THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE CHART BOOK

SECOND EDITION • FALL 2001

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MEDICARE CHART BOOK

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PREFACE

Medicare provides important financial protections against the costs of health care for almost 40 million elderly and disabled Americans. The Medicare population includes many of the nation's most vulnerable individuals for whom the program provides substantial health and financial security. Now 12 percent of the federal budget, Medicare plays a central role in current discussions about how to spend the federal tax dollar. With the dual challenges of providing needed and increasingly expensive medical care to an aging population and keeping the program financially secure for the future, discussions about the Medicare program will become all the more prominent in the years to come.

This Chart Book presents a framework as well as basic data for understanding the Medicare program and the challenges it faces. The book is organized into the following six sections:

Medicare's Beneficiaries. Medicare's 34 million elderly and 5 million under-65 disabled beneficiaries have diverse health needs and economic circumstances. Although most are in good health, more than a quarter report being in fair or poor health and almost one-quarter have cognitive impairments. Physical problems and functional limitations are significantly higher among Latino and African-American beneficiaries, two groups that will comprise an increasing share of the Medicare population over the next generation. Compounding these health disparities, about half of all Medicare beneficiaries have incomes below $25,000, and 40 percent of beneficiaries have incomes of less than 200 percent of the federal poverty level.

Medicare Spending and Utilization. In FY 2001, Medicare benefit payments totaled $239 billion, accounting for 19 percent of national health expenditures. Inpatient hospital stays account for 39 percent, physician services 17 percent, and Medicare+Choice 18 percent of total benefit payments. In 2001, over 74 percent of beneficiaries had a physician visit and 18 percent had a hospital stay within the year. Medicare spending averaged $4,916 per beneficiary in 1998. However, spending was highly concentrated among a minority of beneficiaries, with 41 percent of beneficiaries incurring health-care expenses of less than $500, while 6 percent had expenses of $25,000 or more, accounting for half of all program payments in 1998. Over the long term, the per-capita growth in Medicare spending has generally tracked per-capita growth in spending on private insurance.

Supplemental Insurance and Out-of-Pocket Spending. Medicare provides coverage of basic health services, but has high cost-sharing requirements and generally covers neither outpatient prescription drugs nor long-term care. The majority of Medicare beneficiaries have supplemental health insurance to help fill Medicare's gaps and improve access to needed health care. In recent years, cost increases have led to an erosion of private coverage—particularly employer-sponsored retiree health benefits—and to increases in Medigap premiums, resulting in higher out-of-pocket costs for beneficiaries.

Medicare+Choice. While most Medicare beneficiaries (86 percent) have their health-care bills paid directly by Medicare's traditional fee-for-service program, one in seven is covered under Medicare+Choice (M+C) plans, primarily Health Maintenance Organizations (HMOs). Medicare HMO enrollment grew rapidly during the mid- and late-1990s, but has recently declined for the first time since HMOs began participating in the Medicare program. The drop in enrollment is due largely to plan withdrawals and service area reductions that have occurred over the last three years, predominantly affecting beneficiaries in non-urban areas of the country. Many M+C plans that have remained in the Medicare market have cut back on their supplemental benefits, such as prescription drugs, and increased premiums and the cost-sharing required of enrolled beneficiaries.

Medicare and Prescription Drugs. Medicare beneficiaries account for 14 percent of the U.S. population, but for 43 percent of the nation's spending on prescription drugs. Although prescription drugs are a primary component of medical care, Medicare generally does not cover them. In 2001, annual per-capita out-of-pocket spending on prescription drugs is estimated to be $848 among Medicare beneficiaries, with 9 percent spending more than $2,500 within the year. Despite the high need for prescription drugs among the Medicare population, 27 percent lacked any drug coverage throughout 1998, about half of whom had incomes below 175 percent of poverty. Medicare beneficiaries turn to a variety of sources for supplemental coverage that pays for prescription drugs. However, as spending on prescription drugs continues to rise, there is concern that drug coverage will erode across all sources, increasing the burden faced by beneficiaries and the pressure on policymakers to devise a workable prescription drug benefit under Medicare.

Financing Medicare. Medicare Parts A (Hospital Insurance) and B (Supplementary Medical Insurance) are financed separately. Revenues from the Hospital Insurance (HI) Trust Fund come primarily from a payroll tax paid by workers and employers. By contrast, Part B's Supplementary Medical Insurance (SMI) Trust Fund is financed by a combination of beneficiary premiums (25 percent) and general tax revenues (almost all of the remainder). As of 2001, the HI Trust Fund is projected under intermediate assumptions to have funds sufficient to pay benefits through 2029, the longest period of projected solvency in the program's history. Part B costs are now rising faster than are those paid by the HI Trust Fund. The aging of the Baby Boom generation, the reduction in the ratio of workers to retirees, and other factors will likely play a role in the debate over additional changes in Medicare's financing in the coming years.

Section I

Medicare's Beneficiaries

Section I: Medicare's Beneficiaries

Medicare is a federally sponsored health insurance program that provides benefits to nearly 40 million beneficiaries. People become eligible when they turn 65 and they or their spouse have paid payroll taxes to Social Security for at least 40 quarters. Others become eligible if they are totally and permanently disabled and have received Social Security Disability Insurance (SSDI) payments for 24 months or if they have end-stage renal disease (ESRD).

The Medicare population is demographically diverse and includes significant numbers of individuals who are financially and/or medically vulnerable. Over half (57 percent) of those enrolled in the program are female, reflecting women's longer life expectancy. Compared to men, older women are three times more likely to be widowed and are more apt to live alone. Currently accounting for 11 percent of the Medicare population, the fastest-growing group of Medicare beneficiaries includes those over 85 who are more likely than younger beneficiaries to need medical care. The disabled and ESRD populations represent 13 percent of all beneficiaries.

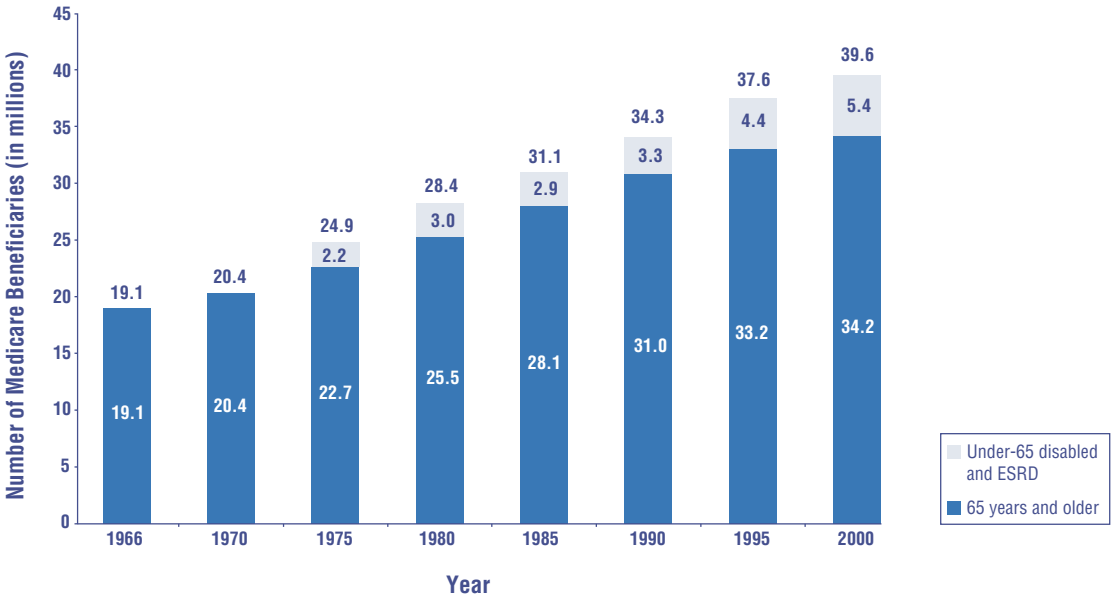
Racial and ethnic minority beneficiaries now comprise about 19 percent of the Medicare population, but are projected to account for 34 percent of all beneficiaries by 2025. The growth in this segment of the Medicare population raises particular challenges for the program as African-American and Latino beneficiaries tend to have greater health needs and lower incomes than their white counterparts.

Twenty-eight percent of all Medicare beneficiaries report being in fair or poor health. Those with disabilities and ESRD, African-American and Hispanic beneficiaries, those dually eligible for Medicare and Medicaid, and those with no supplemental health insurance are more likely to describe their health in this way. Nearly two-thirds of all Medicare beneficiaries live with multiple chronic health conditions. Nearly a quarter have cognitive limitations.

Medicare beneficiaries generally have modest incomes and depend heavily on Social Security as a primary source of income. Twelve percent of Medicare beneficiaries have incomes below 100% of the federal poverty level, while 28 percent have incomes between 100–200% of poverty. Poverty rates also vary greatly among the Medicare population. Beneficiaries who are disabled and under 65, over age 85 (particularly older women), black, or Hispanic are more likely to be poor or near-poor.

Medicare beneficiaries account for a widely ranging share of state populations, from 6 percent in Alaska to 19 percent in Florida. Although those in the Medicare program are generally concentrated in urban regions, 23 percent of all beneficiaries live in rural areas. While Massachusetts, Connecticut, and California have fewer than 5 percent of their beneficiaries in rural areas, rural beneficiaries account for more than 70 percent of the Medicare populations in Montana, South Dakota, and Vermont. Medicare beneficiaries in rural areas face particular challenges given various barriers to access that often characterize delivery systems in less populous areas.

Figure 1
Number of Medicare Beneficiaries, 1966–2000

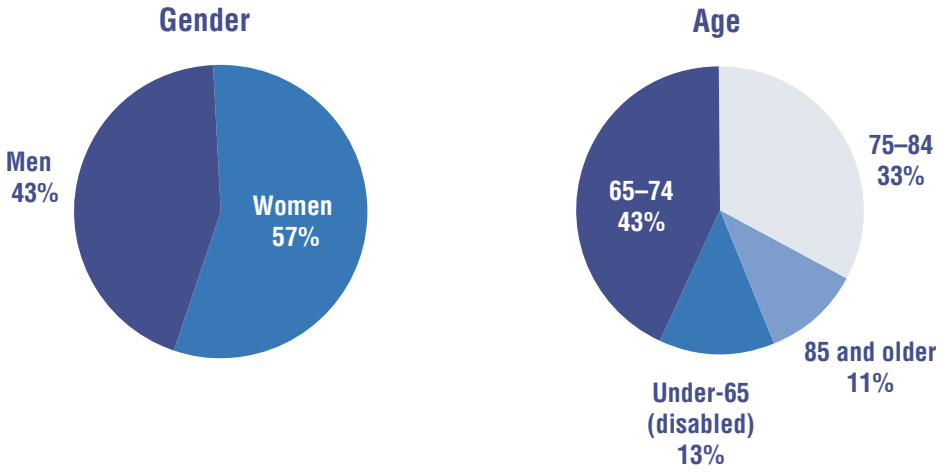


SOURCE: Office of the Actuary, Health Care Financing Administration, November 2000.

