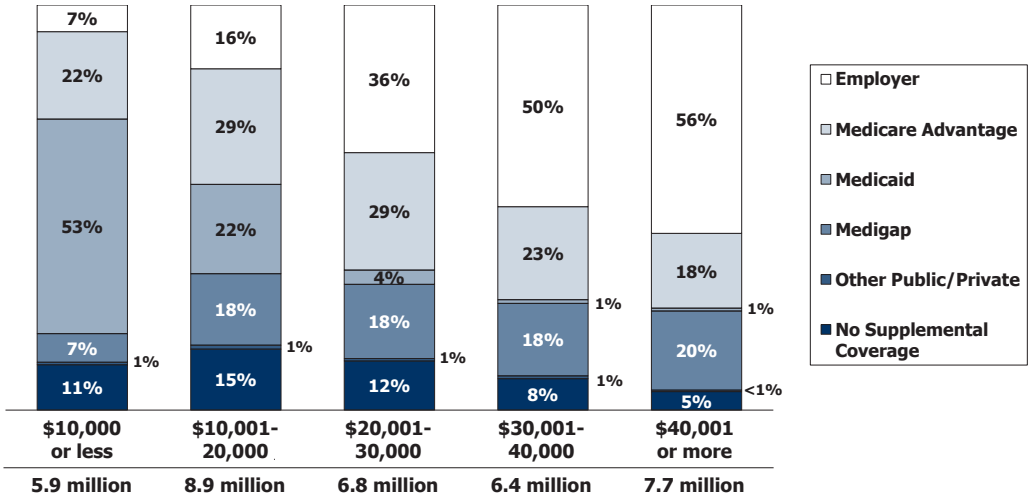
Total Medicare Beneficiaries, 2008 = 41.8 Million

NOTES: 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. RDS is retiree drug subsidy.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Most Medicare beneficiaries (90 percent) have supplemental health insurance coverage that helps pay Medicare's cost-sharing requirements and often provides services not covered by Medicare. This coverage comes from a range of sources, including employer-sponsored insurance (covering 33 percent of all beneficiaries), Medicare Advantage plans (24 percent), Medicaid (15 percent), and Medigap supplement policies (17 percent). Some beneficiaries have multiple sources of coverage, such as Medicare Advantage and Medicaid, which is not reflected in the distribution shown above.

Figure 6.2

Supplemental Coverage Among Medicare Beneficiaries, by Income, 2008

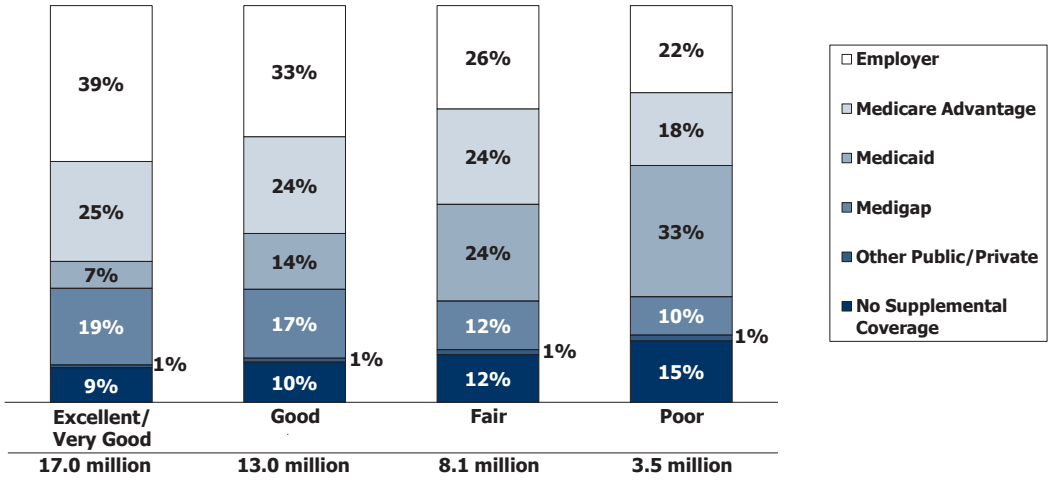


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Sources of supplemental coverage vary significantly by beneficiaries' income, with a larger share of the near poor (with incomes between $10,001 and $20,000) (15 percent) having no insurance to supplement Medicare. Medicaid provides supplemental coverage for half (53 percent) of Medicare beneficiaries with the lowest incomes ($10,000 or less), while employer-sponsored coverage is the primary source of supplemental coverage for beneficiaries with the highest incomes (more than $40,000), covering 56 percent of this group, but just 7 percent of those with incomes of $10,000 or less.

Figure 6.3

Supplemental Coverage Among Medicare Beneficiaries, by Health Status, 2008

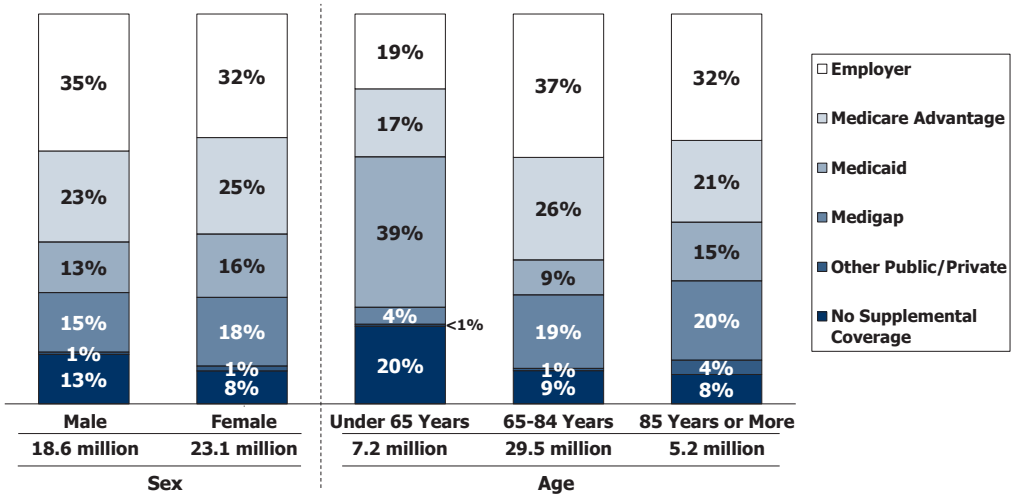


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Medicaid plays a key role in supplementing Medicare for those in fair or poor health, covering 24 percent of all Medicare beneficiaries in fair health and 33 percent of beneficiaries in poor health. Employer-sponsored coverage is the primary source of supplemental coverage for beneficiaries in excellent or very good health (39 percent) and good health (33 percent). Medicare Advantage plans cover about one quarter of all beneficiaries, but a smaller share (18 percent) of those in poor health.

Figure 6.4

Supplemental Coverage Among Medicare Beneficiaries, by Sex and Age, 2008

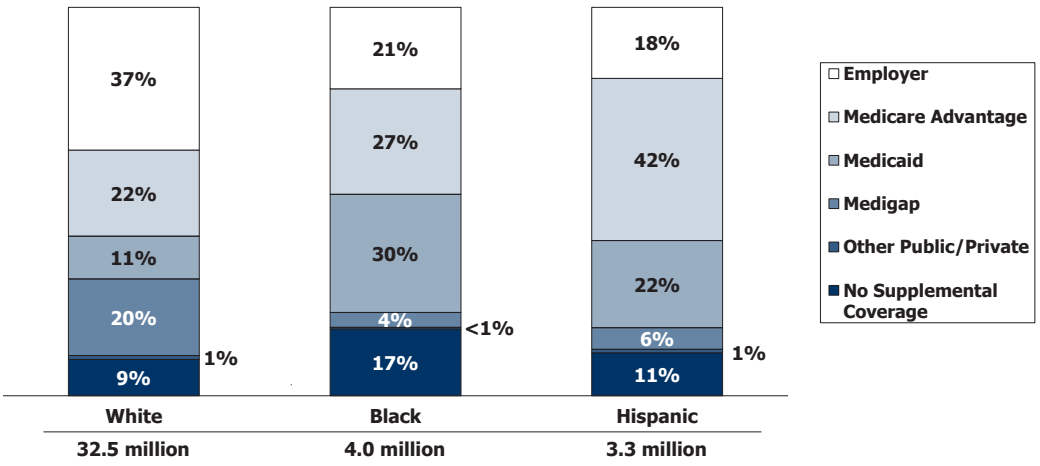


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

One in five (20 percent) nonelderly Medicare beneficiaries with permanent disabilities lacked supplemental coverage from any source in 2008, more than twice the share of those age 65 and older. Nearly four in ten (39 percent) of those under age 65 relied on Medicaid to supplement Medicare. Employer plans were the leading source of supplemental coverage among beneficiaries age 65 and older, covering 37 percent of those ages 65 to 84, and 32 percent of those age 85 and older. Sources of supplemental coverage varied less by sex, with a larger share of male than female beneficiaries having no supplemental coverage (13 percent versus 8 percent, respectively).

Figure 6.5

Supplemental Coverage Among Medicare Beneficiaries, by Race/Ethnicity, 2008

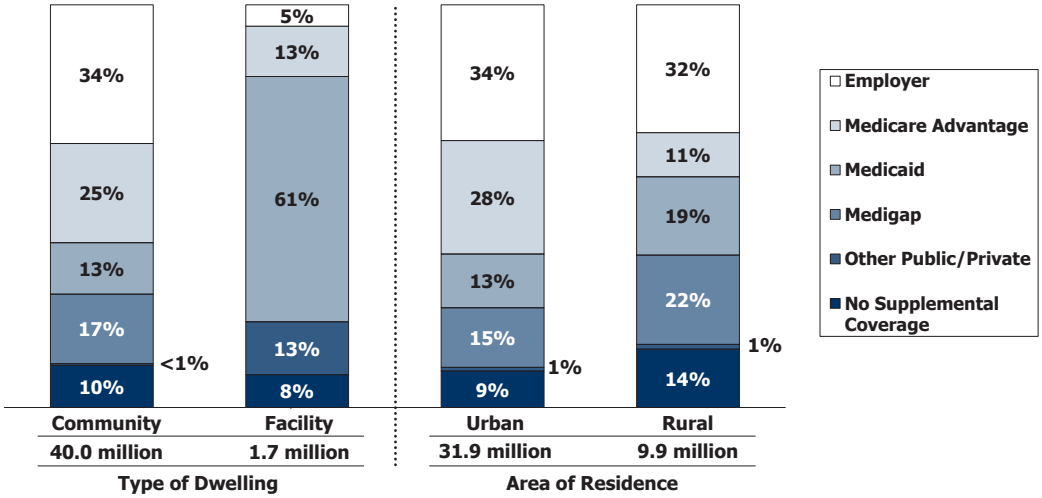


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Nearly three in ten black beneficiaries (30 percent) and more than one in five Hispanic beneficiaries (22 percent) relied on Medicaid to supplement Medicare in 2008, compared to 11 percent of white beneficiaries. A smaller share of black and Hispanic beneficiaries than white beneficiaries had employer-sponsored supplemental coverage. Seventeen percent of black beneficiaries lacked supplemental coverage in 2008, almost twice the share of white beneficiaries (9 percent).

Figure 6.6

Supplemental Coverage Among Medicare Beneficiaries, by Type of Dwelling and Area of Residence, 2008

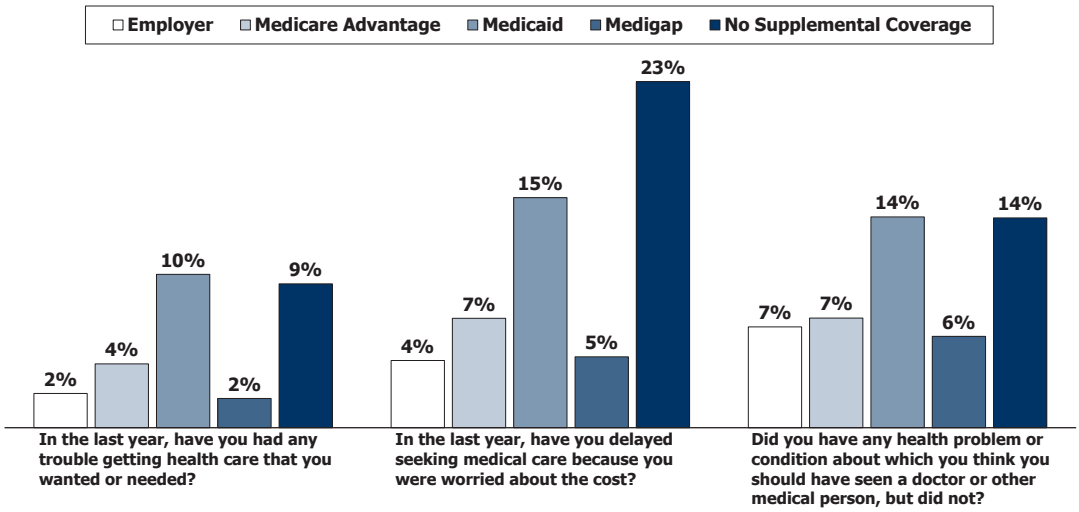


NOTE: Urban counties are defined as those in a metropolitan statistical area (MSA); all other counties are classified as rural.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Because Medicare does not pay for long-term care in nursing homes and other institutions and because Medicaid covers long-term care for those who qualify for the program, a large share of Medicare beneficiaries living in institutions (61 percent) relied on Medicaid to help cover these expenses in 2008. Among all beneficiaries, a larger share of those living in rural areas than urban areas had no supplemental coverage from any source in 2008 (14 percent versus 9 percent). A larger share of beneficiaries in rural areas than urban areas were covered by Medicaid or Medigap policies, while a smaller share were enrolled in Medicare Advantage plans in 2008 (11 percent versus 28 percent).

Figure 6.7

Measures of Access to Care Among Medicare Beneficiaries, by Source of Supplemental Coverage, 2008

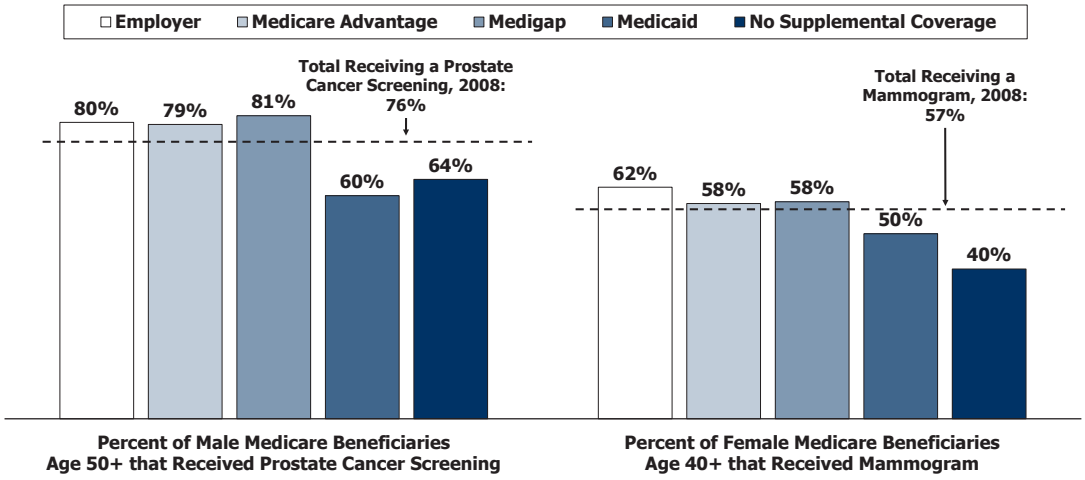


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

While Medicare beneficiaries overall enjoy relatively good access to medical care, the share of beneficiaries experiencing certain access-related problems varies by source of supplemental coverage. In 2008, for example, among those with supplemental coverage, a larger share of beneficiaries with Medicaid than with other sources of supplemental coverage reported trouble getting care they wanted or needed or delaying seeking medical care because of cost concerns. However, a larger share of beneficiaries with no supplemental coverage than beneficiaries with any type of supplemental coverage reported delaying seeking medical care because of cost concerns.

Figure 6.8

Percent of Medicare Beneficiaries Receiving Selected Preventive Services, by Source of Supplemental Coverage, 2008

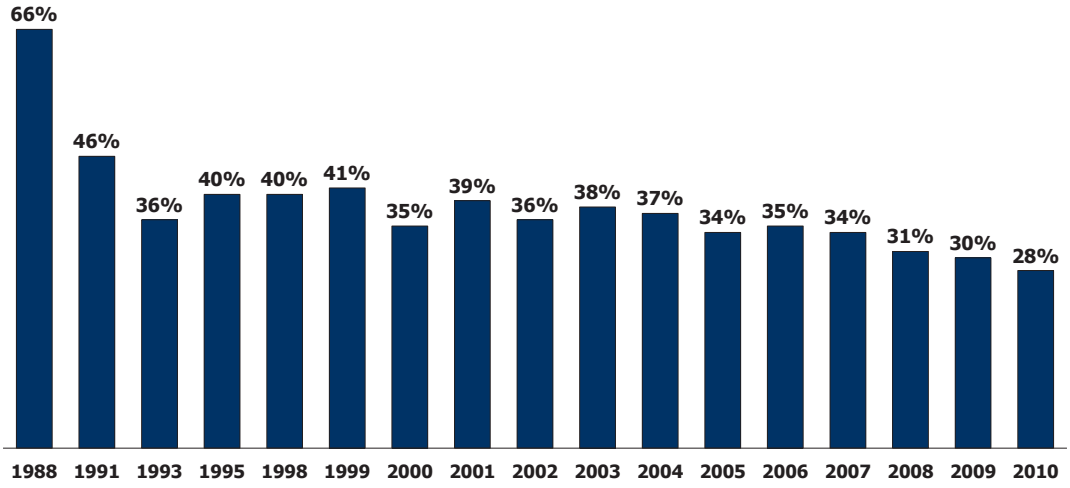


NOTES: Analysis includes community residents only.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

In 2008, three quarters (76 percent) of male beneficiaries age 50 and over received a prostate cancer screening, and 57 percent of female beneficiaries age 40 and over received a mammogram, but the rate of receipt of screening varied depending on whether a beneficiary had any source of supplemental coverage, and if so, the type of coverage they had. A smaller share of beneficiaries with Medicaid or with no source of supplemental coverage than those with supplemental coverage through employer-sponsored plans, Medicare Advantage plans, or Medigap policies received a prostate cancer screening (among males age 50 and over) or a mammogram (among females age 40 and over).

Figure 6.9

Percent of Large Employers Offering Retiree Health Benefits, 1988-2010

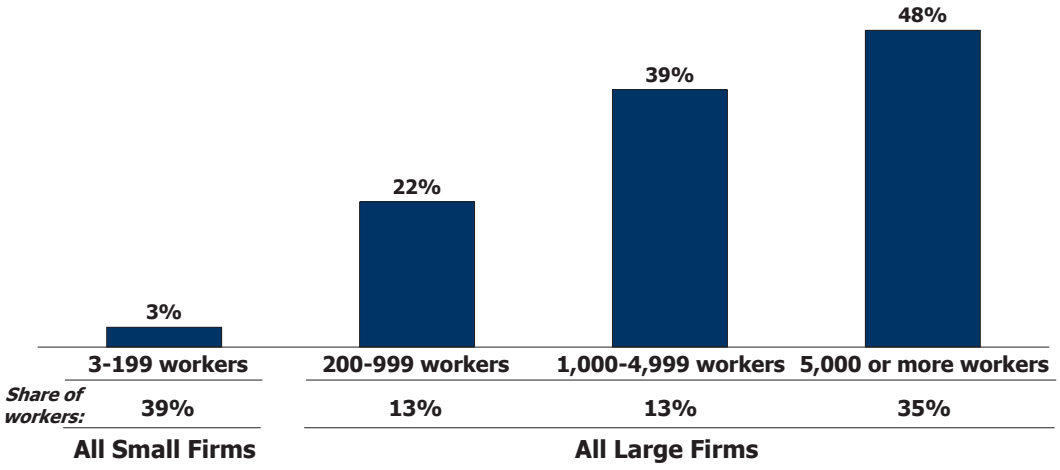


NOTES: Large firms include firms with 200 or more workers. Data not available for all years between 1988 and 1998 because the survey was not conducted each year during that period.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

The share of large employers providing health coverage to their retirees has declined from 66 percent in 1988 to 28 percent in 2010, a trend which is expected to reduce the number of retired Medicare beneficiaries with such coverage in the future.

Figure 6.10

Percent of Employers Offering Retiree Health Benefits, by Firm Size, 2010



NOTES: Percentages are based on firms offering health benefits to active workers.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

The share of employers that offer retiree health benefits varies substantially by firm size. Twenty-two percent of firms with at least 200 employees and fewer than 1000 employees offer retiree health benefits, compared to just 3 percent of small firms (with fewer than 200 employees).

Figure 6.11

Standard Medigap Plan Benefits, 2010

as of June 1, 2010

BENEFITS	MEDIGAP POLICY									
	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance and all costs after hospital benefits are exhausted	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment for other than preventive services	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓*
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance or Copayment				✓		✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)*			✓	✓	✓	✓			✓	✓
At-Home Recovery (Up to Plan Limits)				✓		✓				
Medicare Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Preventive Care not Covered by Medicare (up to $120)										
Out-of-Pocket Limit							$4,620	$2,310		

NOTES: Check marks indicate 100 percent benefit coverage. Amount in table is the plan's coinsurance amount for each covered benefit after beneficiary pays deductibles or cost-sharing amounts, where applicable. *Plan N pays 100% of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits.
SOURCE: Centers for Medicare & Medicaid Services, 2010 Guide to Health Insurance, March 2010.

In 2008, about one in five beneficiaries reported having an individually-purchased private health insurance policy to supplement Medicare, known as Medigap. Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. In general, Medigap policies must conform to one of ten standard benefit packages, each offering coverage of a different set of benefits; these standard plans are not sold in Massachusetts, Minnesota, or Wisconsin. Monthly premiums vary by plan type, insurer, age of the policyholder, and state of residence.

SECTION SEVEN: OUT-OF-POCKET SPENDING

OUT-OF-POCKET SPENDING

Despite the financial protection 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 spending out-of-pocket. In 2006, Medicare covered less than half (48 percent, or $8,344) of beneficiaries' total per capita medical and long-term care expenses ($17,231, on average). Beneficiaries paid, on average, 25 percent of total expenses out-of-pocket.

Of the $191 billion spent by all beneficiaries out of their own pockets for medical and long-term care in 2006, nearly 40 percent was for Medicare and other premiums, such as premiums for Medicare supplemental insurance policies or employer-sponsored retiree health plans. Another 25 percent of out-of-pocket spending was for benefits and services for which Medicare provides minimal or no coverage, including long-term care (19 percent) and dental services (6 percent). In 2006, the first year of the Medicare Part D drug benefit, beneficiaries' out-of-pocket spending for prescription drugs was 14 percent of their total out-of-pocket spending.

Average out-of-pocket spending by beneficiaries on health care services increases with age and varies by health status. In 2006, beneficiaries between the ages of 65 to 74 spent $3,500 on average, while those ages 85 and older spent more than twice as much ($7,487). As might be expected, as health status declines, out-of-pocket spending rises; beneficiaries in poor health spent almost $1,000 more out-of-pocket on health care services in 2006 than did those in good health, and over twice as much as those in excellent or very good health.

Out-of-pocket spending among Medicare beneficiaries also varies by source of supplemental coverage, reflecting differences in the scope of covered services and variations in the health care needs of those with different sources of coverage. Beneficiaries with individually-purchased Medigap policies and employer-sponsored coverage paid more, on average, than did beneficiaries in Medicare Advantage plans. Dual eligibles, those with both Medicare and Medicaid, incurred relatively high average out-of-pocket spending on health and long-term care services in 2006, but this group includes those who "spent down" their resources prior to qualifying for Medicaid at some point during the year in order to pay for their medical expenses.

With health costs rising faster than income for Medicare beneficiaries, median out-of-pocket health spending as a share of beneficiaries' income increased from 11.9 percent in 1997 to 16.2 percent in 2006. Some subgroups of beneficiaries bear a larger burden than others, however, including beneficiaries age 85 and older and those in poor health. Out-of-pocket spending on Medicare premiums and cost-sharing for physician and other services under Part B and prescription drugs under Part D has been rising and is expected to consume more than one-fourth of the average Social Security benefit payment in 2010 (27 percent) and more than one-third by 2030 (36 percent), according to the Social Security and Medicare Boards of Trustees.

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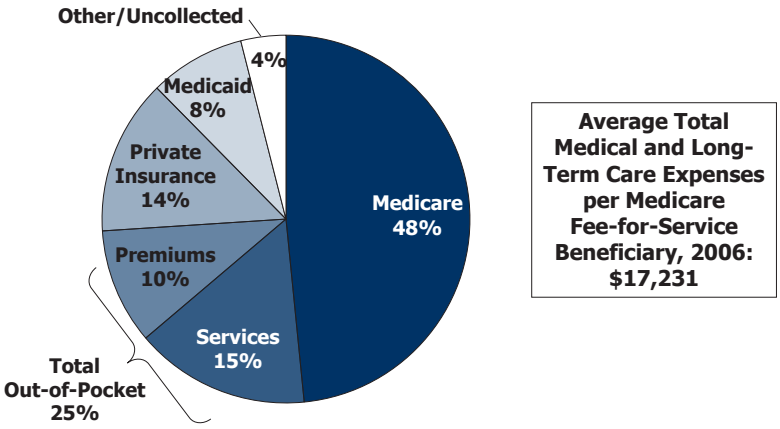
Figure 7.1

Sources of Payment for Medicare Fee-for-Service Beneficiaries' Health Care Spending, 2006

Includes Medical, Long-Term Care, and Premium Expenses

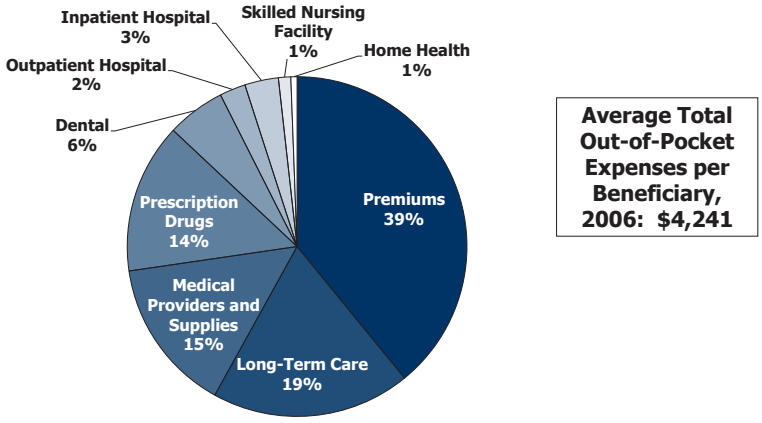


NOTES: Excludes Medicare Advantage enrollees. Includes institutionalized and non-institutionalized beneficiaries. Numbers may not sum to 100 percent due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Each year, a majority of beneficiaries use Medicare to help pay for their hospital, physician, and other medical care. In 2006, Medicare paid less than half (48 percent) of the $17,231 in total medical and premium expenses per beneficiary, while beneficiaries themselves paid 25 percent out-of-pocket, including 10 percent for premiums and 15 percent for medical and long-term care services.

Figure 7.2

Distribution of Out-of-Pocket Spending by Medicare Beneficiaries, by Type of Service, 2006



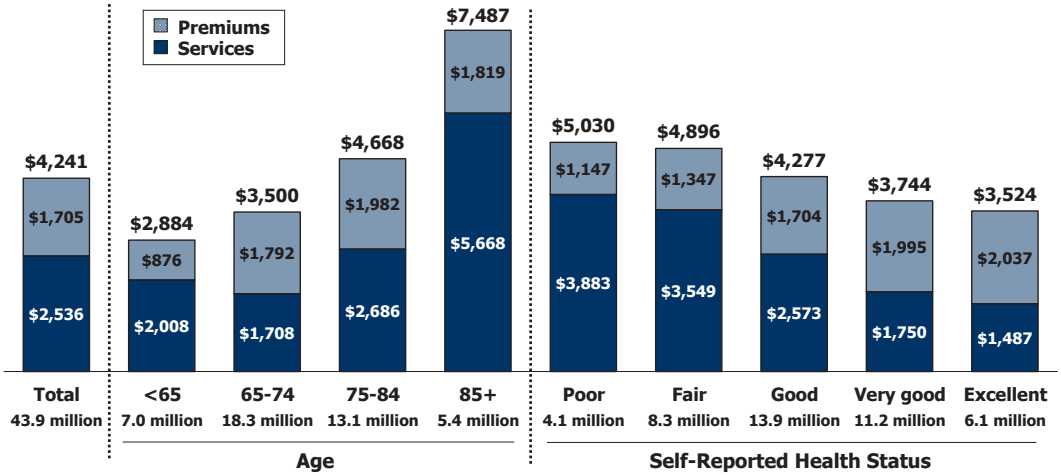
Total Out-of-Pocket Spending for Medicare Beneficiaries, 2006 = $191 Billion

NOTES: Includes Medicare Advantage enrollees, and institutionalized and non-institutionalized beneficiaries. Premium spending includes Medicare Part A, B, C, and D and private health insurance premiums.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

In 2006, Medicare beneficiaries in total spent $191 billion out-of-pocket for their medical, long-term care, and premium expenses. Average out-of-pocket expenses per beneficiary totaled $4,241. Thirty-nine percent of beneficiaries' out-of-pocket spending was for premiums, and another 25 percent was for benefits and services for which Medicare provided only partial or no coverage, including long-term care (19 percent) and dental services (6 percent). Medicare began providing coverage for prescription drugs in 2006, accounting for 14 percent of out-of-pocket spending, only slightly less than the 15 percent of total out-of-pocket spending accounted for by prescription drugs in 2005.

Figure 7.3

Average Per Capita Out-of-Pocket Spending by Medicare Beneficiaries, by Age and Health Status, 2006

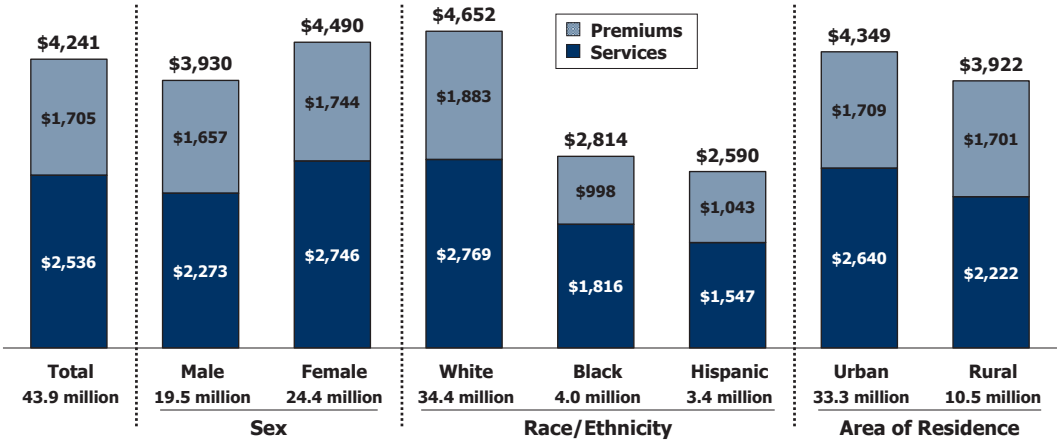


NOTES: Includes Medicare Advantage enrollees, and institutionalized and non-institutionalized beneficiaries. Numbers may not sum to total due to rounding. Premium spending includes Medicare Part A, B, C, and D and private health insurance premiums.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Out-of-pocket spending on health care increases with advancing age and declining health status. In 2006, beneficiaries age 75 or older had higher out-of-pocket spending than elderly beneficiaries ages 65 to 74 and the nonelderly disabled, reflecting the greater health and long-term care needs of Medicare's oldest beneficiaries. Beneficiaries in poor health spent over $1,000 more out-of-pocket on health care services in 2006 than did those in good health, and over twice as much as those in excellent or very good health.