Medicare is a federal health insurance program that covers 34 million Americans ages 65 and older and another 5 million persons with permanent disabilities who are under age 65. Enacted in 1965, the program went into operation on July 1, 1966, immediately covering 19.1 million elderly persons ages 65 and over. Prior to 1966, only about half of all older persons had health insurance. In 1972, Congress extended eligibility for Medicare to permanently disabled people who have received Social Security Disability Insurance (SSDI) payments for two years and to individuals with end-stage renal disease (ESRD) (P.L. 92-603).

With the aging and growth of the population, the number of beneficiaries more than doubled between 1966 and 2000 and is projected to double yet again, with the Medicare population estimated at 77 million in 2030.

Figure 2
Gender and Age of the Medicare Population, 1999



SOURCE: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

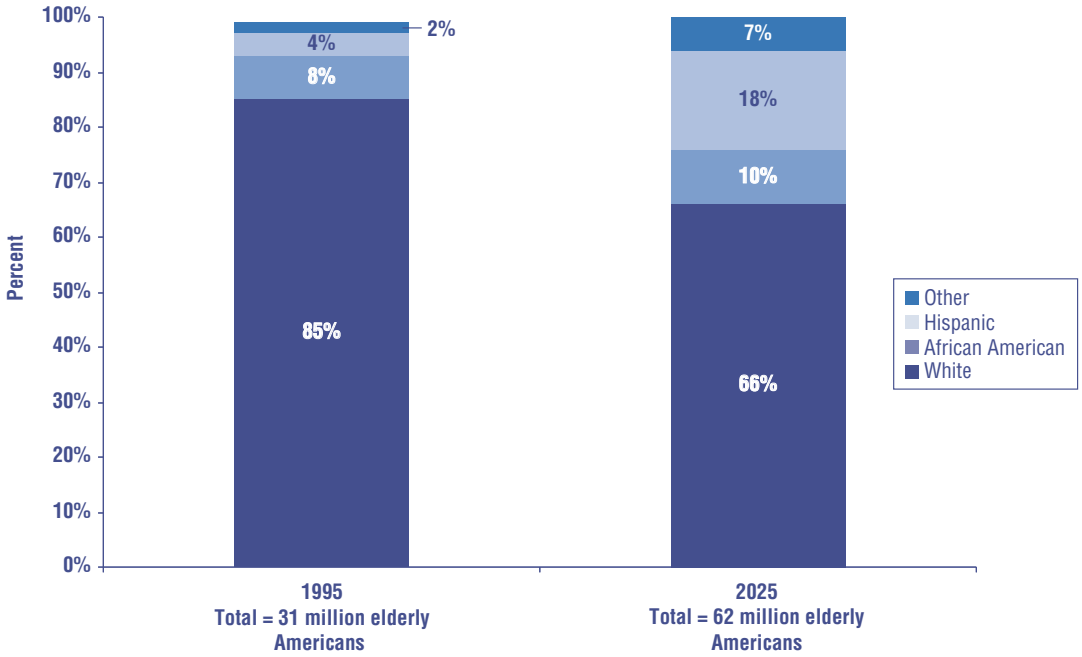
More than half (57 percent) of all Medicare beneficiaries are women, reflecting the fact that their life expectancy at birth is, on average, seven years longer than men's and that they therefore rely on Medicare for a longer period of time. Women account for an even larger share (72 percent) of those ages 85 and older. Compared with men, older women are three times more likely to be widowed and are far more apt to live alone.

Today, 43 percent of all Medicare beneficiaries are between 65 and 74 years old and 11 percent are 85 or older. Those who are 85 or older are the fastest-growing age group among elderly Medicare beneficiaries. Between 1990 and 1996, the population growth of people age 85 or over averaged 3.4 percent a year, compared with 1.1 percent a year for people ages 65–84.[1] About 13 percent of all beneficiaries are under 65 and eligible for Medicare because they are totally and permanently disabled or have end-stage renal disease (ESRD). The number of beneficiaries under age 65 grew at an average rate of 6.4 percent a year between 1990 and 1996, compared with 1.3 percent for elderly beneficiaries.[2]

[1]Based on data for the total elderly population from the U.S. Bureau of the Census.

[2]Based on data from the Health Care Financing Administration, Office of the Actuary, January 1997.

Figure 3
Race and Ethnicity of the Medicare Population, 1995 and 2025

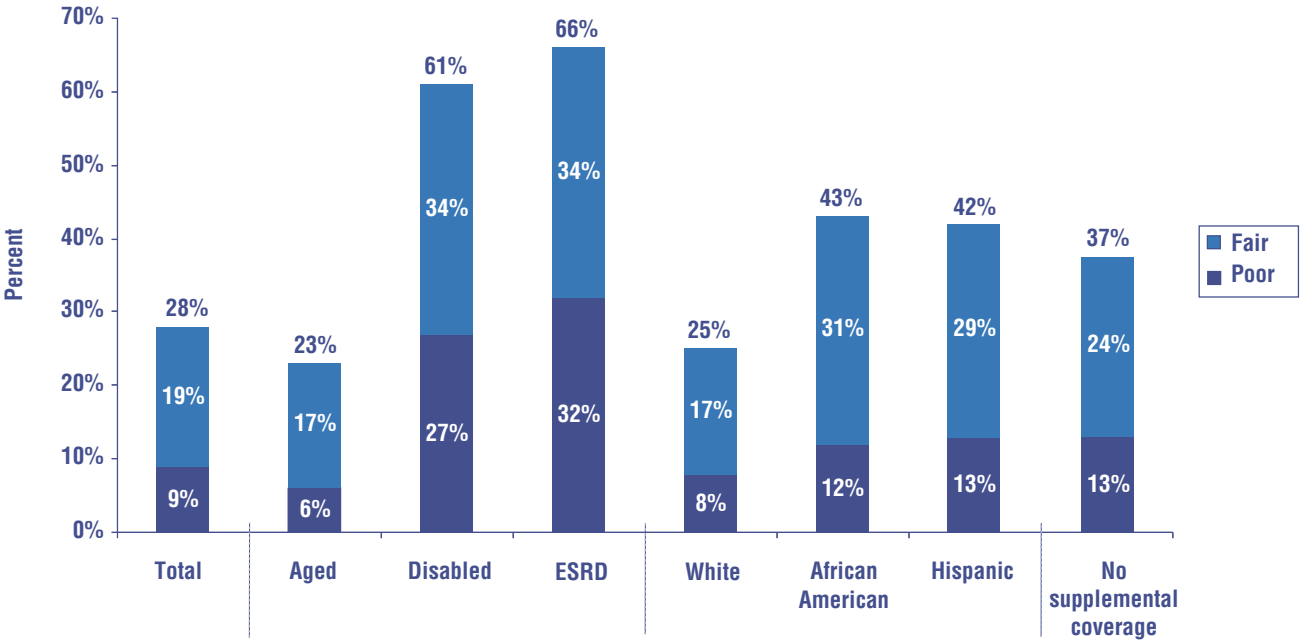


Note: "Other" includes Asian-Pacific Islanders, American Indians, Eskimos, and Aleuts. Numbers may not add up to 100% due to rounding.
SOURCE: The Henry J. Kaiser Family Foundation, *Faces of Medicare,* 1999; U.S. Bureau of the Census Projections, Current Population Survey, 1995.

One of Medicare's major achievements has been helping to ensure mainstream medical care for most elderly and many disabled Americans, especially those who are African-American, Hispanic, and other racial and ethnic minority beneficiaries. Today, minorities account for one in seven Medicare beneficiaries. Racial and ethnic minority beneficiaries are projected to more than double as a share of the Medicare population—from 14 percent to 35 percent—growing from 4.7 million in 1995 to 21 million in 2025. This trend has particular implications for the Medicare program as racial and ethnic minority beneficiaries tend to have more health problems than do white beneficiaries. While 45 percent of African-American beneficiaries and 42 percent of Hispanic beneficiaries assess their own health as fair or poor, only 26 percent of white beneficiaries do so.

Medicare has a strong track record in improving access to care for racial and ethnic minority beneficiaries. However, there is evidence that this segment of the Medicare population continues to receive disparate medical treatment, regardless of income or other socio-economic characteristics. Elderly African Americans receive fewer preventive services such as mammograms and flu shots than do white beneficiaries, and are less likely to have certain elective surgery procedures. In 1993, for instance, elderly African Americans were 60 percent less likely than white beneficiaries to have heart bypass surgery (Gornick, et al., 1996).

Figure 4
Self-Reported Health Status of Non-Institutionalized Medicare Beneficiaries, by Selected Characteristics, 1999



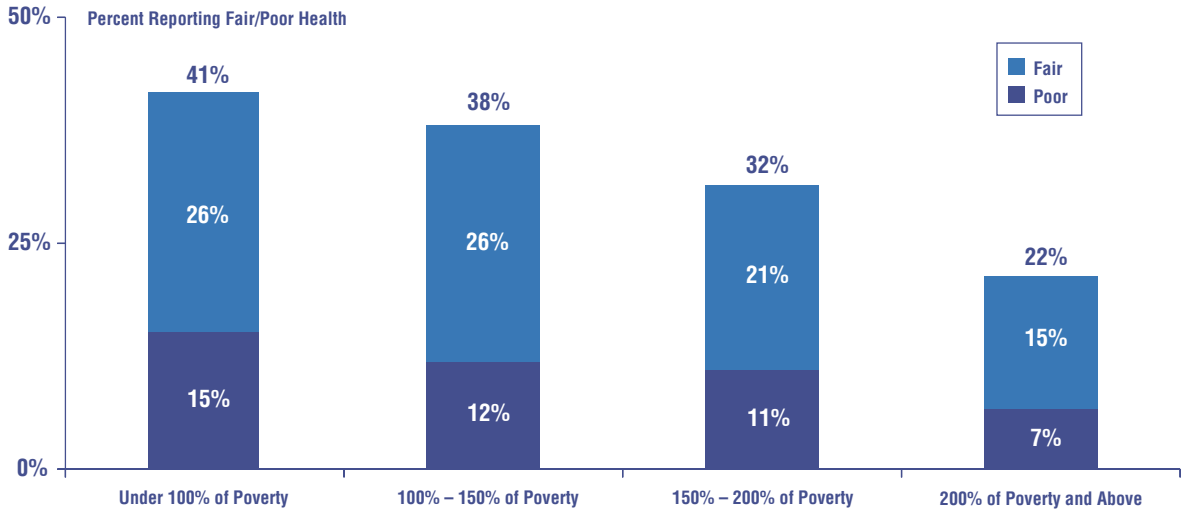
Note: Excludes institutionalized beneficiaries.

SOURCE: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

More than a quarter (28 percent) of non-institutionalized Medicare beneficiaries report being in fair or poor health, with the remaining 72 percent reporting excellent, very good, or good health.