Figure 7.4

Average Per Capita Out-of-Pocket Spending by Medicare Beneficiaries, by Sex, Race/Ethnicity, and Area of Residence, 2006

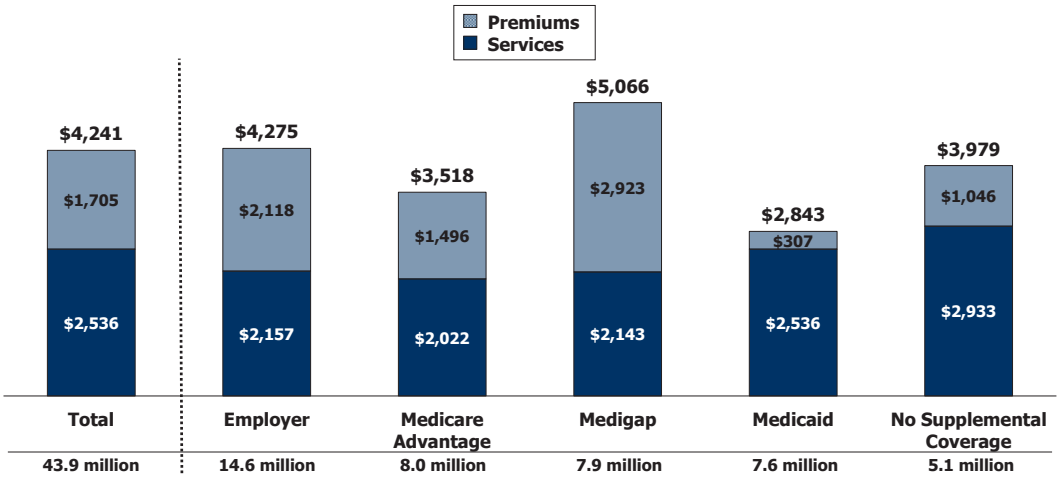


NOTES: Includes Medicare Advantage enrollees, and institutionalized and non-institutionalized beneficiaries. Urban counties are defined as those in a metropolitan statistical area (MSA); all other counties are classified as rural. Numbers may not sum to total due to rounding. Premium spending includes Medicare Part A, B, and D and private health insurance premiums.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Out-of-pocket spending is higher for female Medicare beneficiaries than male beneficiaries, primarily due to higher spending among females on long-term care services. Whites spend more out of pocket on health and long-term care services and insurance premiums than black and Hispanic beneficiaries, a disproportionate share of whom are also enrolled in Medicaid which helps to reduce their out-of-pocket spending burden.

Figure 7.5

Average Per Capita Out-of-Pocket Spending by Medicare Beneficiaries, by Source of Supplemental Coverage, 2006

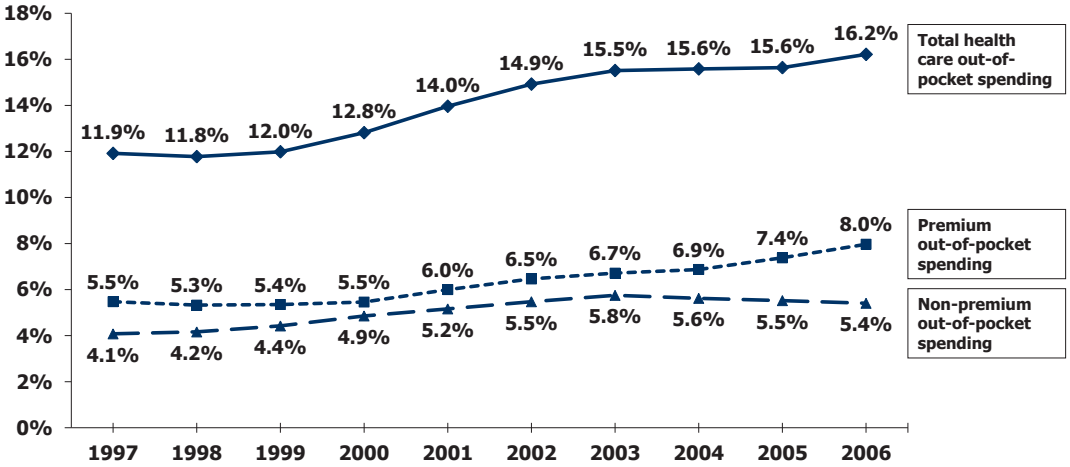


NOTES: Includes Medicare Advantage enrollees, and institutionalized and non-institutionalized beneficiaries. Numbers may not sum to total due to rounding. Premium spending includes Medicare Part A, B, and D and private health insurance premiums.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Out-of-pocket spending by Medicare beneficiaries varies by type of supplemental insurance coverage. In 2006, beneficiaries with Medigap policies spent nearly $1,000 more on average than those with employer coverage, largely due to higher average spending on premiums. Beneficiaries with Medicaid had low average spending on premiums (generally covered by Medicaid), but relatively high out-of-pocket spending on services; this group includes those with modest incomes who "spent down" their savings prior to qualifying for Medicaid at some point during the year. In 2006, those with no supplemental coverage spent on average nearly $4,000 out of pocket—more on services but less on premiums than those with any source of supplemental coverage.

Figure 7.6

Median Out-of-Pocket Health Care Spending As a Percent of Income Among Medicare Beneficiaries, 1997–2006

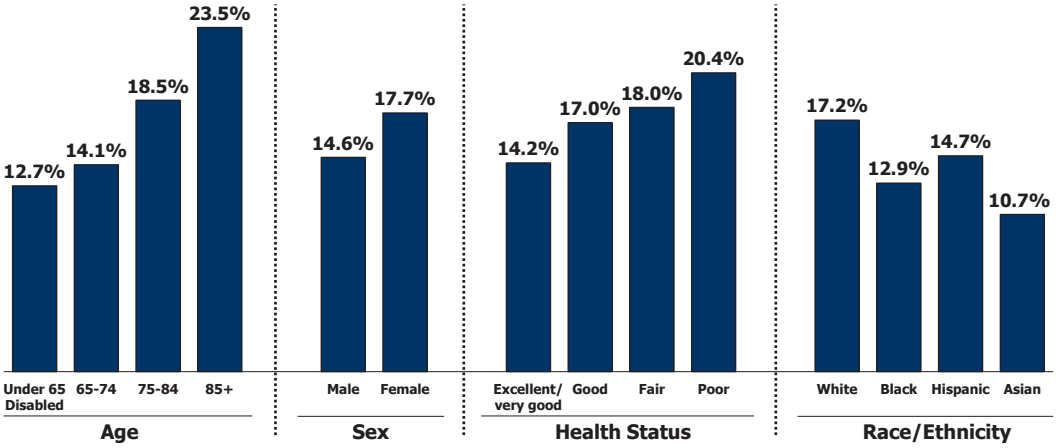


NOTES: Annual amounts for the components of total health care spending do not sum to total amounts because values shown are median, not mean, values. Premium spending includes Medicare Part A, B, and D and private health insurance premiums.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use Files, 1997-2006.

Over the past decade, Medicare beneficiaries have experienced an increase in the financial burden of out-of-pocket health spending. The median out-of-pocket spending as a share of income increased from 11.9 percent in 1997 to 16.2 percent in 2006, with median out-of-pocket premium costs as a share of income increasing from 5.5 percent in 1997 to 8.0 percent in 2006.

Figure 7.7

Median Out-of-Pocket Health Care Spending As a Percent of Income Among Medicare Beneficiaries, by Demographic Characteristics, 2006

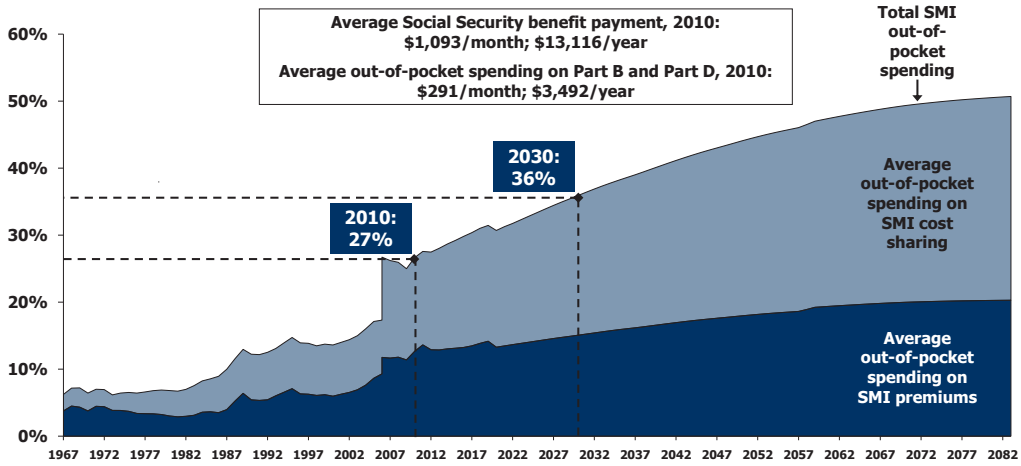


NOTES: Includes Medicare Advantage enrollees, and includes institutionalized and non-institutionalized beneficiaries.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

The out-of-pocket spending burden varies by demographic subgroup. As with absolute levels of out-of-pocket spending, the spending burden increases with advancing age (as income declines) and with declining health status. At the median, those ages 85 and older spent 23.5 percent of their income on health and long-term care in 2006, compared to 14.1 percent among those ages 65-74. The median out-of-pocket spending burden among beneficiaries in poor health was 20.4 percent, compared to 14.2 percent among those in excellent or very good health.

Figure 7.8

Total Part B and Part D (SMI) Out-of-Pocket Spending as a Share of the Average Social Security Benefit, 1967-2084



NOTE: SMI is Supplementary Medical Insurance. Out-of-pocket spending includes SMI (Part B and Part D) premiums and out-of-pocket cost-sharing expenses for SMI covered services.
SOURCE: Kaiser Family Foundation based on data from 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Out-of-pocket spending on medical benefits covered by the Supplementary Medical Insurance (SMI) Trust Fund (including physician and other outpatient services and the Part D prescription drug benefit) has increased steadily as a share of the average Social Security benefit since 1967. In 2010, per capita out-of-pocket spending by beneficiaries for Part B and Part D premiums and cost sharing is projected to consume 27 percent of the average Social Security benefit, and this share is projected to increase to 36 percent by 2030. For 80 percent of beneficiaries, income from Social Security accounted for roughly half or more of their annual income in 2007 (see Figure 1.12).

SECTION EIGHT: MEDICARE SPENDING

MEDICARE SPENDING

In fiscal year (FY) 2010, Medicare spending is estimated to total $524 billion, accounting for 20 percent of national health expenditures and 15 percent of the federal budget. Medicare's share of spending varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2010, Medicare is expected to pay for 30 percent of the nation's total hospital spending, 24 percent of prescription drug costs, and 20 percent of spending on physician services. Medicare spending on prescription drugs has increased significantly in recent years due to the addition of the Medicare prescription drug benefit, up from 3 percent in 2005, the year before the drug benefit took effect.

The distribution of Medicare benefit payments has shifted over time, reflecting changes in health care delivery, what Medicare covers, and how Medicare pays for services. Inpatient and outpatient hospital care accounted for 73 percent of benefit payments in 1966, but 48 percent in 2010—a decrease due primarily to a shift away from inpatient hospital care—while spending on physician and clinical services has remained at roughly one-fourth of benefit payments over time. Administrative payments have accounted for a very small share of Medicare spending over time, currently accounting for less than 2 percent of Medicare benefit payments, significantly less than the cost of running private health plans.

In 2010, inpatient hospital services and payments to Medicare Advantage plans comprise the largest categories of Medicare benefit payments for specific services (27 and 23 percent, respectively). In contrast, home health and skilled nursing facility services combined account for only 9 percent of total benefit spending. In 2010, prescription drugs account for 11 percent of Medicare benefit payments.

Medicare spending is concentrated among a minority of beneficiaries. In 2006, 10 percent of beneficiaries accounted for 58 percent of Medicare spending. Medicare payments for each beneficiary enrolled in the traditional fee-for-service program averaged $8,344 in 2006. Per capita payments for the elderly ($7,962) were similar to the payments for the nonelderly disabled that year ($7,805), but far lower than for those who qualify for Medicare because they have end-stage renal disease ($48,460).

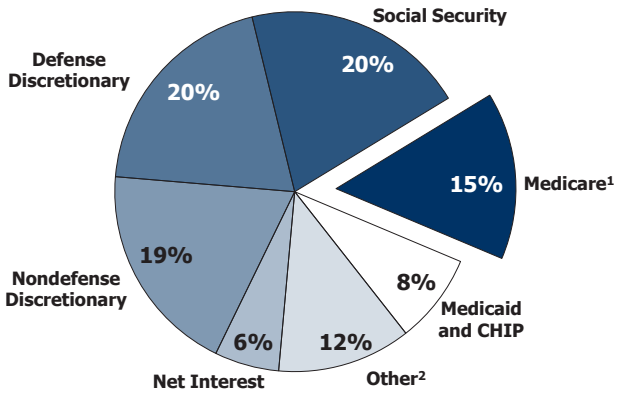
Researchers have documented wide variation in Medicare spending across various geographic areas, which is not explained entirely by demographics nor clearly associated with quality of care or health outcomes. In 2007, Medicare spending per beneficiary across 306 geographic areas, defined by hospital referral patterns, ranged from a low of $5,221 to a high of $17,274 (averaging $8,682).

On a per capita basis, over the long term, average Medicare spending has grown at a slightly slower pace than private health insurance spending for comparable services. Medicare spending is projected to consume an increasing share of the overall economy, from 2.3 percent of the gross domestic product (GDP) in 2000 to 5.1 percent of GDP in 2030. The Affordable Care Act of 2010 includes a number of changes that are expected to reduce the growth in Medicare spending over the next decade and beyond. Average annual growth in Medicare spending is projected to be 5.8 percent between 2012 and 2020, according to CBO, and 5.9 percent between 2010 and 2019, nearly one percentage point lower than projections for this period prior to the passage of the health reform law.

SECTION EIGHT TABLE OF CONTENTS

Figure 8.1

Medicare Spending as a Percent of Total Federal Spending, Fiscal Year 2010



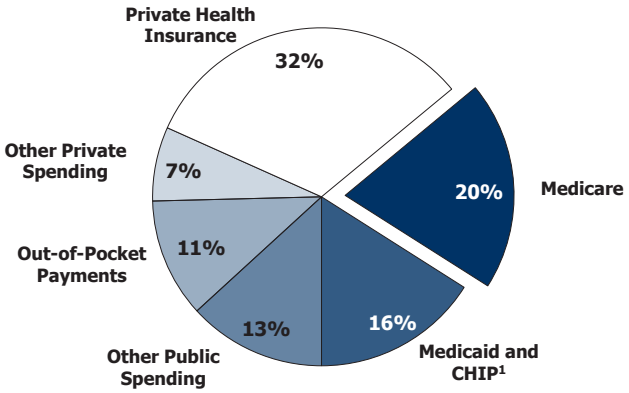
Total Federal Spending, FY2010 = $3.5 Trillion

NOTES: FY is fiscal year. [1]Amount for Medicare excludes offsetting premium receipts (premiums paid by beneficiaries, amounts paid to providers and later recovered, and state contribution (clawback) payments to Medicare Part D). [2]Other category includes other mandatory outlays, offsetting receipts, and negative outlays for Troubled Asset Relief Program.
SOURCE: Congressional Budget Office, The Budget and Economic Outlook: An Update, August 2010.

Federal spending for fiscal year 2010 totaled $3.5 trillion, and Medicare comprised 15 percent of the total amount. Spending on Social Security, the largest entitlement program in the federal budget, accounted for 20 percent, while federal spending on Medicaid and the Children's Health Insurance Program (CHIP) comprised 8 percent.

Figure 8.2

National Health Expenditures in the United States, by Source of Payment, 2010



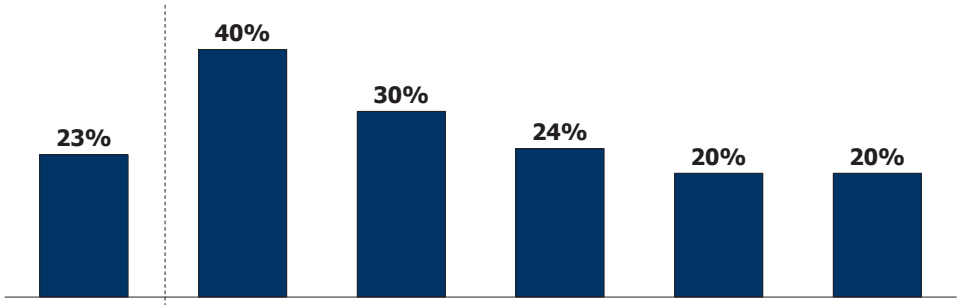
Total National Health Expenditures, 2010 = $2.6 Trillion

NOTES: [1]Includes Children's Health Insurance Program (CHIP) and Children's Health Insurance Program expansion (Title XIX).
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Projections 2009-2019, February 2010.

Health care expenditures in the United States are estimated to total $2.6 trillion in 2010 (including personal health spending, research, and administrative costs). Medicare represents 20 percent of these expenditures, while private health insurance accounts for 32 percent, and consumers pay 11 percent out-of-pocket.

Figure 8.3

Medicare's Share of National Personal Health Expenditures, by Type of Service, 2010



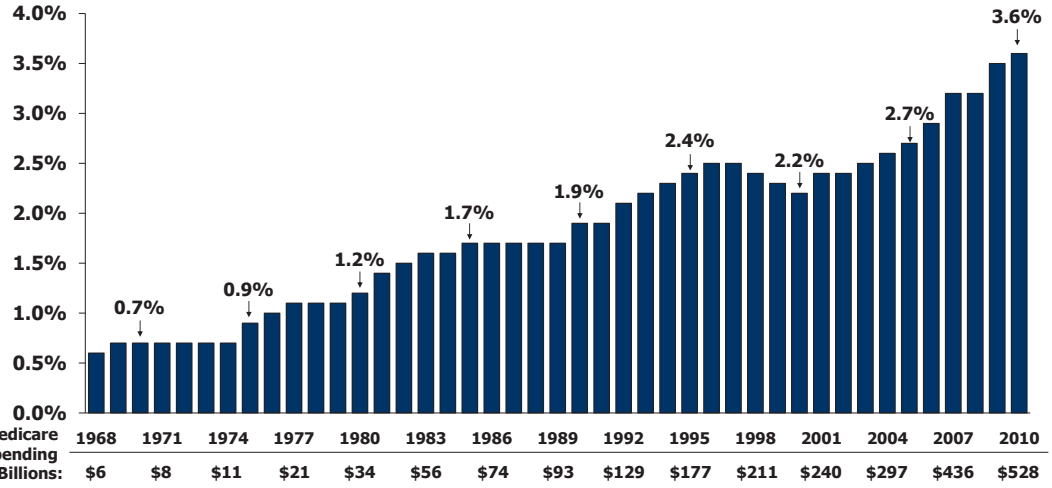
	Total Services	Home Health Care	Hospital Services	Prescription Drugs	Physician Services	Nursing Home Care
		Expenditures in Billions				
Medicare	$489	$31	$235	$62	$105	$29
Total	$2,142	$77	$789	$260	$536	$149

NOTES: Total also includes dental care, durable medical equipment, other professional services, and other personal health care/products.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Projections 2009-2019, February 2010.

Medicare is estimated to finance more than one-fifth of the $2.1 trillion in personal health care expenditures in the U.S. in 2010. Medicare's share varies by type of service, reflecting benefits covered and services used by the Medicare population. In 2010, Medicare is projected to pay for 40 percent of total national home health care spending, 30 percent of all hospital spending, and 20 percent of nursing home care. Medicare is estimated to pay for 24 percent of total national prescription drug spending in 2010, up from 3 percent in 2005, the year before the Medicare Part D drug benefit went into effect.

Figure 8.4

Medicare Spending as a Percent of Gross Domestic Product, Fiscal Years 1968-2010



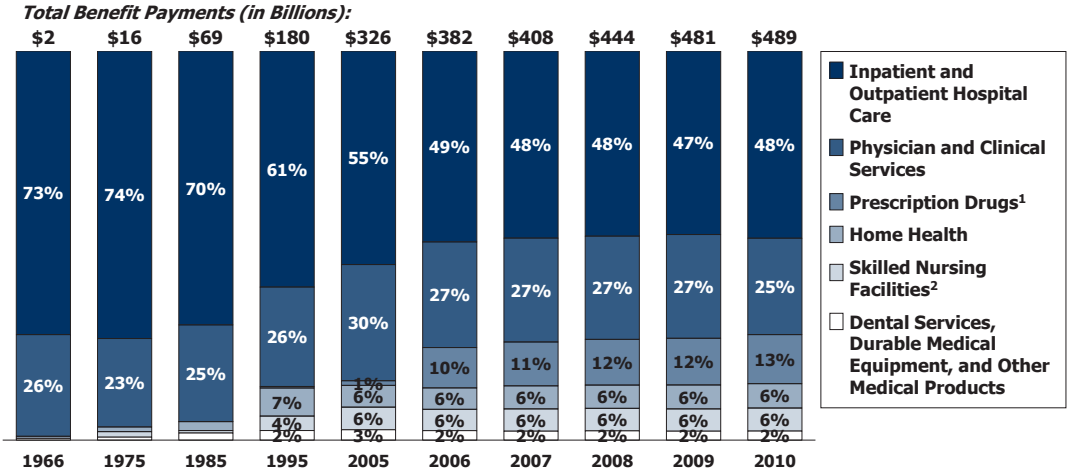
Medicare Spending in Billions:	1968	1971	1974	1977	1980	1983	1986	1989	1992	1995	1998	2001	2004	2007	2010
	$6	$8	$11	$21	$34	$56	$74	$93	$129	$177	$211	$240	$297	$436	$528

NOTES: Medicare spending amounts rounded to nearest billion.
SOURCE: Congressional Budget Office, Budget and Economic Outlook, Current Budget Projections and Historical Budget Data, January 2010.

Total Medicare spending is expected to reached $528 billion in fiscal year (FY) 2010, or 3.6 percent of gross domestic product (GDP). With the exception of FY1998-2000, when changes in provider payment systems contributed to a reduction in program spending, Medicare spending has increased as a share of the national economy every year since the program began in 1966.

Figure 8.5

Distribution of Medicare Payments for Health Care Services and Supplies, 1966-2010



NOTES: [1] Coverage for prescription drugs was effective January 1, 2006. [2] Coverage for skilled nursing facilities was effective January 1, 1967. Total excludes administrative payments.
SOURCE: Centers for Medicare & Medicaid Services, National Health Expenditure Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965-2019.

The distribution of Medicare benefit payments has shifted over time, reflecting changes in health care delivery, covered benefits, and how Medicare pays for services. Inpatient and outpatient hospital care constituted 73 percent of Medicare benefit payments in 1966, but only 48 percent of the total in 2010—a decrease largely due to a shift away from inpatient hospitalizations. Conversely, Medicare spending on prescription drugs has risen from 1 percent or less in 2005 and earlier years, when Medicare did not cover prescription drugs, to 10 percent of Medicare benefit payments in 2006, when the Medicare drug benefit took effect, and 13 percent in 2010.

Figure 8.6

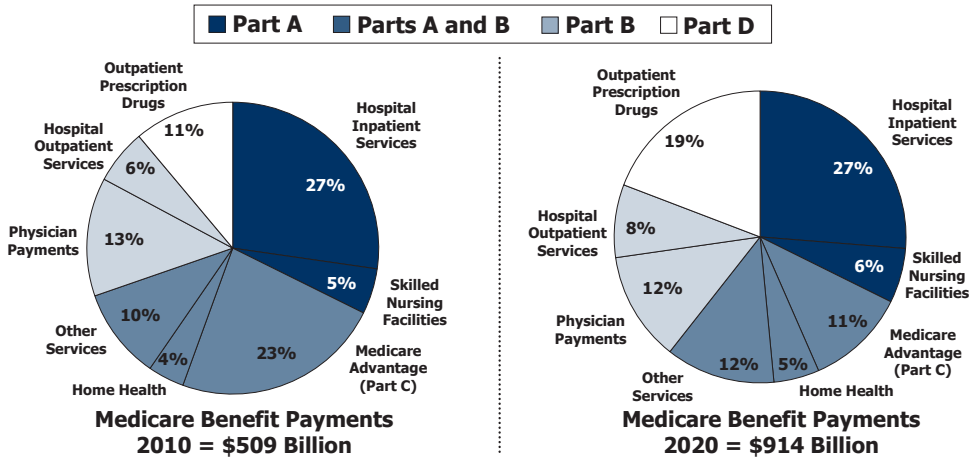
Medicare Administrative Expenditures as a Percent of Medicare Benefit Payments, Fiscal Years 1975-2009

NOTES: *The Health Care Fraud and Abuse Control Program was created in 1997 to fund the health care fraud and abuse activities of the Department of Health and Human Services and the Department of Justice. These costs do not reflect recoveries obtained through such investigations. Numbers may not sum to total due to rounding.
SOURCE: 1999-2001 Annual Reports of the Federal Hospital Insurance Trust Fund, 2002-2010 Annual Reports of the Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Administrative payments currently account for less than 2 percent of Medicare benefit payments, significantly lower than the cost of running private health plans. Between 1975 and 2009, Medicare's administrative budget declined from 4.9 percent to 1.4 percent of total benefit spending, despite more complicated reimbursement rules and more health care service delivery options available to beneficiaries.

Figure 8.7

Medicare Benefit Payments, by Type of Service, 2010 and 2020

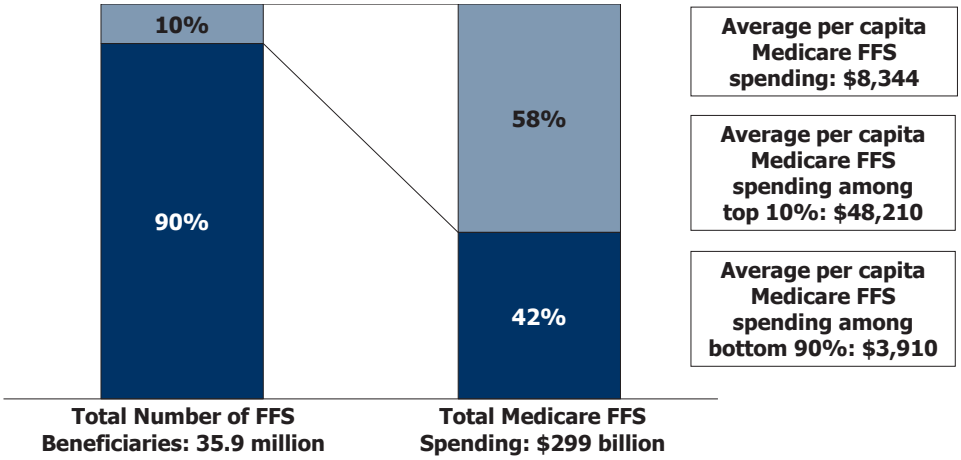


NOTES: Totals do not include administrative expenses and are net of recoveries. Other Services include hospice services; durable medical equipment; ambulance services; independent, physician in-office, and hospital outpatient department laboratory services; hospital outpatient services that are not paid for using the prospective payment system (PPS); Part B prescription drugs; rural health clinic services; outpatient dialysis; and benefit payments not allocated to specific services, including adjustments to reflect year-to-date spending (2010), and savings from the Independent Payment Advisory Board (2020).
SOURCE: Congressional Budget Office, Medicare Baseline, August 2010.

Medicare benefit payments in 2010 are expected to total $509 billion. The largest category of Medicare benefit payments in 2010 is inpatient hospital services (27 percent). The prescription drug benefit, Part D, is projected to account for about 11 percent of all Medicare benefit payments, while payments to Medicare Advantage plans make up 23 percent of benefit spending. In 2020, Medicare benefit payments are projected to total $914 billion, with the share allocated to Medicare Advantage plans projected to decrease from 23 percent in 2010 to 11 percent in 2020. Prescription drugs are projected to be a larger share of Medicare benefit payments in 2020 than in 2010, increasing from 11 percent to 19 percent.

Figure 8.8

Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending, 2006

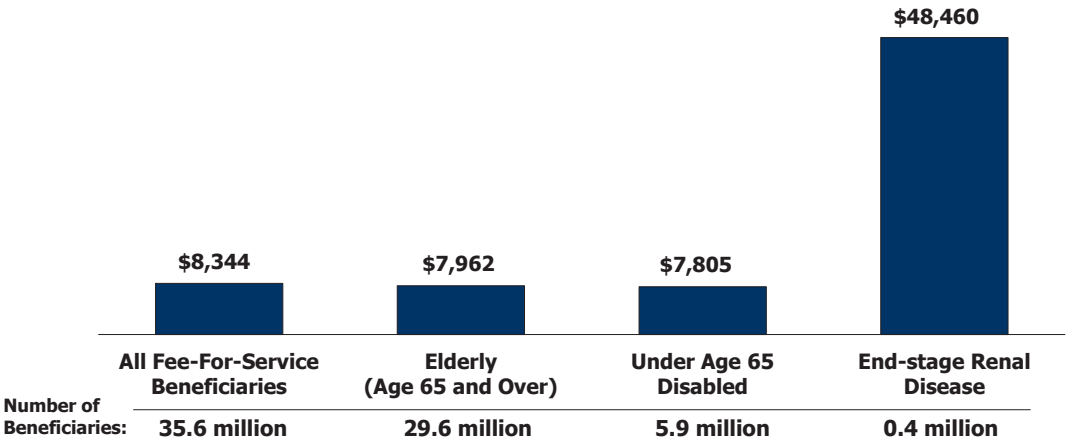


NOTES: FFS is fee-for-service. Excludes Medicare Advantage enrollees. Includes noninstitutionalized and institutionalized beneficiaries.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Medicare spending is highly skewed, with a small share of beneficiaries accounting for a large share of program spending. In 2006, 10 percent of fee-for-service Medicare beneficiaries (those not enrolled in Medicare Advantage) accounted for 58 percent of total Medicare spending. Average per capita Medicare spending for these beneficiaries was $48,210, compared to average per capita spending of $3,910 among the bottom 90 percent, and $8,344 for traditional fee-for-service enrollees overall.