However, certain subgroups of the Medicare population are far likelier to report being in fair or poor health than are others: Sixty-one percent of disabled Medicare beneficiaries, 66 percent of Medicare beneficiaries with end-stage renal disease (ESRD), 43 percent of African-American beneficiaries, 42 percent of Hispanic beneficiaries, and 37 percent of beneficiaries with no supplemental insurance report being in fair or poor health.

Figure 5
Self-Reported Health Status of Non-Institutionalized Medicare Beneficiaries, by Poverty Status, 1998



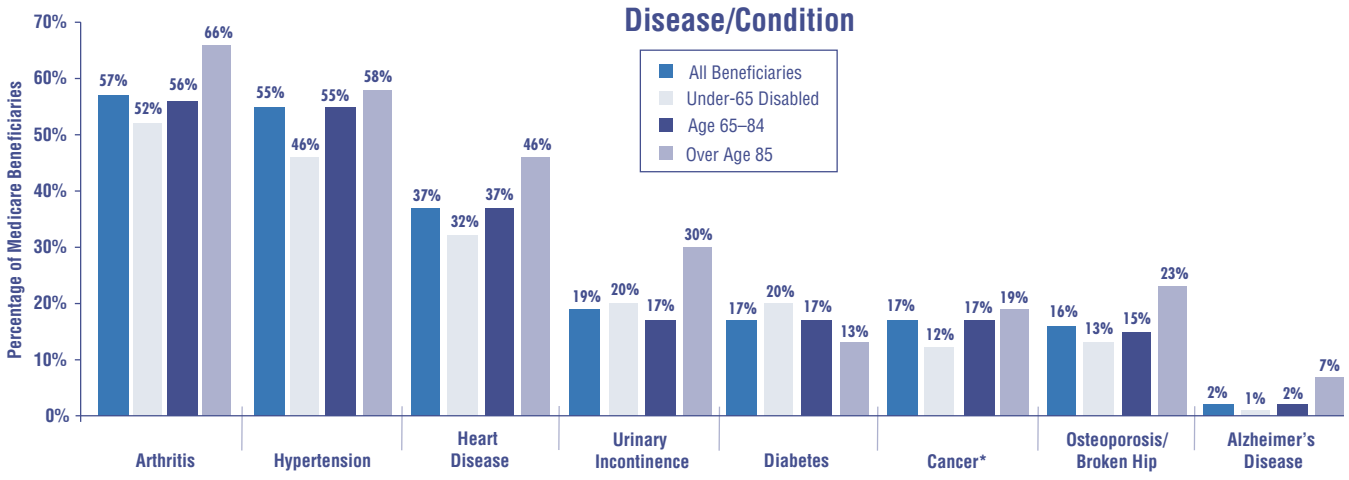
Note: The federal poverty level was $8,050 for an individual and $10,850 for a couple in 1998.

SOURCE: M. Moon, The Urban Institute (analysis of 1998 Medicare Current Beneficiary Survey).

Medicare beneficiaries with lower incomes are generally in poorer health than their wealthier counterparts. While 41 percent of those living under the poverty level describe their own health as either poor (15 percent) or fair (26 percent), only 22 percent of those with incomes above twice the poverty level do so.

Poor health is a particular concern for those with limited financial resources as they—especially the near-poor living just above the poverty line who often do not qualify for Medicaid—are less likely to have health insurance to cover the cost of health-care services.

Figure 6
Chronic Conditions Among Non-Institutionalized Medicare Beneficiaries, 1999



*Excludes skin cancer.

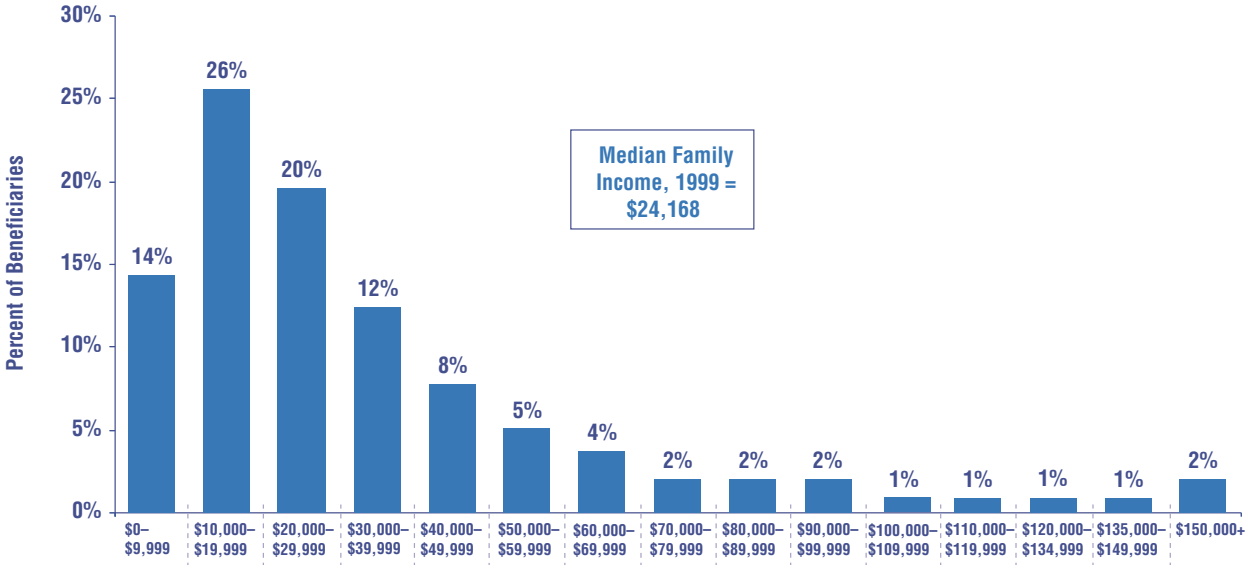
Note: Excludes institutionalized beneficiaries.

SOURCE: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

Many Medicare beneficiaries report that they live with one or more chronic illnesses, reflecting the widespread need for medical services within this population. The most common chronic conditions among Medicare beneficiaries are arthritis (found among 57 percent of beneficiaries) and hypertension (found among 55 percent of beneficiaries).

While the prevalence of many conditions increases with age (e.g., arthritis, hypertension, and heart disease), others are more associated with disabilities that qualify younger beneficiaries for Medicare (e.g., diabetes). The prevalence of some conditions does not increase dramatically with age because many beneficiaries with them tend to die at an earlier age than do those without them.

Figure 7
Family Income of Medicare Beneficiaries, 1999



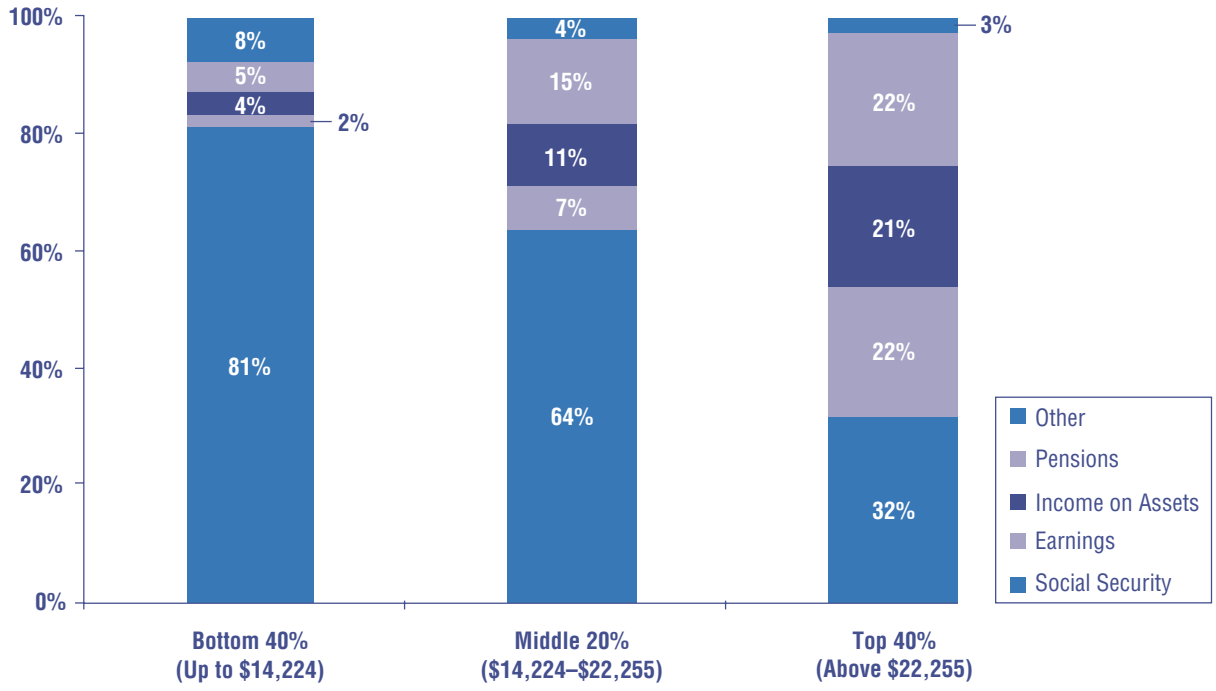
Note: Family income defined as income for individuals and their spouses (if applicable). Numbers may not total to 100% due to rounding.

SOURCE: The Urban Institute (analysis of 2000 Current Population Survey (excludes institutionalized beneficiaries)).

The majority of Medicare beneficiaries live on modest family incomes. In 1999, one in seven (14 percent) non-institutionalized beneficiaries was living on a family income of less than $10,000, while about one-half (51 percent) had incomes below $25,000. Income also declines with age among Medicare's elderly. In 1999, while the median family income among all elderly beneficiaries was $24,817, it declined from $30,194 (among those ages 65 to 69) to $17,287 (among beneficiaries over age 85).

Elderly women generally have lower incomes then do elderly men. The mean income for women ages 65 and over was $15,615 in 1999, whereas it was $29,171 among men of the same age.

Figure 8
Sources of Income Among Single and Married Elderly Beneficiaries, 1998

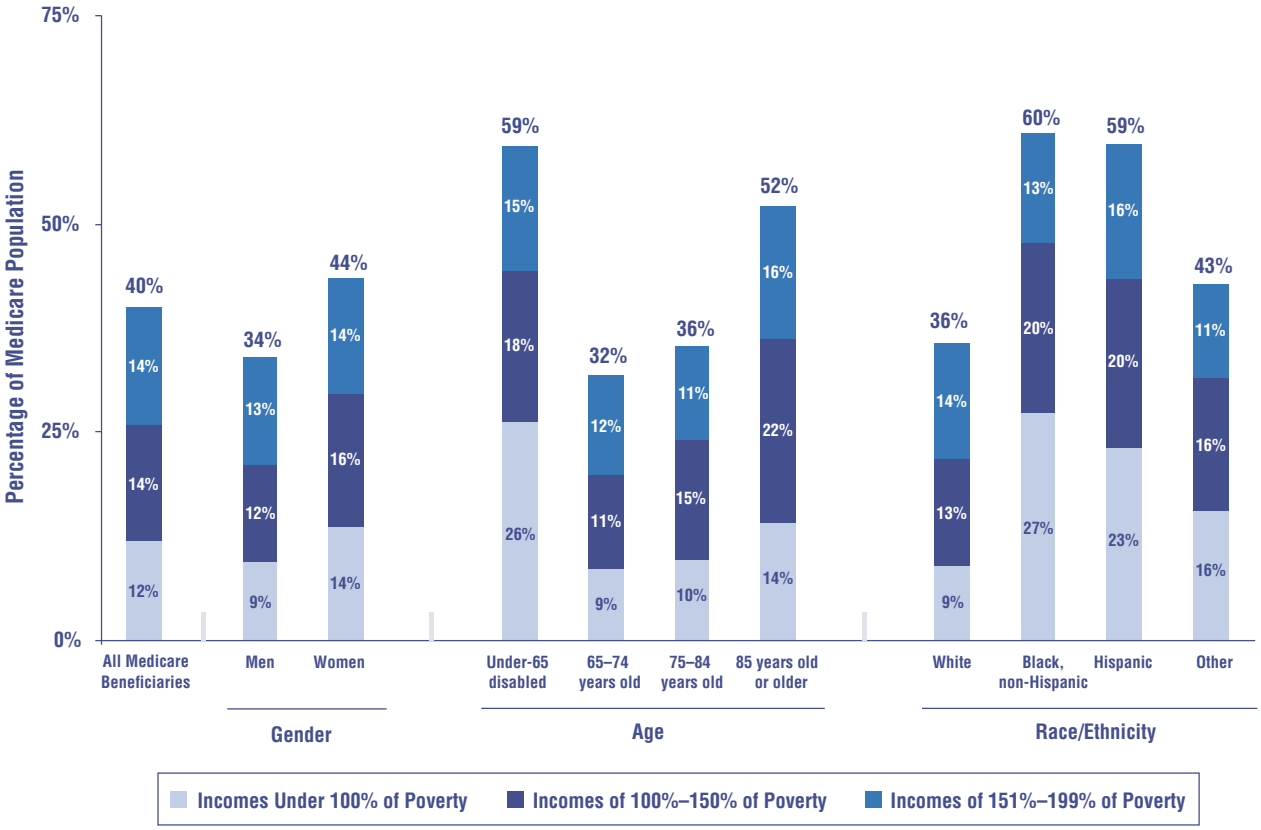


Note: Numbers may not add up to 100% due to rounding.

SOURCE: Social Security Administration, *Income of the Population 55 or Older,* March 2000.

Most Medicare beneficiaries—particularly those in the lowest-income segments of the population—rely on Social Security for the bulk of their income and are especially vulnerable to the high and rising costs of health-care services. For the 40 percent of Medicare beneficiaries with the lowest incomes (i.e., under $14,224), Social Security comprised 81 percent of their incomes on average in 1998, while pensions provided just 5 percent. Among beneficiaries with incomes in the top 40 percent (i.e., above $22,255), Social Security represented slightly less than a third of their incomes on average, while pensions comprised 22 percent of income.

Figure 9
Poverty Among the Medicare Population, 1999



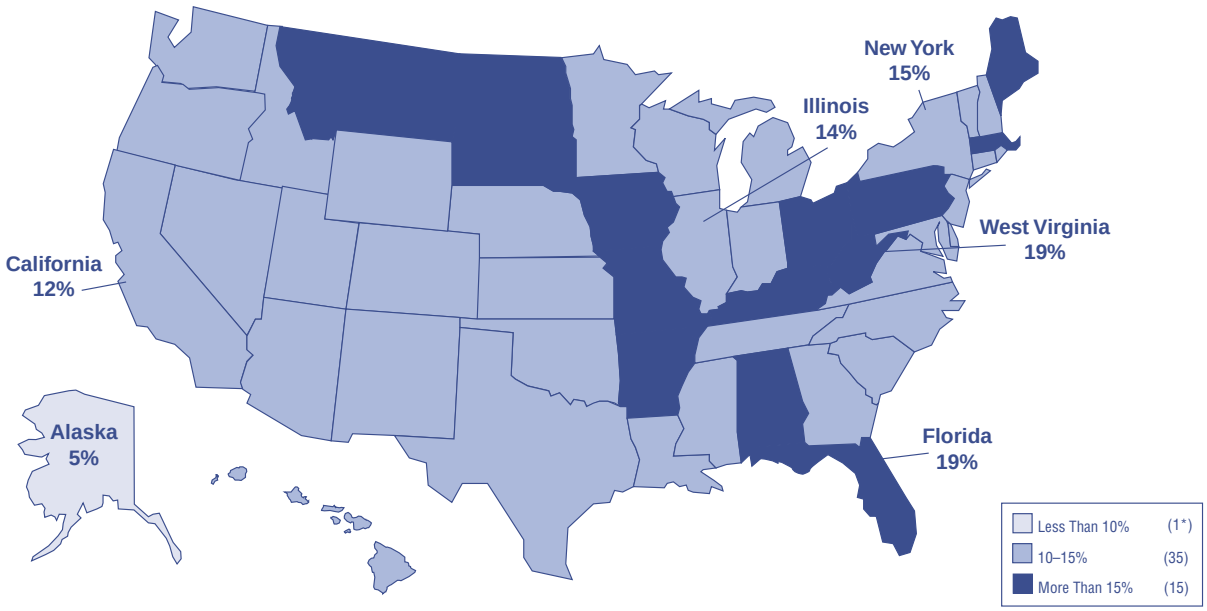
Note: The federal poverty level was $8,240 for an individual and $11,060 for a couple in 1999.

SOURCE: The Urban Institute (analysis of 2000 Current Population Survey (excludes institutionalized beneficiaries)).

Four in ten Medicare beneficiaries have an income below twice the federal poverty level—or, $16,480 for an individual and $22,120 for a couple in 1999. Poverty rates vary greatly among different segments of the Medicare population. Women, the under-65 disabled, those ages 85 and older, and African-American and Hispanic beneficiaries are more likely than others to have low incomes. Among under-65 disabled and African-American and Hispanic beneficiaries, about 6 in 10 beneficiaries have incomes below 200% of the poverty level.

Low-income beneficiaries tend to have more health problems than do their higher-income counterparts, suggesting that those least able to afford health-care services are often most in need of them.

Figure 10
Medicare Beneficiaries as a Percentage of State Populations, 1998

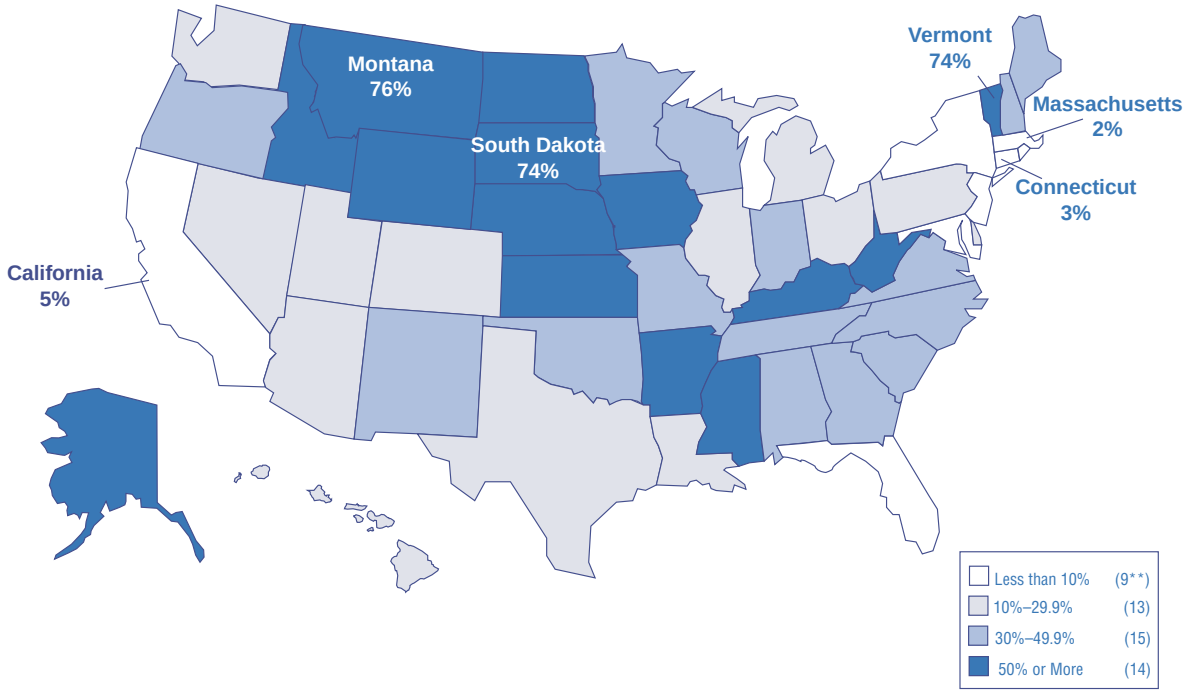


*Includes the District of Columbia.

SOURCE: Office of the Actuary, Health Care Financing Administration, February 2001.

In 1998, Medicare beneficiaries represented 14 percent of the U.S. population. However, the share of each state's population that is covered by Medicare both varies widely—ranging from 5 percent in Alaska to 19 percent in both Florida and West Virginia in 1997—and is projected to increase substantially in the future. This demographic trend and variations in the age distribution of each state's elderly population have significant implications for the health and long-term care needs of beneficiaries living within each state as well as for state health-care delivery systems.