Figure 8.9

Average Medicare Spending Per Fee-For-Service Beneficiary, by Eligibility Category, 2006

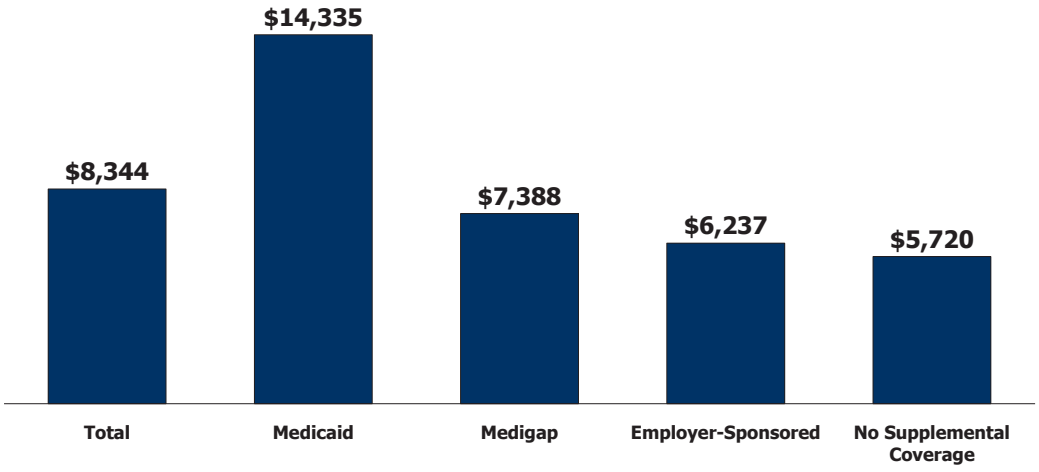


NOTES: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

In 2006, Medicare payments for each beneficiary enrolled in the fee-for-service program (excluding those enrolled in Medicare Advantage plans) averaged $8,344. Average Medicare payments for the elderly on Medicare were about the same as for nonelderly beneficiaries with disabilities ($7,962 and $7,805, respectively). Spending is substantially higher for those beneficiaries who are eligible for Medicare because they have end-stage renal disease (ESRD), who comprise about one percent of the Medicare population—$48,460 on average in 2006.

Figure 8.10

Average Medicare Spending Per Fee-for-Service Beneficiary, by Source of Supplemental Coverage, 2006

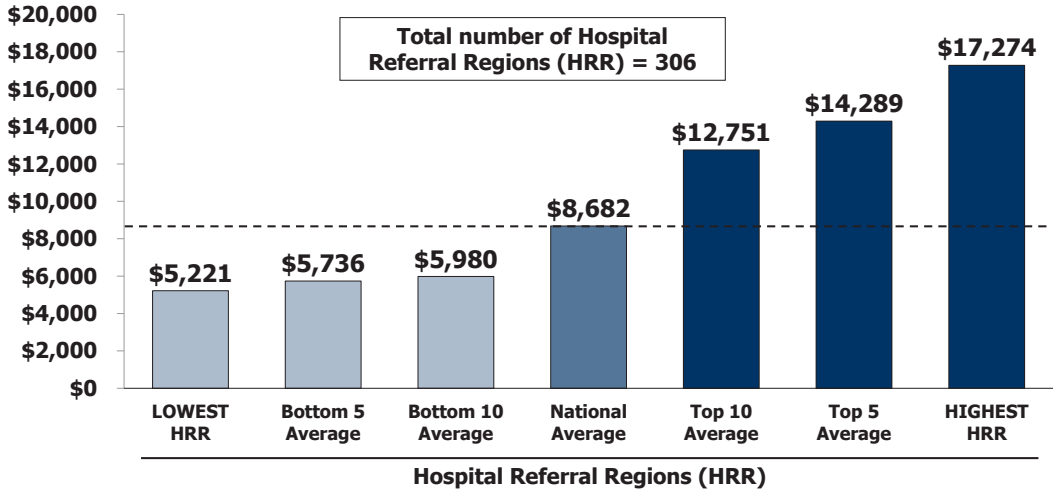


NOTES: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

Medicare spending per fee-for-service beneficiary varies by source of supplemental coverage, reflecting both differences in health status among those with different types of coverage and the relative generosity of various sources of coverage. In 2006, average Medicare spending for beneficiaries with Medicaid was higher than for other Medicare beneficiaries, reflecting the greater health needs and poorer health status of the dual eligible population.

Figure 8.11

Geographic Variation in Medicare Reimbursement, 2007

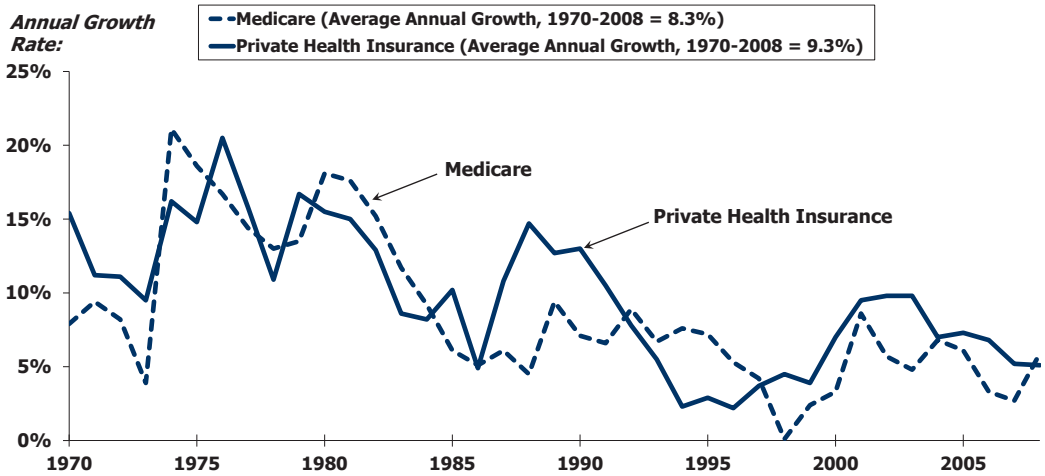


NOTES: Hospital Referral Regions (HRRs) represent regional health care markets for tertiary medical care. Each HRR contains at least one hospital that performed major cardiovascular procedures and neurosurgery.
SOURCE: Kaiser Family Foundation based on the Dartmouth Atlas of Health Care, Medicare Reimbursement per Enrollee, 2007.

Researchers have documented wide variations in Medicare spending across various geographic areas, which is not explained entirely by demographics nor clearly associated with quality of care or health outcomes. In 2007, Medicare spending per beneficiary across 306 geographic areas, defined by hospital referral patterns, ranged from a low of $5,221 in Salem, Oregon to a high of $17,274 in Miami, Florida—averaging $8,682.

Figure 8.12

Annual Percentage Change in Per Enrollee Medicare Spending and Private Health Insurance Spending, 1970-2008

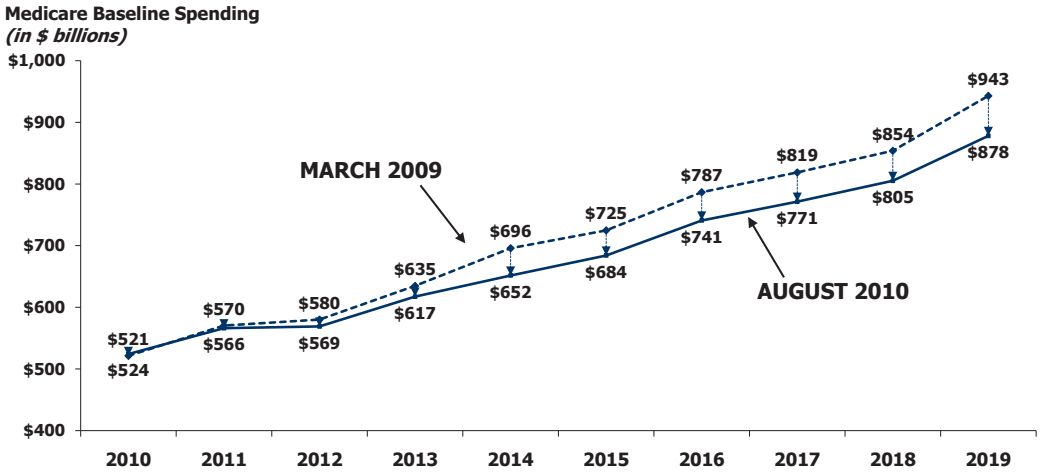


NOTES: Figure shows spending on common benefits covered by Medicare and private health insurance, including hospital services, physician and clinical services, other professional services, and durable medical products.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2010.

On a per enrollee basis, Medicare and private health insurance per capita spending have grown at roughly similar rates over the long term, with some notable exceptions (for example, the late 1980s and early 1990s). Between 1970 and 2008, Medicare spending grew at a somewhat slower pace, on average, than private health insurance spending for common benefits. Private health insurance grew at an average annual rate of 9.3 percent per year in the period between 1970 and 2008, while Medicare grew at an average annual rate of 8.3 percent.

Figure 8.13

Change in Projected Medicare Spending, 2010-2019, Between March 2009 and August 2010

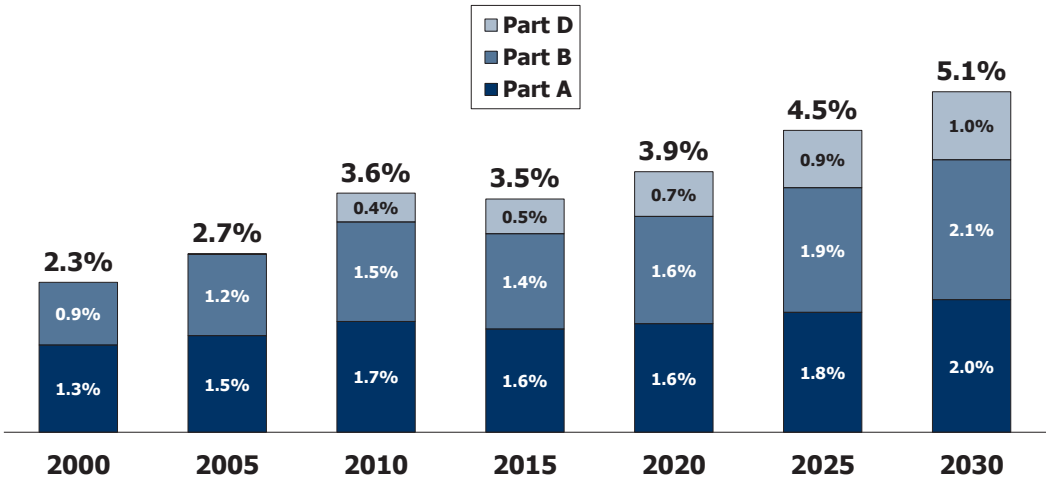


NOTE: Estimates for Medicare total outlays do not take into account additional spending to offset the physician payment reductions that are required under current law according to the Sustainable Growth Rate formula.
SOURCE: CBO, Medicare Baseline, March 2009 and August 2010.

The Affordable Care Act of 2010 includes a number of changes that are expected to reduce the growth in Medicare spending over the next decade and beyond. Average annual growth in Medicare spending is projected to be 5.8 percent between 2012 and 2020, according to CBO. Total Medicare outlays for the ten-year period between 2010 and 2019 are now projected to be $322 billion lower than had been estimated for the same period, partly as a result of the Medicare provisions included in the health care reform law. The average annual growth rate in Medicare spending between 2010 and 2019 is estimated to be 5.9 percent, nearly one percentage point lower than projections for this period prior to the passage of the health reform law.

Figure 8.14

Medicare Spending as a Percent of Gross Domestic Product, 2000-2030



NOTES: HI is Hospital Insurance. SMI is Supplementary Medical Insurance. Numbers may not sum to total due to rounding.
SOURCE: 2010 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 consume a growing share of economic output in the future. According to Medicare actuaries, Medicare's share of gross domestic product (GDP) is estimated to increase from 2.3 percent in 2000 to 5.1 percent in 2030. This reflects a reduction in the growth rate of Medicare spending as a result of changes to Medicare enacted in the Affordable Care Act.

SECTION NINE: MEDICARE FINANCING

MEDICARE FINANCING

The separate parts of Medicare are financed differently. Part A, paid through the Hospital Insurance (HI) Trust Fund, is financed primarily through a 1.45 percent payroll tax paid each by employees and their employers. In fiscal year (FY) 2010, these taxes will account for 85 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 (74 percent in FY2010), beneficiary premiums (25 percent), and interest (1 percent). The Part D prescription drug benefit is financed by general revenue (82 percent in FY2010), beneficiary premiums (10 percent), and payments from states (7 percent). The payments from states are meant to partially cover the costs of low-income Medicare beneficiaries who received prescription drug coverage under state Medicaid programs prior to 2006, but are now covered under Part D.

Over the long term, Medicare will face significant financing challenges due to rising health care costs and the aging of the American population. The first of the "baby boom" generation will reach age 65 and became eligible for Medicare in 2011. Between 2000 and 2030, the number of Medicare beneficiaries is projected to double, from 40 million to 80 million. Because the HI Trust Fund is financed primarily through payroll taxes, its income is directly related to the number of individuals in the workforce, which is not projected to rise as fast as the number of beneficiaries. While there were 4.0 workers per beneficiary in 2000, there are projected to be only 2.3 workers per beneficiary in 2030.

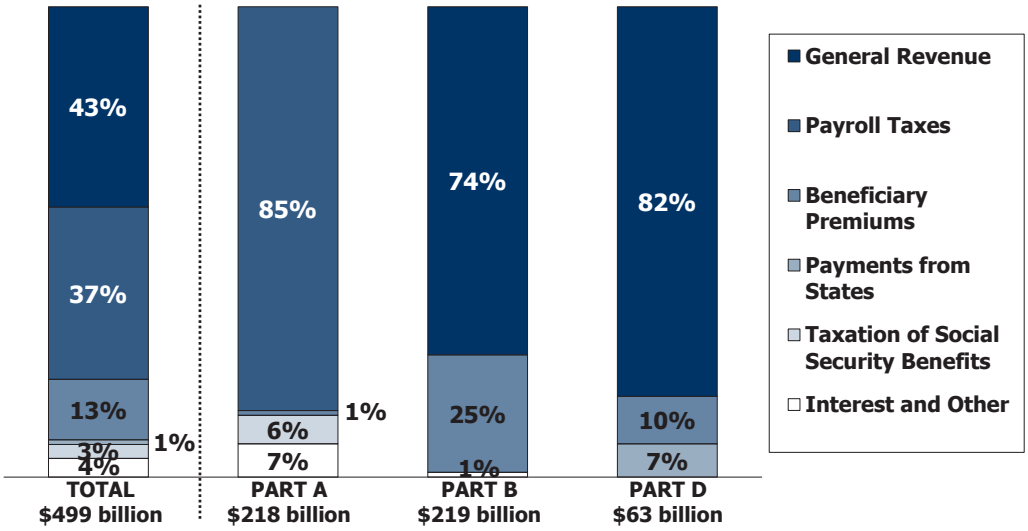
In FY2010, total Medicare revenues are projected to be $499 billion. These funds will come from general revenue (43 percent), payroll taxes (37 percent), beneficiary premiums (13 percent), interest (4 percent), taxation of Social Security benefits (3 percent), and payments from states (1 percent). General revenue represents a growing share of Medicare revenue, as Part B and Part D spending increases relative to spending on Part A. Conversely, the share of Medicare revenue from payroll taxes, which was the largest source of income to the Medicare trust funds prior to 2010, has decreased since the early 1970s.