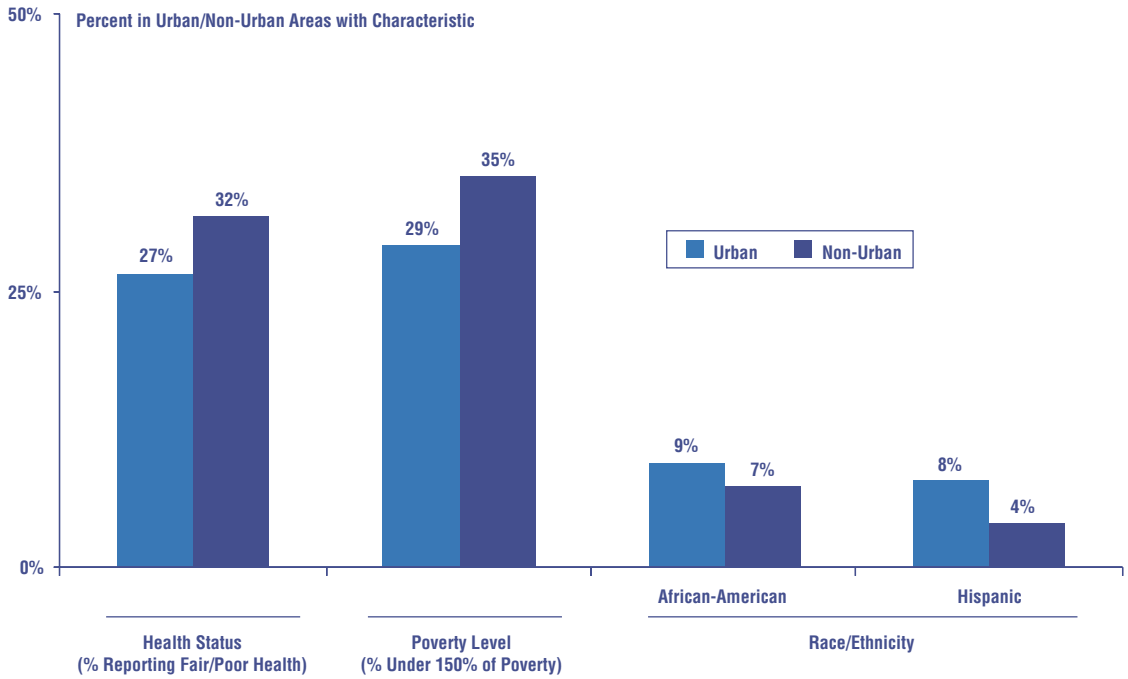
Figure 11
Percentage of Medicare Beneficiaries Residing in Rural Areas,* by State, 1998



*'Rural': Living outside of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. **Includes the District of Columbia.
Note: There are no areas defined as 'rural' in New Jersey, Rhode Island, and the District of Columbia.
SOURCE: Office of Information Services, Office of Strategic Planning, Health Care Financing Administration, May 2001.

Overall, 23 percent of Medicare beneficiaries live in rural areas. However, the share of each state's Medicare population that lives in rural regions varies dramatically across states. Fourteen states have more than half of their Medicare populations living in rural areas, with the states with the highest shares of rural beneficiaries being Montana (76 percent), South Dakota (74 percent), and Vermont (74 percent). This variation has implications for both states and beneficiaries given the challenge of maintaining hospitals, health plans, physicians, and other health care providers in rural areas. Beneficiaries living in rural areas tend to be poorer and less healthy than those living in urban areas.

Figure 12
Characteristics of Non-Institutionalized Medicare Beneficiaries in Urban and Non-Urban Areas,* 1998



*'Urban': Living within a (MSA) as defined by the Office of Management and Budget.

SOURCE: M. Moon, The Urban Institute (analysis of 1998 Medicare Current Beneficiary Survey).

Medicare beneficiaries living outside of urban areas are more likely to have health problems and low incomes than are those in metropolitan areas. For instance, while slightly more than a quarter (27 percent) of beneficiaries in urban areas describe their own health as fair or poor, almost a third (32 percent) of those in non-urban areas do so.

While 29 percent of urban beneficiaries have incomes below 150 percent of the poverty level, 35 percent of those in non-urban areas have incomes of this level.

These disparities pose particular challenges for beneficiaries living in the most rural regions of the country, where access to care is often a problem due to the nature of their delivery systems and a disproportionate share of the Medicare population is over age 85. In North Dakota, for example, where 67 percent of the state's Medicare population resides in rural areas, 14 percent of beneficiaries are ages 85 or older (compared to 11 percent nationwide).

Section II

Utilization of Benefits and Spending

Section II: Utilization of Benefits and Spending

Medicare Part A, the Hospital Insurance (HI) program, covers inpatient hospital services, short-term care in skilled nursing facilities (SNFs), post-acute home health care, and hospice care. Medicare Part B, the Supplementary Medical Insurance (SMI) program, covers physician services, outpatient hospital services, x-rays, and laboratory and other ambulatory services. In addition, there is a new Medicare Part C, the Medicare+Choice program, which pays HMOs and other private plans to provide Medicare services (both Part A and Part B).

Part B costs are currently rising faster than are those of Part A due to both higher rates of growth in the costs of Part B services and the gradual shift of some home health services from Part A to Part B. While Part A expenditures are projected to rise by 64 percent between 2001 and 2011, Part B spending is expected to increase by 88 percent over the same period.

Medicare represented about 18 percent of the nation's $1.21 trillion in health care expenditures in 1999. It accounts for almost a third of all hospital payments in the country, over a quarter of all home health care, and a fifth of payments for physician services. In FY 2001, Medicare represents 13 percent of the $1.85 trillion federal budget. It is the second largest domestic program (after Social Security).

Total Medicare payments averaged just under $5,000 per beneficiary in 1998. However, the distribution of spending across the Medicare population is highly skewed. While 41 percent of beneficiaries are responsible for less than $500 in Medicare spending in any year (representing about 1 percent of all Medicare spending), about 6 percent use more than $25,000 in services and account for half of all program spending.

Medicare's costs have generally tracked those in the private health insurance market, although there have been sustained periods in which Medicare cost growth was either higher or lower than that of private health insurance. In the period after the Balanced Budget Act of 1997, Medicare actually experienced negative cost growth.

In any given year, most beneficiaries use at least one Medicare service, with physician office visits being the most common (74 percent of beneficiaries). In 1998, 18 percent of beneficiaries had at least one hospital stay with an average duration of 6.1 days. The growth in Medicare spending for different types of services has reflected changes in the practice of medicine and the way in which such services are paid for. Over time, spending on inpatient hospital stays has fallen from 87 percent of total Medicare benefit payments in 1966 to 41 percent in 1999. Physician services, outpatient hospital visits, and other Part B services have increased correspondingly as a share of total benefit payments over the same period (from 12 percent to 30 percent).

Figure 13
Medicare Benefits and Cost-Sharing Requirements, 2001

SERVICES	BENEFICIARY COST-SHARING
Part A (Hospital Insurance Program)*	
Deductible	$792 per inpatient hospital episode
Inpatient Hospital: Semiprivate room, board, general nursing, and other hospital services and supplies for treatment of illness or injury	Days 1–60 covered subject to the deductible, $198/day coinsurance for days 61–90, and $396/day for 60 lifetime reserve days
Skilled Nursing Facility (SNF): For beneficiaries who need daily skilled nursing or rehabilitation services and are admitted to a SNF within 30 days following a hospital stay of at least three days, benefit covers semiprivate room, board, and services	No coinsurance for the first 20 days, for days 21–100, $99/day coinsurance
Home Health Care: For homebound beneficiaries needing skilled care, covers part-time or intermittent skilled nursing, therapy, home health aide services, and supplies**	None
Hospice Care: Terminally ill beneficiaries with a prognosis of six months or less may elect to receive hospice services rather than standard Medicare benefits	Nominal coinsurance for outpatient drugs and inpatient respite care
Part B (Supplementary Medical Insurance Program)	
Premium	$50/month ($600/year)
Deductible	$100 annually***
Physician and Other Medical Services: Medically necessary doctor's services, medical and surgical supplies, physical and speech therapy, diagnostic tests, and durable medical equipment	Coinsurance of 20% of the approved amount (beneficiaries may also be required to pay charges that exceed the approved amount by up to 15%)
Outpatient Hospital Care	20% of the national median charge, adjusted by the area wage index
Ambulatory Surgical Services	20% of the approved amount
Clinical Diagnostic Laboratory Services	None
Outpatient Mental Health Services	50% of the approved amount
Preventive Services: Annual mammography, pelvic exams, prostate examinations, and colorectal cancer screening. Diabetes outpatient self-management, bone mass measurement (high-risk beneficiaries only), hepatitis B vaccine (high-risk beneficiaries only), and glaucoma screening (high-risk beneficiaries only)	20% of the approved amount
Biennial pap smear, pneumococcal vaccine, flu shot, annual clinical laboratory prostate screening	No coinsurance

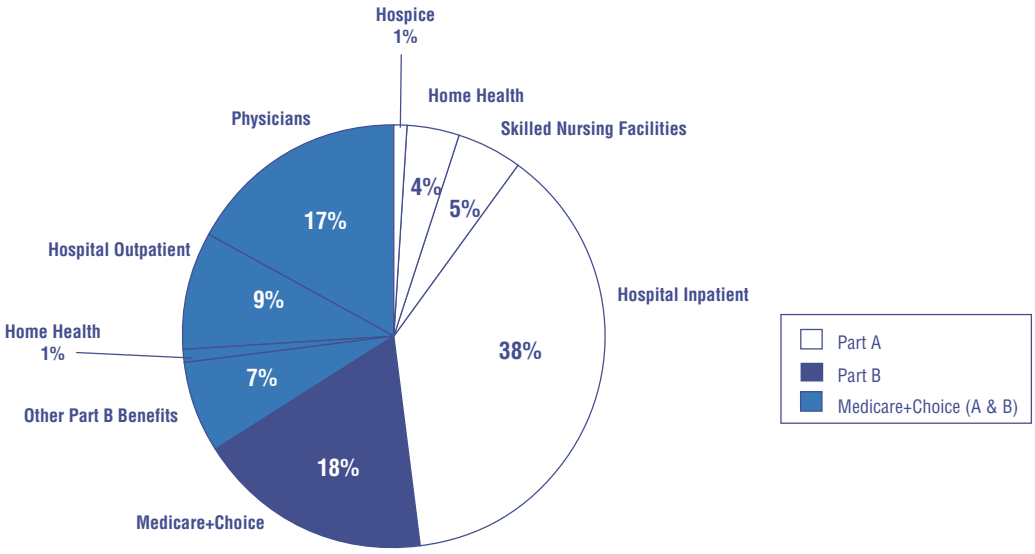
*Part A coverage is available on a voluntary basis to individuals ages 65 and older who are not otherwise legally entitled, provided they meet certain requirements and pay the monthly premium ($300/month in 2001).

**The Balanced Budget Act of 1997 gradually shifted some home health expenditures from Part A to Part B over a five-year period ending in 2002. Part A covers up to 100 visits following an institutional stay.

***The Part B deductible does not apply to pneumococcal vaccine; flu shot; or clinical, preventive, and diagnostic laboratory services.

SOURCE: Health Care Financing Administration, *Medicare and You,* 2001.

Figure 14
Medicare Benefit Payments, by Type of Service, 2001



Total Medicare Benefit Payments, FY 2001 = $237 Billion*

*Excludes administrative expenses.