Each year as part of an assessment of Medicare's financial outlook, the Medicare Board of Trustees issues a report on the current and projected status of the Medicare program. Because the HI Trust Fund can theoretically become insolvent, with higher annual spending than income, its status has become a proxy for Medicare's overall financial health. The Medicare Trustees currently project that fund reserves will be depleted in 2029, meaning there will be insufficient funds to pay full benefits in that year. This is an increase from the 2009 projection, when the Trust Fund was projected to be depleted in 2017. The 12-year extension of the solvency of the Part A Trust Fund is due to a projected reduction in the growth rate of Medicare from changes enacted as part of the Affordable Care Act of 2010, as well as a provision that increased the payroll tax rate for higher-income people. The solvency 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.

SECTION NINE: MEDICARE FINANCING

Figure 9.1

Estimated Sources of Medicare Revenue, 2010

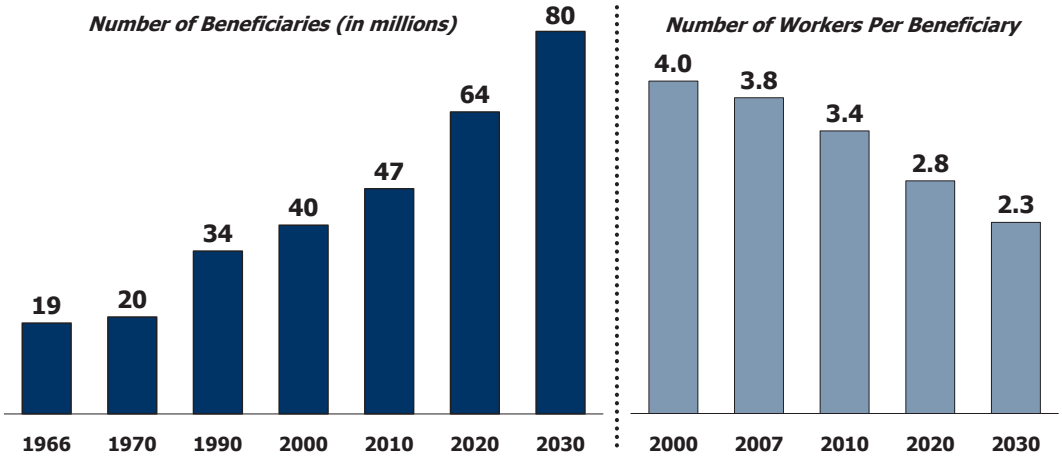


SOURCE: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Medicare Parts A, B, and D are financed differently. Payroll taxes account for the majority (85 percent) of Part A revenues, while general revenues fund the majority of Part B and Part D (74 percent and 82 percent, respectively). In total, Medicare revenue in fiscal year 2010 is estimated to come largely from general revenue (43 percent), payroll taxes (37 percent), and beneficiary premiums (13 percent).

Figure 9.2

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

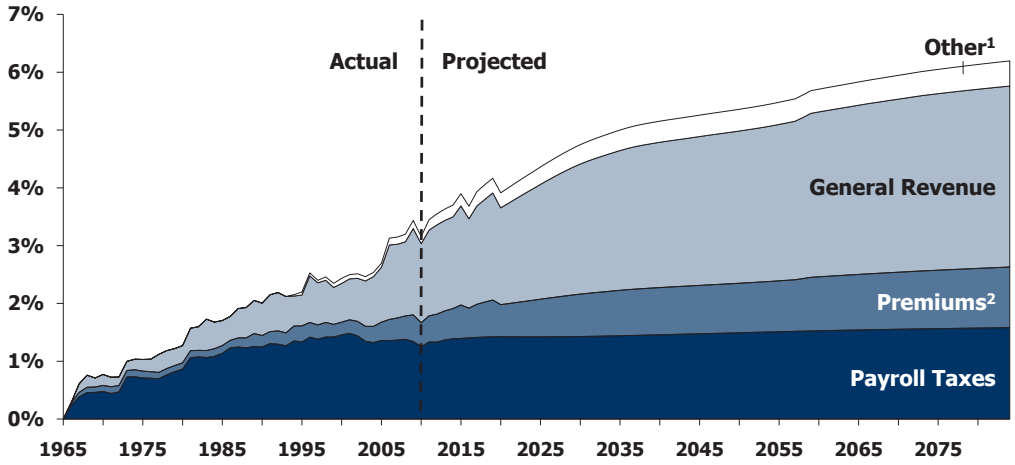


SOURCE: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Between 2000 and 2030, the number of Medicare beneficiaries is projected to increase from 40 million to 80 million. Because the Medicare Hospital Insurance Trust Fund is financed primarily through payroll taxes, its income is directly related to the number of people in the workforce. As the number of beneficiaries is on the increase, the number of workers per beneficiary is projected to decrease from 4.0 in 2000 to 2.3 in 2030.

Figure 9.3

Medicare Income as a Percent of Gross Domestic Product, by Source, 1966-2084

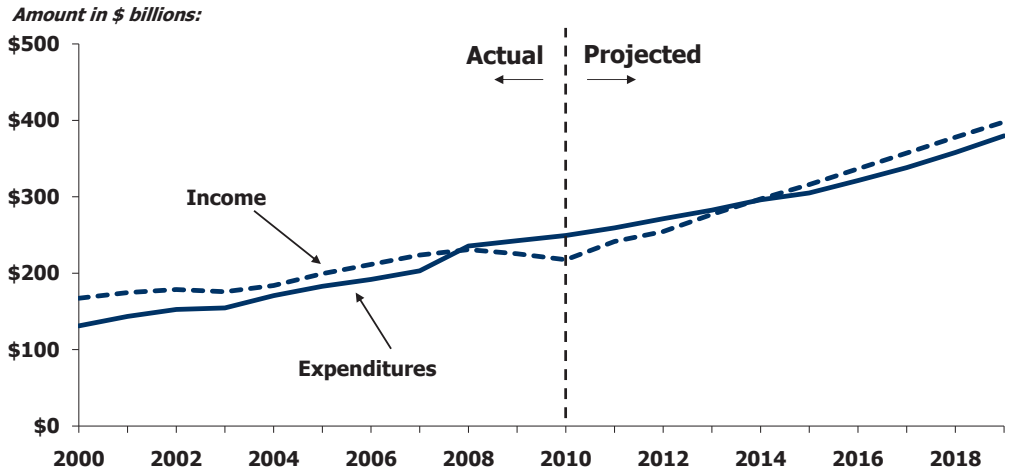


NOTES: [1] Includes income from taxation of Social Security benefits and payments from states. [2] Includes premiums from voluntary enrollees in the Hospital Insurance Program and all enrollees in the Supplementary Medical Insurance Program.
SOURCE: Summary of the 2010 Annual Reports, Social Security and Medicare Board of Trustees.

In 1970, total Medicare income—including general revenue, premiums, and payroll taxes—was less than one percent of U.S. gross domestic product (GDP). By 2010, Medicare income had increased to 3.2 percent of GDP, with income from general revenue and payroll taxes each accounting for 1.4 and 1.3 percent of total GDP, respectively. By 2030, Medicare income from general revenue is projected to account for a larger share of GDP (2.3 percent), while income from Medicare payroll taxes is projected to remain at approximately 1.4 percent of GDP.

Figure 9.4

Income and Expenditures of the Medicare Part A Trust Fund, 2000-2019

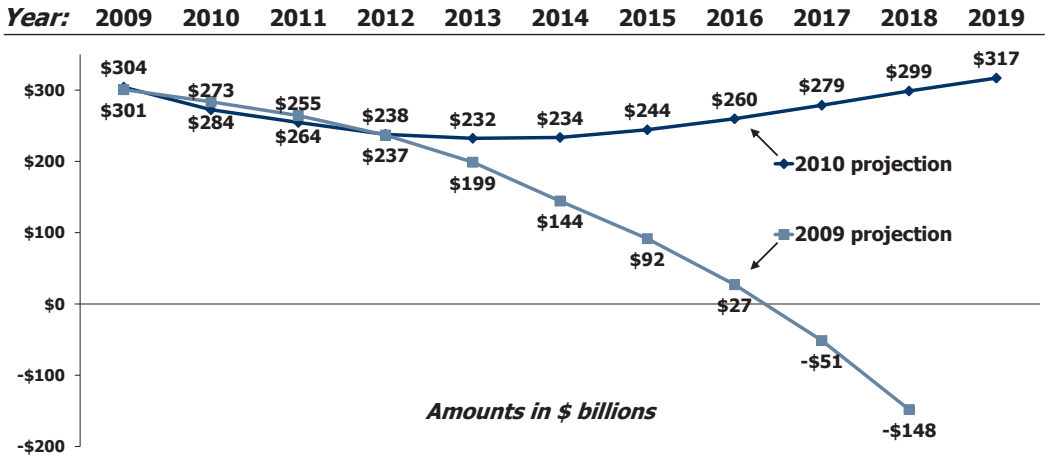


SOURCE: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

In almost every year to date since Medicare's inception, total income to the Part A (Hospital Insurance) Trust Fund exceeded expenditures, until 2008. Under current law, Medicare spending is projected to exceed income to the Part A Trust Fund until 2014, when income will again exceed spending through the remainder of the projection period.

Figure 9.5

2009 and 2010 Projections of the Medicare Part A Trust Fund Balance, 2010-2019

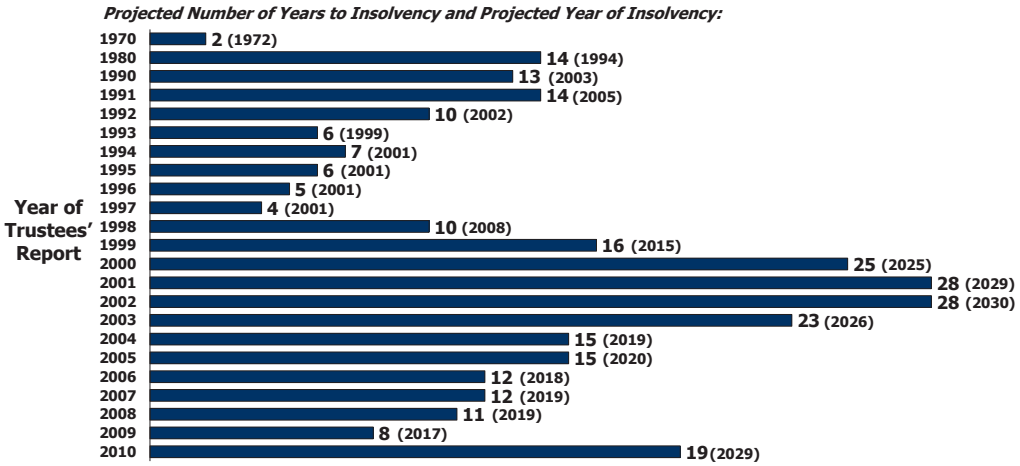


NOTE: 2009 projection period does not include 2019. Estimate for each year represents the trust fund balance at calendar year's end.
SOURCE: Kaiser Family Foundation based on data from the 2009 and 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Medicare's financial condition is measured in a number of ways, including assessing the status of the Part A Hospital Insurance Trust Fund (i.e., the number of years to depletion of the trust fund). The Part A Trust Fund is projected to be depleted by 2029, 12 years later than the 2009 projection of 2017. This is largely due to reductions in the growth rate of Medicare spending as a result of provisions in the 2010 health care reform law, as well as a provision to increase the payroll tax paid by higher-income people. As a result, the Part A Trust Fund is projected to have a positive asset balance of $317 billion at the end of 2019.

Figure 9.6

Solvency Projections of the Medicare Part A Trust Fund, 1970-2010

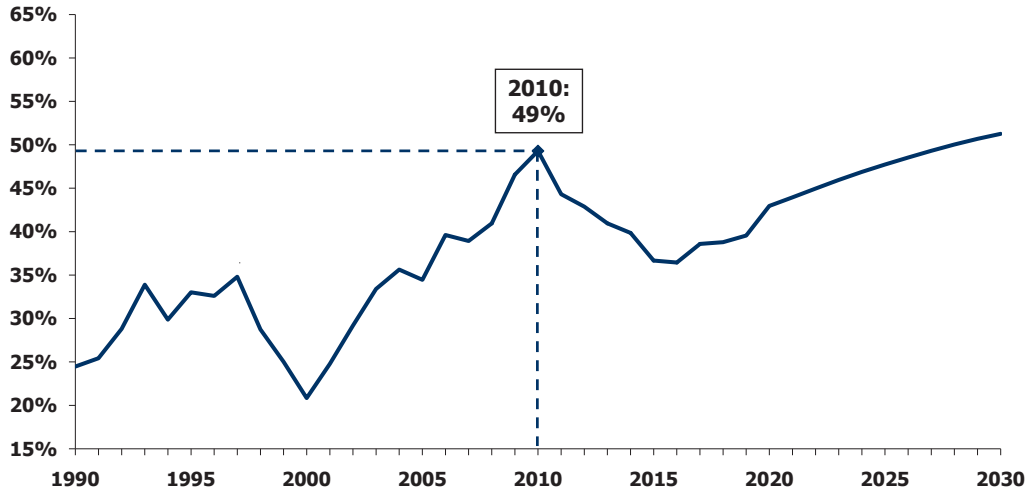


NOTES: 'Insolvency' refers to the depletion of the trust fund. No insolvency projections were made for 1973-1975 and 1989. For all other years not displayed, the Hospital Insurance Trust Fund was projected to remain solvent for 17 or fewer years.
SOURCE: Intermediate projections from 1970-2010 Annual 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 Part A Hospital Insurance Trust Fund has varied significantly from year to year, with projections ranging from 2 years to 28 years of remaining solvency. Between 2005 and 2009, the solvency projection decreased from 15 years to 8 years, due in part to an economic downturn, faster than expected expenditure growth, increased payments to private Medicare Advantage health plans and rural health providers, and accounting for the addition of the Part D prescription drug benefit that took effect in 2006. Provisions in the Affordable Care Act of 2010 extended the solvency of the Part A Trust Fund by 12 years, to 2029.

Figure 9.7

General Revenue as a Percent of Medicare Spending, 1990-2030



SOURCE: 2010 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 test annually whether general revenues will finance 45 percent or more of total Medicare spending in any of the next seven years. In 2010, for the fifth year in a row, the Trustees projected that general revenues will exceed 45 percent of total spending within a seven-year timeframe (in 2010), prompting them to issue a "Medicare funding warning." However, general revenue is projected to fall below the 45 percent level in 2011 and not reach that level again until 2022.

APPENDICES

APPENDIX A: MEDICARE TIMELINE, 1965–2010

1960s

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 poor 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.

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.

1970s

October 30, 1972

President Nixon signed the Social Security Amendments of 1972 (Public Law 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.

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.

1980s

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.

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 Medicare Part A Hospital Insurance 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 operating 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.

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, included an outpatient prescription drug benefit and 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 (QMB). The U.S. Bipartisan Commission on Comprehensive Health Care (which became known as "Pepper" Commission after the late Congressman Claude Pepper of Florida) was established to assess the feasibility of a long-term care benefit under Medicare.
– 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 1988 Medicare Catastrophic Coverage Act, including both the outpatient drug benefit and the out-of-pocket 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.

1990s

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.

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 wages subject to the HI payroll tax.
– States started to cover Medicare Part B premiums for SLMBs.

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 the 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-serve 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.

2000s

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 covered 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.

2001

- Secretary of Health and Human Services, Tommy Thompson, renamed HCFA, which became the Centers for Medicare and Medicaid Services (CMS).
- Medicare began covering people with ALS (Lou Gehrig's Disease).

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-1.
– 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 (Public Law 108-173) by President Bush on December 8, 2003, providing a new outpatient prescription drug benefit under Medicare beginning in 2006. In the interim, it created 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 named Medicare+Choice), along with 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 looking at general revenues 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 begins covering a "Welcome to Medicare" physical, along with other preventive services, such as cardiovascular screening blood tests and diabetes screening tests. Medicare begins education and outreach activities to implement the 2006 prescription drug benefit.

November 15, 2005—May 15, 2006

This six-month period marked the first open enrollment period for the new Part D drug benefit, in which Medicare beneficiaries could enroll in a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD plan).

January 1, 2006

Medicare Part D took effect and Medicare beneficiaries began receiving subsidized prescription drug coverage through Part D plans.

March 2006

In their annual report, the Medicare Board of Trustees calculated for the first time that general revenues would exceed 45% of total Medicare outlays within a seven-year period.

2007

Starting in 2007, Medicare beneficiaries with higher incomes (more than $80,000/individual; $160,000/couple) began paying a higher monthly Part B premium based on their modified adjusted gross income, ranging from $105.80 to $161.40 per month.

March 2007

For the second consecutive year, Medicare Board of Trustees calculated that general revenue would exceed 45% of Medicare funding within the succeeding seven years, triggering a "Medicare funding warning."

December 2007

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) was signed into a law. The Act prevented a 10.1 percent reduction in Medicare physician payments that was scheduled for 2008 and gave physicians a 0.5 percent increase through June 30, 2008.

February 2008

In response to the "Medicare funding warning" issued in 2007, the President submitted proposals to Congress to reduce the share of general revenues as a share of total spending, as required by law.

March 2008

The Medicare Trustees issued a "Medicare funding warning" in 2008, as required by law, indicating general revenues would exceed 45 percent of total Medicare spending within a seven-year period.

July 2008

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was signed into law (Public Law 110-275). The bill prevented a reduction in physician fees through the end of 2008, and increased fees by 1.1 percent through 2009. The cost of the postponement of physician fee cuts was offset by cutting bonus payments to Medicare Advantage plans. The Act also provided benefit improvements; it reduced coinsurance for mental health visits, eliminated the deductible for the welcome to Medicare exam, and increased allowable resources for low-income beneficiaries applying for the Medicare Savings Programs (MSP) and modified the definition of excludable assets in determining Low-Income Subsidy (LIS) program eligibility. The law also prohibits deeming of providers for Private Fee-for-Service plans in certain counties.

2010s

March 2010

The health care reform law enacted in March 2010 (the Patient Protection and Affordable Care Act, Public Law 111-148, as modified by the Health Care and Education Reconciliation Act, Public Law 111-152) expanded prescription drug and prevention benefits covered under Medicare and introduced new programs designed to improve the quality and delivery of care to people covered by Medicare. The law phases out the coverage gap in the Medicare Part D prescription drug benefit by 2020. In addition, the law reduced the growth in Medicare payments to health care providers and Medicare Advantage plans, and included other provisions designed to slow the growth in Medicare spending and strengthen the solvency of the Medicare Hospital Insurance Trust Fund, including the creation of a new Independent Payment Advisory Board.

APPENDIX B

MEDICARE BENEFICIARY PREMIUMS, DEDUCTIBLES, AND COINSURANCE,1966–2019
(Actual and Projected)

		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[1]	Standard Monthly Premium[2]	Annual Deductible	Standard Monthly Premium[3]	Standard Initial Deductible
Actual	1966	$40	$10	-	$5.00	-	$3.00	$50	-	-
	1970	$52	$13	$26	$6.50	-	$4.00	$50	-	-
	1975	$92	$23	$46	$11.50	$40 (-)	$6.70	$60	-	-
	1980	$180	$45	$90	$22.50	$78 (-)	$8.70	$60	-	-
	1985	$400	$100	$200	$50.00	$174 (-)	$15.50	$75	-	-
	1990	$592	$148	$296	$74.00	$175 (-)	$28.60	$75	-	-
	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	-	-
	2006	$952	$238	$476	$119.50	$393 ($216)	$88.50	$124	$32.20	$250
	2007	$992	$248	$496	$124.00	$410 ($226)	$93.50	$131	$27.35	$265
	2008	$1,024	$256	$512	$128.00	$423 ($233)	$96.40	$135	$27.93	$275
	2009	$1,068	$267	$534	$133.50	$443 ($244)	$96.40	$135	$30.36	$295
	2010	$1,100	$275	$550	$137.50	$461 ($254)	$110.50	$155	$31.94	$310
Projected	2011	$1,140	$285	$570	$142.50	$451 ($248)	$120.10	$168	$33.41	$310
	2012	$1,172	$293	$586	$146.50	$454 ($250)	$113.80	$159	$35.01	$330
	2013	$1,208	$302	$604	$151.00	$457 ($251)	$117.20	$164	$36.59	$345
	2014	$1,252	$313	$626	$156.50	$464 ($255)	$123.10	$172	$38.65	$360
	2015	$1,300	$325	$650	$162.50	$464 ($255)	$128.10	$179	$41.39	$380
	2016	$1,348	$337	$674	$168.50	$474 ($261)	$133.90	$187	$43.96	$405
	2017	$1,388	$347	$694	$173.50	$486 ($267)	$141.30	$197	$47.10	$430
	2018	$1,428	$357	$714	$178.50	$499 ($274)	$150.90	$210	$50.60	$460
	2019	$1,468	$367	$734	$183.50	$514 ($283)	$160.10	$223	$54.47	$490

NOTES: SNF is Skilled Nursing Facility.

[1]Figures in parentheses are for persons who have paid Medicare taxes during at least 30 of the 40 quarters required to be fully insured.

[2]The Medicare Part B premium was originally 50 percent of projected costs. Congress set it at 25 percent permanently in 1997. Beneficiaries with higher incomes (above $85,000 (single) or $170,000 (married couple) in 2010) pay a higher income-related Medicare Part B premium; beginning in 2011 these income thresholds will be frozen at their current levels through 2019. Because there was no Social Security cost-of-living increase in 2010, beneficiaries who have the Social Security Administration (SSA) withhold their Part B premium and have incomes of $85,000 or less (or $170,000 or less for couples) had no increase in their Part B premium in 2010, and pay the 2009 amount ($96.40).

[3]Beginning in 2011, beneficiaries with higher incomes (above $85,000 (single) or $170,000 (married couple) will pay a higher income-related Medicare Part D premium. These income thresholds will be frozen through 2019.

SOURCE: 2010 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, 2006

			Community						
		Total Population	Total Community	Under Age 65 (Disabled)	Ages 65+[1]	Ages 65-84[1]	Ages 85+[1]	ESRD[2]	Total Facility
	Number of Beneficiaries	43,877,456	41,632,367	6,464,323	34,722,699	30,350,463	4,366,652	387,291	2,245,089
Sex	Male	44.4%	45.0%	51.1%	43.8%	45.4%	32.7%	57.6%	32.3%
	Female	55.6%	55.0%	48.9%	56.2%	54.6%	67.3%	42.4%	67.7%
Age	Under 65	16.0%	16.1%	100.0%	N/A	N/A	N/A	44.2%	15.0%
	65-74	41.8%	43.4%	N/A	51.7%	59.2%	N/A	31.6%	10.6%
	75-84	29.9%	29.9%	N/A	35.7%	40.8%	N/A	19.7%	29.1%
	85 and over	12.3%	10.5%	N/A	12.6%	N/A	100.0%	4.5%	45.3%
Living Arrangement	Lives alone	28.0%	29.5%	27.3%	30.1%	27.4%	49.2%	12.8%	N/A
	Lives with spouse	49.2%	51.9%	37.8%	54.5%	58.5%	26.5%	52.2%	N/A
	Lives with children	9.7%	10.2%	11.2%	10.0%	8.7%	19.3%	16.3%	N/A
	Lives with others	7.9%	8.4%	23.7%	5.4%	5.5%	4.9%	18.6%	N/A
	Lives in long-term care facility	5.1%	N/A	N/A	N/A	N/A	N/A	N/A	100.0%
Race/Ethnicity	White (non-Hispanic)	78.4%	78.1%	68.2%	80.3%	79.9%	83.6%	48.3%	84.2%
	Black (non-Hispanic)	9.1%	9.0%	16.5%	7.4%	7.5%	6.8%	25.0%	10.5%
	Hispanic	7.7%	7.9%	10.5%	7.4%	7.5%	6.1%	15.7%	3.9%
	Asian	2.1%	2.2%	1.1%	2.3%	2.3%	1.9%	8.2%	0.5%
	Other	2.7%	2.8%	3.7%	2.6%	2.8%	1.5%	2.8%	0.8%
Marital Status	Married	52.0%	54.0%	40.4%	56.5%	60.4%	28.8%	55.9%	14.5%
	Widowed	28.3%	26.8%	7.1%	30.6%	25.7%	64.4%	18.4%	57.1%
	Divorced/Separated	12.4%	12.6%	27.6%	9.8%	10.6%	4.0%	17.6%	8.4%
	Never Married	7.3%	6.6%	24.9%	3.2%	3.2%	2.8%	8.1%	20.0%
Residential Area[3]	Urban	75.9%	75.9%	72.1%	76.6%	76.2%	79.1%	83.2%	75.2%
	Rural	23.9%	23.9%	27.8%	23.2%	23.5%	20.9%	16.8%	24.8%
Education Level	8th grade or less	12.4%	11.7%	11.2%	11.8%	10.6%	19.7%	9.8%	27.8%
	Some high school	15.3%	15.2%	18.5%	14.6%	14.3%	16.3%	20.9%	18.0%
	High school graduate	30.4%	30.5%	33.9%	29.9%	30.1%	28.3%	28.0%	28.4%
	Some college or 2-year degree	25.0%	25.5%	27.6%	25.1%	25.7%	21.4%	16.8%	15.5%
	College graduate or more	16.8%	17.1%	8.7%	18.6%	19.2%	14.3%	24.5%	10.2%
Income	$10,000 or less	16.9%	15.8%	33.3%	12.4%	11.4%	19.6%	22.5%	37.7%
	$10,001-$20,000	28.5%	28.2%	33.4%	27.1%	25.6%	37.2%	36.9%	35.8%
	$20,001-$30,000	19.8%	20.1%	13.9%	21.2%	21.4%	19.7%	24.3%	14.0%
	$30,001-$40,000	12.5%	12.9%	8.0%	13.9%	14.5%	9.8%	3.1%	5.8%
	More than $40,000	22.2%	23.1%	11.4%	25.4%	27.0%	13.8%	13.2%	6.7%
Supplemental Insurance Coverage	Medicare Advantage	18.2%	18.7%	13.2%	19.8%	20.1%	18.0%	11.5%	9.6%
	Employer-sponsored	33.2%	34.7%	17.5%	37.9%	38.8%	32.3%	27.3%	5.0%
	Medigap	18.1%	19.0%	4.0%	22.0%	21.2%	27.5%	8.5%	0.9%
	Medicaid	17.2%	14.9%	40.8%	9.9%	9.6%	12.0%	32.7%	59.3%
	No supplemental coverage	11.7%	11.8%	23.4%	9.5%	9.7%	8.3%	20.0%	10.4%
	Other	1.6%	0.8%	1.1%	0.8%	0.7%	1.8%	0.0%	14.7%
Self-Reported Health Status	Excellent	13.9%	14.5%	4.3%	16.6%	17.0%	13.6%	2.4%	2.6%
	Very good	25.7%	26.7%	10.7%	29.9%	30.3%	27.0%	8.8%	8.3%
	Good	32.0%	32.0%	27.0%	33.1%	32.8%	35.1%	22.9%	30.6%
	Fair	19.1%	18.1%	33.9%	15.0%	14.6%	17.8%	28.1%	36.9%
	Poor	9.3%	8.7%	24.1%	5.4%	5.3%	6.4%	37.8%	21.6%

NOTES: N/A is not applicable. Numbers may not sum to 100 percent due to rounding or exclusion of missing/don't know/refused responses.

[1] Aged beneficiaries (Ages 65+, 65-84, and 85+) do not include aged beneficiaries with ESRD.

[2] ESRD (end stage renal disease) includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD.

[3] Urban counties are defined as those in a metropolitan statistical area (MSA); all other counties are classified as rural.

SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.

APPENDIX C

CHARACTERISTICS OF THE MEDICARE POPULATION, 2006 (CONTINUED)

		Community						
	Total Population	Total Community	Under Age 65 (Disabled)	Ages 65+[1]	Ages 65-84[1]	Ages 85+[1]	ESRD[2]	Total Facility
Number of Beneficiaries	43,877,456	41,632,367	6,464,323	34,722,699	30,350,463	4,366,652	387,291	2,245,089
Presence of Chronic Conditions				***Percent of Beneficiaries with Condition***				
No Chronic Conditions[3]	6.7%	7.0%	3.4%	7.8%	8.5%	2.8%	0.0%	1.2%
One Chronic Condition	15.0%	15.0%	15.6%	15.0%	15.8%	9.6%	6.4%	15.1%
Two Chronic Conditions	22.6%	22.6%	20.3%	23.0%	23.5%	19.6%	19.3%	22.9%
Three Chronic Conditions	21.9%	21.7%	22.0%	21.6%	21.3%	23.5%	29.1%	24.2%
Four Chronic Conditions	16.3%	16.2%	16.6%	16.1%	15.8%	18.7%	14.9%	17.6%
Five or More Chronic Conditions	17.5%	17.5%	22.0%	16.5%	15.2%	25.8%	30.3%	19.1%
Hypertension	62.8%	63.9%	53.9%	65.4%	64.6%	70.4%	93.8%	42.3%
Emphysema	16.9%	17.2%	26.1%	15.5%	15.9%	12.9%	15.0%	11.8%
Diabetes	23.0%	22.9%	25.8%	21.9%	23.0%	14.2%	57.8%	24.5%
Heart Condition[4]	42.0%	42.5%	35.6%	43.6%	41.9%	55.6%	57.7%	32.0%
Arthritis	59.0%	61.1%	59.1%	61.7%	60.5%	70.0%	44.9%	20.0%
Osteoporosis	20.4%	20.6%	14.5%	21.9%	20.8%	29.6%	9.2%	16.8%
Broken Hip	3.6%	3.7%	3.5%	3.7%	2.8%	10.3%	2.5%	2.7%
Parkinson's Disease	1.5%	1.3%	1.0%	1.3%	1.2%	2.3%	1.8%	5.3%
Stroke	11.9%	11.8%	14.2%	11.1%	10.5%	15.6%	34.2%	13.8%
Alzheimer's Disease	4.6%	3.9%	2.7%	4.1%	3.2%	10.6%	2.1%	17.8%
Skin Cancer	17.9%	18.8%	6.5%	21.3%	20.2%	28.5%	7.0%	0.5%
Other Types of Cancer	17.3%	18.0%	12.4%	19.0%	18.3%	23.8%	17.3%	4.4%
Depression	8.9%	7.4%	21.6%	4.6%	4.5%	5.7%	14.6%	36.3%
Complete/partial Paralysis	4.2%	4.4%	11.3%	3.1%	3.1%	2.7%	5.4%	N/A
Urinary Incontinence[5]	10.5%	9.3%	7.9%	9.6%	8.4%	18.2%	7.0%	31.8%
Cognitive/Mental Impairment[6]	34.2%	31.2%	68.8%	24.1%	22.9%	32.7%	39.7%	89.3%
One or More Limitations in Activities of Daily Living (ADLs)[7]	28.9%	28.9%	42.9%	26.1%	22.9%	48.1%	43.0%	N/A
One or More Limitations in Instrumental Activities of Daily Living (IADLs)[8]	30.4%	30.4%	54.5%	25.8%	23.3%	43.3%	36.6%	N/A

NOTES: N/A is not applicable or not available.