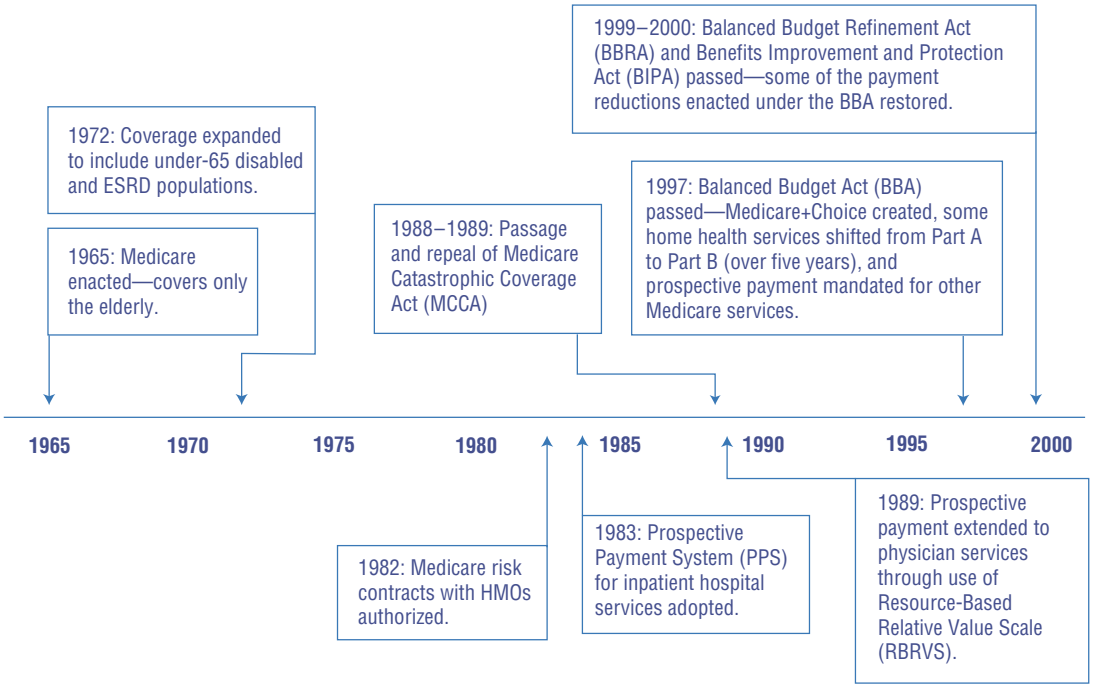
SOURCE: Congressional Budget Office, April 2001 Baseline.

According to Congressional Budget Office estimates, total Medicare benefits spending in 2001 is estimated to be $237 billion.

The two largest categories of Medicare benefit payments are inpatient hospital services (38 percent), followed by physician services (17 percent). Including Part B payments for services in hospital outpatient departments, hospitals receive just less than one-half of all Medicare payments (48 percent).

Managed care organizations participating in the Medicare+Choice program receive about 18 percent of Medicare benefit payments. Home health, skilled nursing facilities, and hospice care together accounted for 11 percent of benefit payments, down from 16 percent in 1997. This decrease is due primarily to changes in home health payments, which have declined from 9 percent to 4 percent as a share of total Medicare benefit payments since 1997 (see Figures 27 and 28).

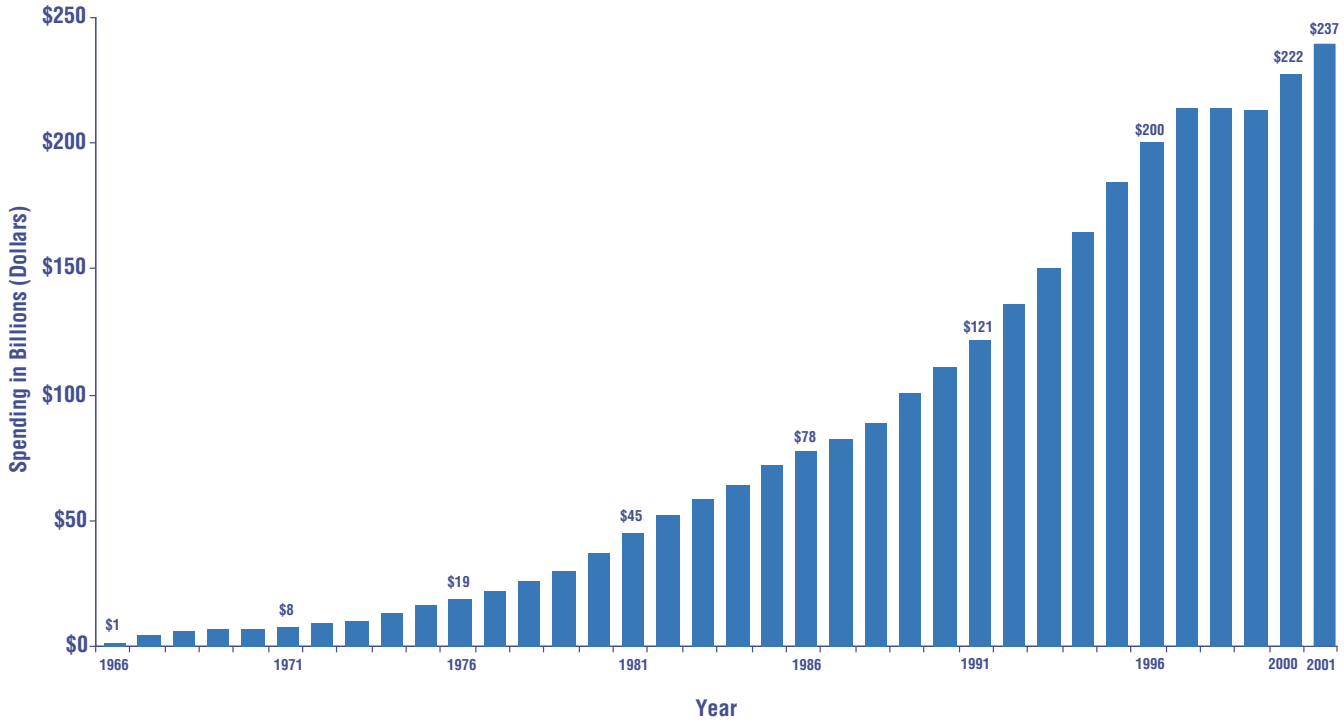
Figure 15
Medicare's Milestones: An Overview of Medicare's Legislative History, 1965–2001



Over the course of its history, Medicare has undergone several legislative changes that have defined the population covered by the program; the benefits to which they are entitled; and the manner in which physicians, hospitals, and skilled nursing facilities are paid for the services they provide.

Medicare has moved from reimbursing providers for their "usual, customary, and reasonable" costs to a series of payment formulas that prospectively set reimbursement levels for each encounter or use of a service. In 1983, Congress adopted the prospective payment system (PPS) that reimburses hospitals for individual Medicare patients' hospital stays based on diagnosis-related groups (DRGs). In 1989, Congress extended prospective payment to physicians by establishing a fee schedule for their services based on a resource-based relative-value scale (RBRVS), which was designed to take into account the complexity and length of time required on the part of physicians to perform various services as well as practice expenses. Other major changes include the creation of the Medicare+Choice program, which facilitated the enrollment of Medicare beneficiaries in managed care plans, and the adoption of prospective payment for outpatient and rehabilitation hospitals, skilled nursing facilities (SNFs), and home health services.

Figure 16
Medicare Spending, 1966–2001

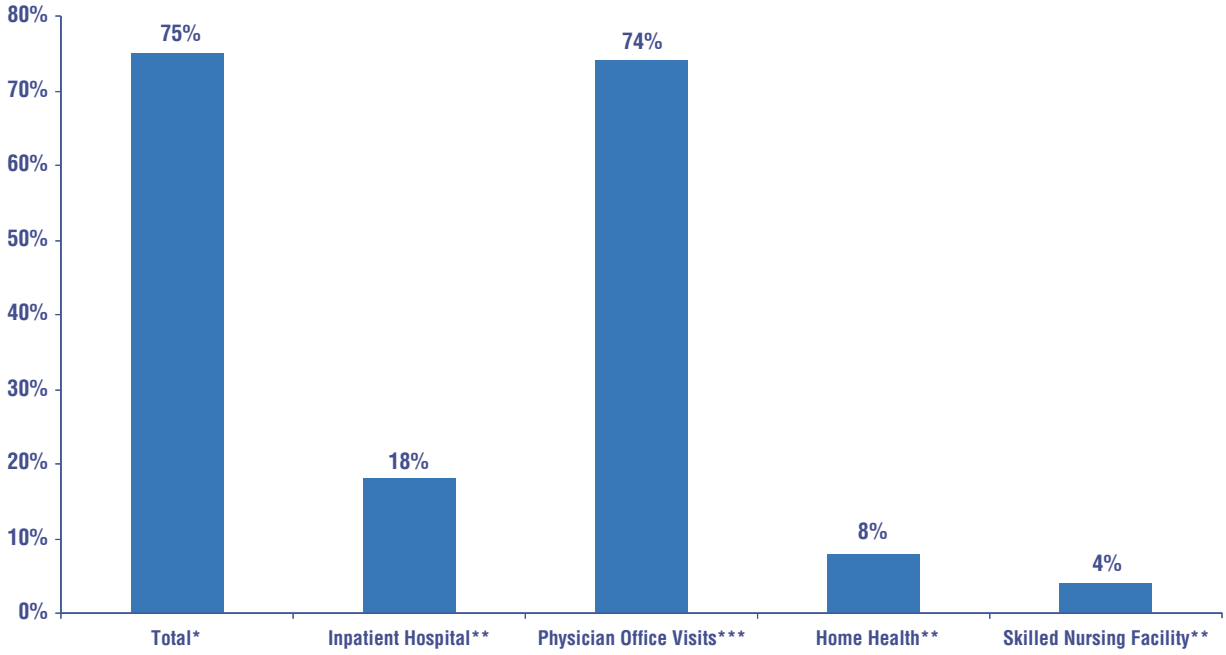


SOURCE: Medicare and Medicaid Cost Estimates Group, Office of the Actuary, Health Care Financing Administration, March 2001; Congressional Budget Office, April 2001 Baseline (for 2001).

Total Medicare spending (benefit payments and all other expenses) increased each year between 1966 and 1997, reaching $213.6 billion in 1997. After dropping slightly in 1998 and 1999 for the first time in the history of the program, spending increased to $222 billion in 2000, and is estimated by the Congressional Budget Office to reach $237 billion in 2001.

According to the 2001 Report of the Trustees of the Medicare Trust Funds, the recent slowdown in Medicare spending growth is due to changes in provider payment policies enacted under the Balanced Budget Act, reductions in the use of home health and skilled nursing facility services, efforts to reduce fraud and abuse within the program, and the slowdown in health-care costs overall.

Figure 17
Percentage of Medicare Beneficiaries Using Selected Services, 1998



*Percent of beneficiaries with Hospital Insurance (HI) and/or Supplementary Medical Insurance (SMI) who used any service.