[1] Aged beneficiaries (Ages 65+, 65-84, and 85+) do not include aged beneficiaries with ESRD.

[2] ESRD (end stage renal disease) includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD.

[3] 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.

[4] Heart condition is defined as diagnosis with hardening of arteries, angina, myocardial infarction, congestive heart failure, and/or problem with heart valves or heart rhythm.

[5] Urinary incontinence is defined as loss of urine control more than once per week in the last 12 months.

[6] Cognitive/mental impairment is defined as presence of mental retardation, mental disorder, Alzheimer's disease, and/or memory loss that interferes with daily activity. For facility residents, definition also includes presence of schizophrenia and/or dementia.

[7] Activities of daily living are eating, dressing, getting into and out of bed or chair, taking a bath or shower, and using the toilet; not reported for facility residents.

[8] Instrumental activities of daily living are preparing meals, managing money, shopping, doing light and heavy housework, and using the telephone; not reported for facility residents.

SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.

APPENDIX D

CHARACTERISTICS OF THE MEDICARE POPULATION, BY STATE, SELECTED YEARS

	Number of Medicare Beneficiaries (2010)	Projected Age 65+ (2030)	Age 65+ (2008)	Under Age 65 (2008)	Residing in Rural County (2010)	Income <100% of Poverty (2007-2008)	Income 100%-199% of Poverty (2007-2008)	Enrolled in Medicaid (2008)	Enrolled in Medicare Advantage (2010)	Enrolled in Part D (2010)
United States Total	45,830,913 (15% of U.S. population)	20% of U.S. Population	83% of U.S. Medicare population	17% of U.S. Medicare Population	21% of U.S. Medicare Population	16% of U.S. Medicare population	30% of U.S. Medicare population	17% of U.S. Medicare population	25% of U.S. Medicare Population	59% of U.S. Medicare Population
STATE	**Medicare Beneficiary with Characteristic as a Percent of State Medicare Population**									
Alabama	832,913 (18%)	21%	76%	24%	33%	18%	31%	23%	20%	57%
Alaska	63,974 (9%)	15%	81%	19%	36%	7%	24%	21%	1%	39%
Arizona	909,557 (14%)	22%	85%	15%	15%	14%	29%	15%	35%	61%
Arkansas	524,907 (18%)	20%	77%	23%	47%	17%	33%	21%	13%	61%
California	4,669,125 (13%)	18%	86%	14%	4%	16%	32%	25%	35%	69%
Colorado	609,849 (12%)	17%	85%	15%	17%	13%	27%	13%	33%	59%
Connecticut	560,340 (16%)	22%	86%	14%	14%	14%	26%	13%	17%	55%
Delaware	145,842 (16%)	24%	84%	16%	30%	15%	31%	15%	3%	50%
District of Columbia	77,028 (13%)	13%	84%	16%	--[1]	24%	30%	22%	9%	47%
Florida	3,314,477 (18%)	27%	87%	13%	8%	14%	29%	16%	29%	60%
Georgia	1,211,860 (12%)	16%	80%	20%	26%	19%	35%	20%	19%	61%
Hawaii	202,750 (16%)	22%	89%	11%	29%	17%	26%	14%	40%	66%
Idaho	224,133 (14%)	18%	84%	16%	38%	10%	28%	13%	28%	59%
Illinois	1,818,883 (14%)	18%	85%	15%	18%	16%	29%	13%	9%	55%
Indiana	991,222 (15%)	18%	83%	17%	25%	15%	31%	14%	14%	56%
Iowa	513,404 (17%)	22%	87%	13%	52%	12%	32%	14%	12%	67%
Kansas	428,471 (15%)	20%	85%	15%	42%	15%	30%	13%	10%	62%
Kentucky	748,151 (17%)	20%	75%	25%	49%	20%	35%	20%	15%	61%
Louisiana	677,365 (15%)	20%	79%	21%	28%	25%	38%	23%	23%	62%
Maine	260,686 (20%)	27%	79%	21%	46%	13%	32%	31%	11%	62%
Maryland	771,790 (14%)	18%	86%	14%	7%	18%	24%	13%	7%	44%
Massachusetts	1,045,371 (16%)	21%	83%	17%	<1%	16%	33%	20%	18%	58%
Michigan	1,625,605 (16%)	20%	82%	18%	23%	12%	28%	13%	14%	47%
Minnesota	774,433 (15%)	19%	86%	14%	36%	11%	25%	12%	38%	68%
Mississippi	489,980 (17%)	21%	75%	25%	61%	22%	30%	29%	8%	65%
Missouri	991,772 (17%)	20%	81%	19%	33%	17%	31%	13%	20%	62%
Montana	166,315 (17%)	26%	85%	15%	67%	11%	33%	10%	17%	57%
Nebraska	276,731 (15%)	21%	86%	14%	52%	10%	26%	11%	11%	65%
Nevada	347,112 (13%)	19%	85%	15%	14%	14%	25%	11%	30%	56%
New Hampshire	213,449 (16%)	21%	82%	18%	44%	14%	26%	9%	6%	47%
New Jersey	1,310,966 (15%)	20%	87%	13%	--[1]	18%	28%	14%	12%	53%
New Mexico	307,056 (15%)	26%	82%	18%	38%	21%	30%	20%	24%	62%
New York	2,954,341 (15%)	20%	84%	16%	10%	18%	29%	18%	29%	59%
North Carolina	1,460,593 (16%)	18%	80%	20%	36%	16%	33%	20%	16%	59%
North Dakota	107,765 (17%)	25%	88%	12%	62%	14%	33%	8%	7%	69%

APPENDIX D

CHARACTERISTICS OF THE MEDICARE POPULATION, BY STATE, SELECTED YEARS (CONTINUED)

	Number of Medicare Beneficiaries (2010)	Projected Age 65+ (2030)	Age 65+ (2008)	Under Age 65 (2008)	Residing in Rural County (2010)	Income <100% of Poverty (2007-2008)	Income 100%-199% of Poverty (2007-2008)	Enrolled in Medicaid (2008)	Enrolled in Medicare Advantage (2010)	Enrolled in Part D (2010)
United States Total	45,830,913 (15% of U.S. population)	20% of U.S. Population	83% of U.S. Medicare population	17% of U.S. Medicare Population	21% of U.S. Medicare Population	16% of U.S. Medicare population	30% of U.S. Medicare population	17% of U.S. Medicare population	25% of U.S. Medicare Population	59% of U.S. Medicare Population
STATE				Medicare Beneficiary with Characteristic as a Percent of State Medicare Population						
Ohio	1,876,347 (16%)	20%	84%	16%	21%	17%	30%	14%	31%	55%
Oklahoma	596,181 (16%)	19%	81%	19%	42%	14%	30%	15%	14%	60%
Oregon	608,330 (16%)	18%	85%	15%	29%	9%	28%	14%	40%	65%
Pennsylvania	2,259,681 (18%)	23%	85%	15%	18%	15%	33%	13%	36%	63%
Rhode Island	180,984 (17%)	21%	82%	18%	--[1]	16%	31%	16%	34%	68%
South Carolina	755,843 (17%)	22%	79%	21%	28%	18%	32%	18%	14%	54%
South Dakota	135,136 (17%)	23%	87%	13%	60%	14%	24%	12%	7%	65%
Tennessee	1,038,035 (16%)	19%	79%	21%	33%	17%	36%	24%	23%	64%
Texas	2,938,054 (12%)	16%	84%	16%	19%	21%	32%	19%	18%	57%
Utah	277,162 (10%)	13%	86%	14%	15%	9%	30%	10%	31%	56%
Vermont	109,156 (18%)	24%	82%	18%	73%	15%	31%	21%	3%	56%
Virginia	1,122,504 (14%)	19%	83%	17%	22%	19%	25%	14%	13%	52%
Washington	950,097 (14%)	18%	84%	16%	17%	12%	24%	14%	23%	53%
West Virginia	378,108 (21%)	25%	75%	25%	48%	14%	34%	17%	21%	61%
Wisconsin	898,374 (16%)	21%	85%	15%	33%	14%	33%	11%	28%	54%
Wyoming	78,705 (14%)	27%	86%	14%	69%	14%	33%	11%	6%	54%

NOTES: [1]There are no counties designated as rural in the District of Columbia, New Jersey, or Rhode Island.

SOURCE: CMS Statistics: Medicare State Enrollment; U.S. Census Bureau 2009 population estimates; State Interim Population Projections by Age and Sex: 2004-2030, Census Bureau;Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, July 2008; Kaiser Family Foundation analysis of pooled March 2007-2008 Current Population Survey data; Medicare beneficiaries as a share of state population estimates are based on July 1, 2009 state-level population estimates from the U.S. Census Bureau.

APPENDIX E: MAJOR TYPES OF MEDICARE PRIVATE PLANS — STAND-ALONE PRESCRIPTION DRUG PLANS AND MEDICARE ADVANTAGE PLANS

Prescription Drug Plans (PDPs) are private plans that cover only the Medicare Part D prescription drug benefit. Stand-alone PDPs are offered in one or more of 34 defined regions comprised of individual states or aggregations of states. Benefits and premiums must be uniform and available to beneficiaries across the regions, but can differ across regions. Beneficiaries in these plans continue to receive Medicare Part A and Part B benefits through the traditional fee-for-service Medicare program. Some PDP enrollees may be in Medicare Advantage (MA) plans of a type that are not allowed to offer a prescription drug benefit, or have the option not to do so (see below).

Medicare Advantage Plans

Local Coordinated Care Plans (CCPs) are network-based plans offered in defined aggregations of counties. Health Maintenance Organizations (HMOs) have been available as an option under Medicare for several years; in 1997, the Balanced Budget Act authorized other types of CCPs. CCPs, as well as private fee-for-service (PFFS) plans, are called "local plans' because they define their service areas on a county-by-county basis.

- ***Health Maintenance Organizations (HMOs)*** are typically the most tightly managed plans. They have a defined network of providers that beneficiaries generally must use to receive coverage (with some exceptions, such as emergency care). These plans account for the largest share of MA enrollment.

- ***Preferred Provider Organizations (PPOs)*** also are network-based plans. In a PPO, enrollees may generally go to any provider they choose. However, using providers outside of the network will result in higher out-of-pocket costs.

Regional Preferred Provider Organizations (R-PPOs) are PPOs that serve large areas in 26 defined regions comprising one or more states. R-PPOs must offer the same plan (with the same benefits and premiums) across an entire region. Benefits must integrate cost sharing across traditional Medicare benefits (Parts A and B) and include an annual out-of-pocket limit on cost sharing for these benefits, a feature not included in traditional Medicare. (Local plans may set such a limit, but this is not required.)

Private Fee-for-Service (PFFS) Plans, in contrast to HMOs and PPOs, place no restrictions on the providers that a Medicare beneficiary can use, although providers may limit their willingness to see Medicare beneficiaries in such plans. PFFS plans must pay providers on a fee-for-service basis and accept all of those willing to meet their payments. Payment rates do not have to match those of Medicare, as long as CMS concludes that the rates will afford adequate provider access.

Medical Savings Accounts (MSAs) have high deductibles accompanied by an annual deposit in an interest-bearing checking account that can be used to cover qualified medical expenses. MSAs do not provide drug coverage, but beneficiaries can purchase it through a stand-alone PDP.

Special Need Plans (SNPs) are designed to serve one or more of three subgroups of individuals with certain special needs: dual eligibles, those who are institutionalized, and those with serious chronic or disabling conditions. SNPs may be offered through separate contracts, or as unique plans under existing HMO, PPO, or other contracts.

Other Types of Plans include cost contracts and various demonstrations that may be offered in particular locales.

APPENDIX F: ACRONYMS AND ABBREVIATIONS

The following is a list of acronyms and abbreviations used in this chartbook.

ADL . . . . . Activities of daily living
ALS . . . . . Amyotrophic lateral sclerosis
BBA . . . . . Balanced Budget Act of 1997 (Public Law 105-33)
BBRA . . . . . Balanced Budget Reconciliation Act of 1995
BIPA. . . . . Benefits Improvement Protection Act of 2000
CBO . . . . . Congressional Budget Office
CCP . . . . . Coordinated Care Plans
CHIP. . . . . Children's Health Insurance Program
CMS. . . . . Centers for Medicare & Medicaid Services
CPS . . . . . Current Population Survey
COBRA. . . . Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)
DEFRA . . . . Deficit Reduction Act of 2005 (Pubic Law 109-171)
DRG . . . . . Diagnosis related group
EBRI. . . . . Employee Benefits Research Institute
EMTALA . . . Emergency Medical Treatment and Labor Act
ESRD . . . . . End-stage renal disease
FEHBP . . . . Federal Employees Health Benefits Plan
FPL. . . . . Federal poverty level
FY. . . . . Fiscal Year
GDP . . . . . Gross domestic product
GSA . . . . . Geographic Service Area
HCBS . . . . . Home- and Community-Based Services
HCERA . . . . Health Care and Education Reconciliation Act (Public Law 111-152)
HCFA . . . . . Health Care Financing Administration
HCPP . . . . . Health Care Prepayment Plans
HHS . . . . . Health and Human Services
HI . . . . . Hospital Insurance (Medicare Part A)
HIPAA . . . . Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)
HMO. . . . . Health maintenance organization
IADL. . . . . Instrumental activities of daily living
KCMU. . . . . Kaiser Commission on Medicaid and the Uninsured
KFF. . . . . Kaiser Family Foundation
LIS . . . . . Low-income subsidy

LTC. . . . . Long-term care
MA . . . . . Medicare Advantage
MA-PD . . . . Medicare Advantage prescription drug (plan)
MCBS. . . . . Medicare Current Beneficiary Survey
MedPAC . . . Medicare Payment Advisory Commission
MIPPA . . . . Medicare Improvements for Providers and Patients Act of 2008 (Public Law 110-275)
MMA . . . . . Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)
MSA. . . . . Metropolitan Statistical Area
MSP. . . . . Medicare Savings Programs
OACT . . . . . Office of the Actuary
OBRA. . . . . Omnibus Budget Reconciliation Act
OOP . . . . . Out-of-pocket
PACE . . . . . Program of All-inclusive Care for the Elderly
PDP . . . . . (Stand-alone) Prescription drug plan
PFFS. . . . . Private fee-for-service (plan)
PPACA . . . . Patient Protection and Affordable Care Act of 2010 (Public Law 111-148)
PPO . . . . . Preferred provider organization
PPS . . . . . Prospective payment system
PRO . . . . . Peer Review Organizations
PSRO. . . . . Professional Standards Review Organization
QI. . . . . Qualifying Individual
QMB. . . . . Qualified Medicare Beneficiaries
QDWI . . . . . Qualified Disabled and Working Individual
RBRVS. . . . Resource-Based Relative Value Scale
RDS . . . . . Retiree Drug Subsidy
SLMB. . . . . Specified Low-Income Medicare Beneficiary
SMI . . . . . Supplementary Medical Insurance (Medicare Part B)
SNF . . . . . Skilled nursing facility
SNP . . . . . Special needs plan
SSA . . . . . Social Security Administration
SSDI. . . . . Social Security Disability Insurance
SSI. . . . . Supplemental security income
TEFRA . . . . Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248)
TWWIIA . . . Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170)
VA . . . . . Department of Veterans Affairs

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