**Percent of beneficiaries with HI who used the service.

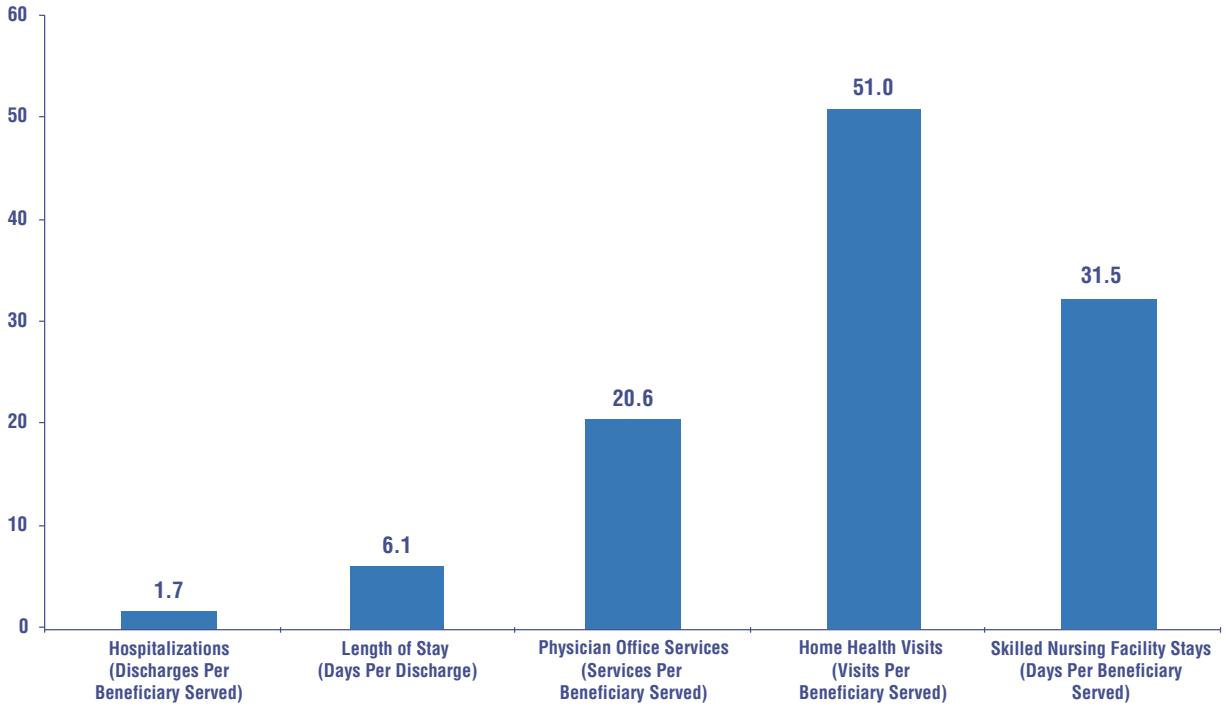
***Percent of beneficiaries with SMI who used the service.

SOURCE: Health Care Financing Administration, March 2001.

Most Medicare beneficiaries (75 percent) use at least one Medicare service during the course of a year. Services provided in a physician's office are the most common, with 74 percent of beneficiaries using this benefit. In 1998, 18 percent of beneficiaries had at least one inpatient hospital stay paid for by Medicare, 8 percent used Medicare home health services, and 4 percent had a stay in a Medicare skilled nursing facility.

According to the 2001 Trustees' Report, 22 percent of all Medicare beneficiaries currently use Part A services, while 87 percent use Part B services.

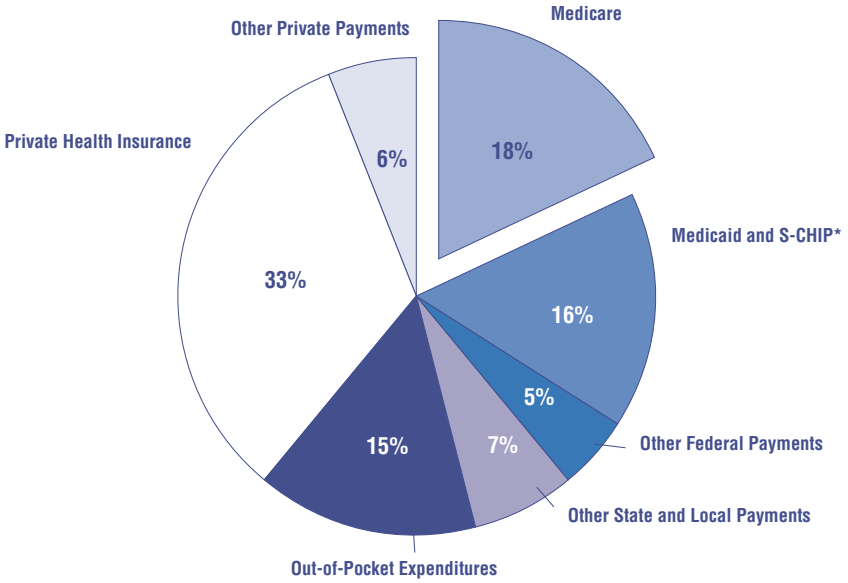
Table 18
Utilization of Selected Medicare Services, 1998



SOURCE: Health Care Financing Administration, March 2001.

The 18 percent of Medicare beneficiaries using inpatient hospital services in 1998 averaged 1.7 hospital stays, with an average length of stay of 6.1 days. Beneficiaries who visited a physician's office used services relatively intensely, with an average of 20.6 physician office services per beneficiary receiving such services. Similarly, those using home health services received 51.0 visits on average, and those with a stay in a skilled nursing facility spent 31.5 days there on average in 1998.

Figure 19
National Health Expenditures in the United States, by Source of Payment, 1999



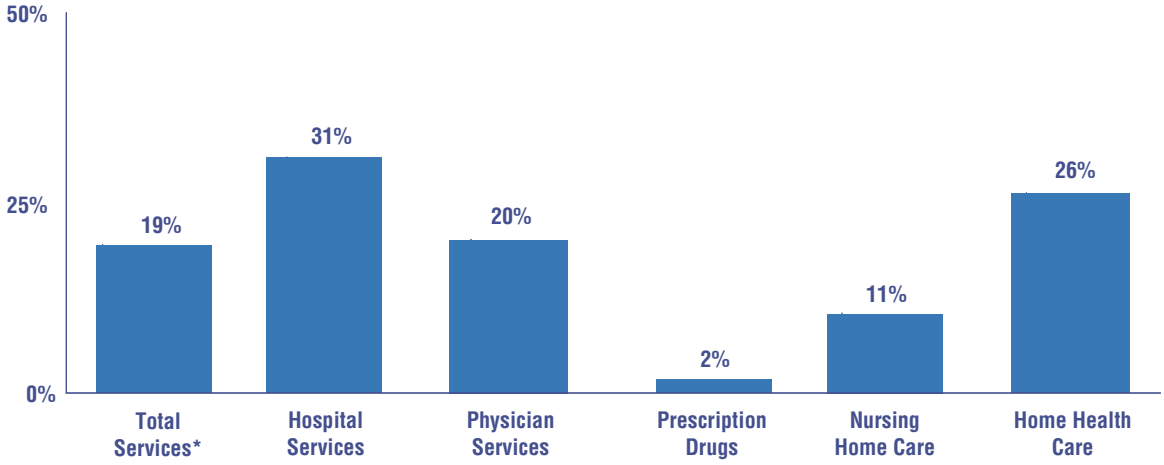
Total National Health Expenditures, 1999 = $1.21 Trillion

*Medicaid and S-CHIP include funds from both federal and state governments. S-CHIP is the Title XIX State Children's Health Insurance Program.
SOURCE: S. Heffer, 2001.

Health care expenditures in the United States have grown over time, totaling $1.21 trillion dollars in 1999. Medicare represented about 18 percent ($214 billion) of this spending. Medicaid and the State Children's Health Insurance Program (S-CHIP), which are financed by both federal and state governments, together constituted about 16 percent ($188 billion) of health expenditures.

Of the remaining funds, private health insurance paid for about a third ($401 billion); consumers paid about 15 percent ($187 billion) out-of-pocket; other federal, state, and local government payments represented an additional 12 percent ($147 billion); and other private payments represented the final 6 percent ($74 billion).

Figure 20
Medicare's Share of National Personal Health Expenditures, by Type of Service, 1999



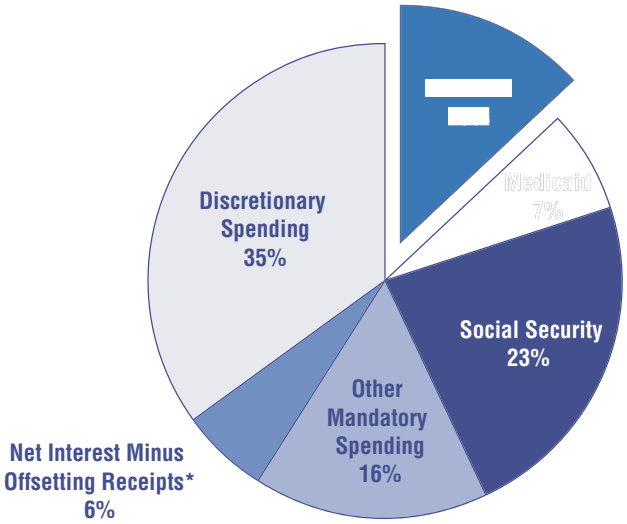
	(Expenditures in Billions)					
Medicare	$205.9	$121.4	$54.7	$2.0	$9.6	$8.7
Total	$1,057.7	$390.9	$269.4	$99.6	$90.0	$33.1

*'Total services' also includes dental care and other professional services.

SOURCE: Office of the Actuary, Health Care Financing Administration, March 2001.

Overall, Medicare is responsible for almost one-fifth of the $1.1 trillion in personal health care expenditures in the United States, which do not include the costs of program administration, investments in research and construction, and other public health activities. However, Medicare's share varies by type of service, reflecting both the benefits covered by Medicare and the use of particular services among the Medicare population. For example, Medicare pays for 31 percent of all hospital expenditures and 26 percent of home health expenditures. However, Medicare pays for only 2 percent of all prescription drug costs, reflecting the fact that the traditional fee-for-service Medicare program does not include an outpatient pharmaceutical benefit.

Figure 21
Medicare Spending as a Share of the Federal Budget, 2001 (Estimated)



Total Federal Budget = $1.85 Trillion, FY 2001

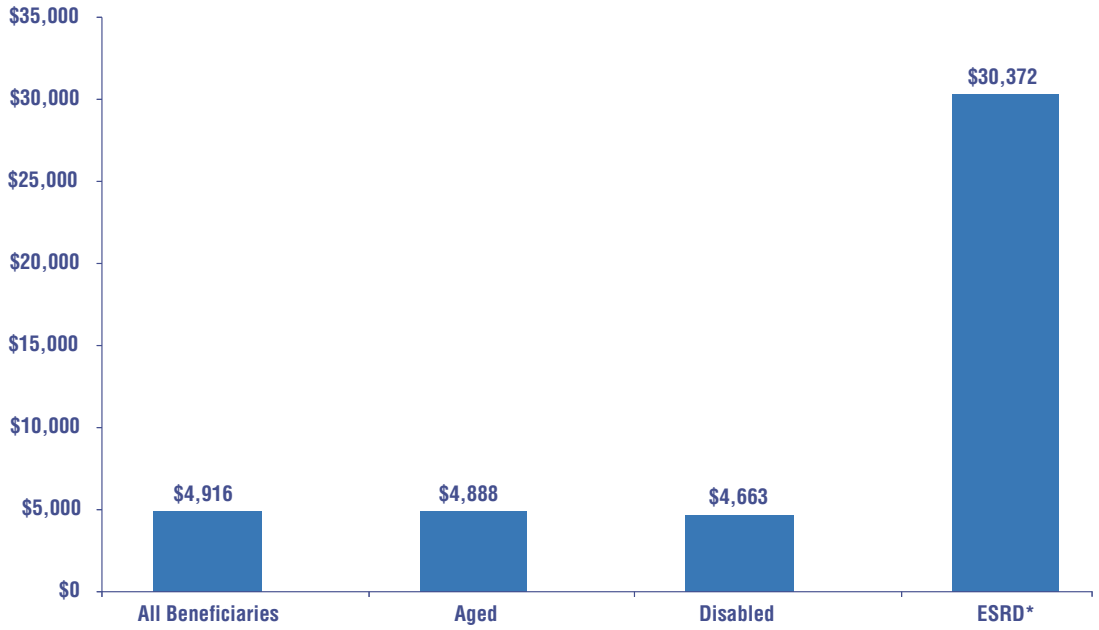
*Includes $205 billion in net interest on the federal government's debt minus $87 billion in fees and other charges that are collected without annual appropriations action.

SOURCE: Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2002–2011.*

Federal spending for fiscal year (FY) 2001 is projected to be $1.85 trillion. Medicare is expected to spend $237 billion, representing about 13 percent of the total federal budget. By comparison, Social Security is the single largest program in the federal budget and is expected to total 23 percent of the federal budget ($430 billion) in 2001.

Federal Medicaid spending accounts for 7 percent ($130 billion) of the budget. Other mandatory federal spending (e.g., other retirement and disability programs, unemployment compensation, and farm price supports) represents another 16 percent ($296 billion). Discretionary spending—which includes funding for a broad array of programs, including defense, transportation, education, and public health—represents 35 percent ($646 billion).

Figure 22
Medicare Spending Per Beneficiary, by Eligibility Category, 1998

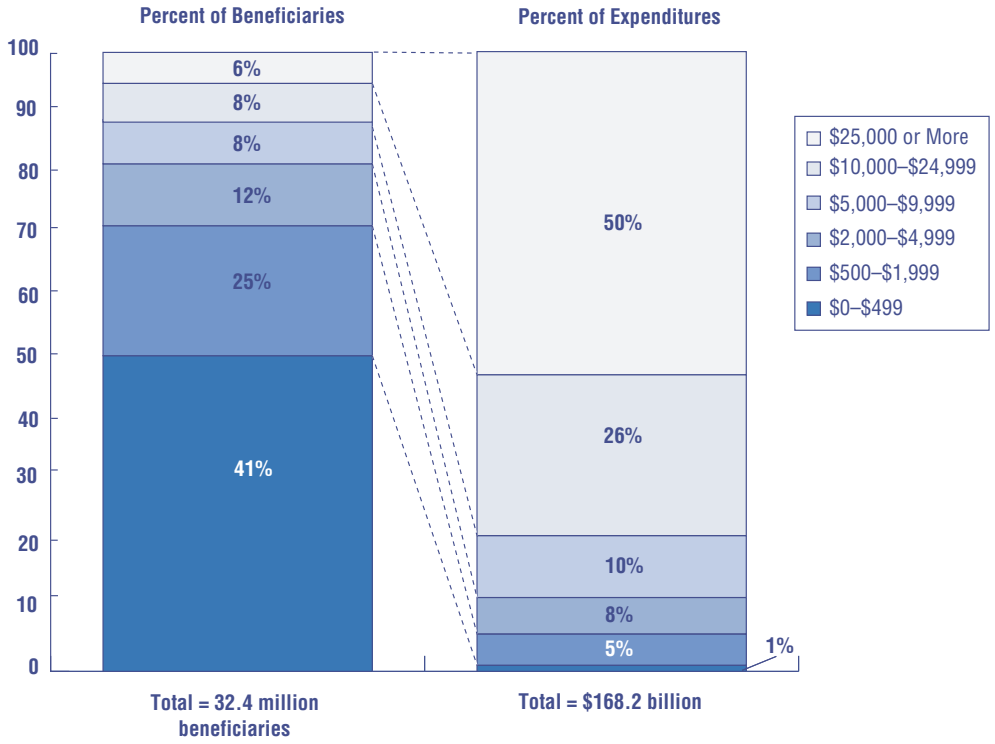


*ESRD category includes beneficiaries eligible due to renal disease. Aged and disabled categories include some beneficiaries with ESRD eligible for Medicare due to age or disability.

SOURCE: Office of the Actuary, Health Care Financing Administration, February 2001.

In 1998, Medicare payments per beneficiary were $4,916. However, average payments vary across different categories of beneficiaries. While spending on each elderly beneficiary averaged $4,888 in 1998, spending on under-65 disabled beneficiaries was slightly lower, averaging $4,663. By contrast, per-beneficiary spending on the end-stage renal disease (ESRD) population averaged $30,372.

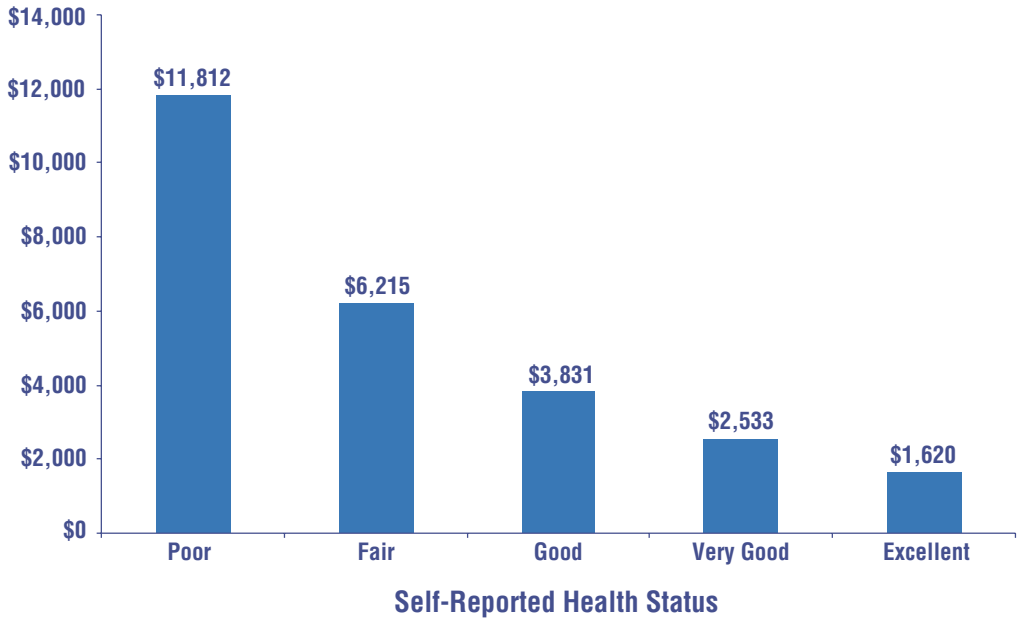
Figure 23
Distribution of Fee-for-Service Medicare Beneficiaries and Expenditures, 1998



Note: Medicare beneficiaries enrolled in M+C plans and payments made on their behalf are excluded from this figure.
SOURCE: Health Care Financing Administration, March 2001.

Medicare spending is concentrated among a relatively small number of beneficiaries. Excluding Medicare+Choice enrollees, 41 percent of all Medicare beneficiaries are responsible for less than $500 in Medicare spending per person in any given year. As a group, they account for about 1 percent of program spending. By contrast, about 6 percent of beneficiaries incur more than $25,000 in Medicare expenses per person, accounting for half of all program spending.

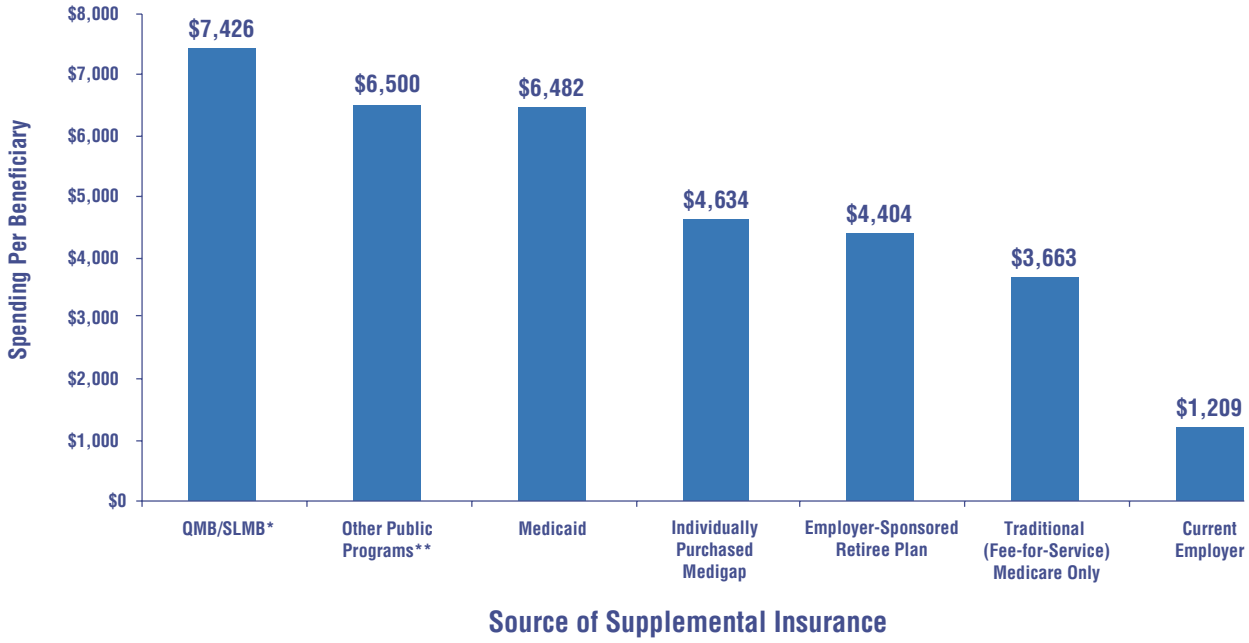
Figure 24
Medicare Spending Per Beneficiary, by Health Status, 1997



Note: Figure excludes HMO, ESRD, and institutionalized beneficiaries.
SOURCE: M. Moon, The Urban Institute (analysis of 1997 Medicare Current Beneficiary Survey).

Medicare spending generally decreases as health status increases. While average Medicare spending for those in excellent health is $1,620, those who report poor health incur on average $11,812 in Medicare spending.

Figure 25
Total Medicare Spending Per Beneficiary, by Supplemental Insurance Status, 1997



*Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs provide some subsidies for low-income Medicare beneficiaries who do not qualify for full Medicaid benefits.

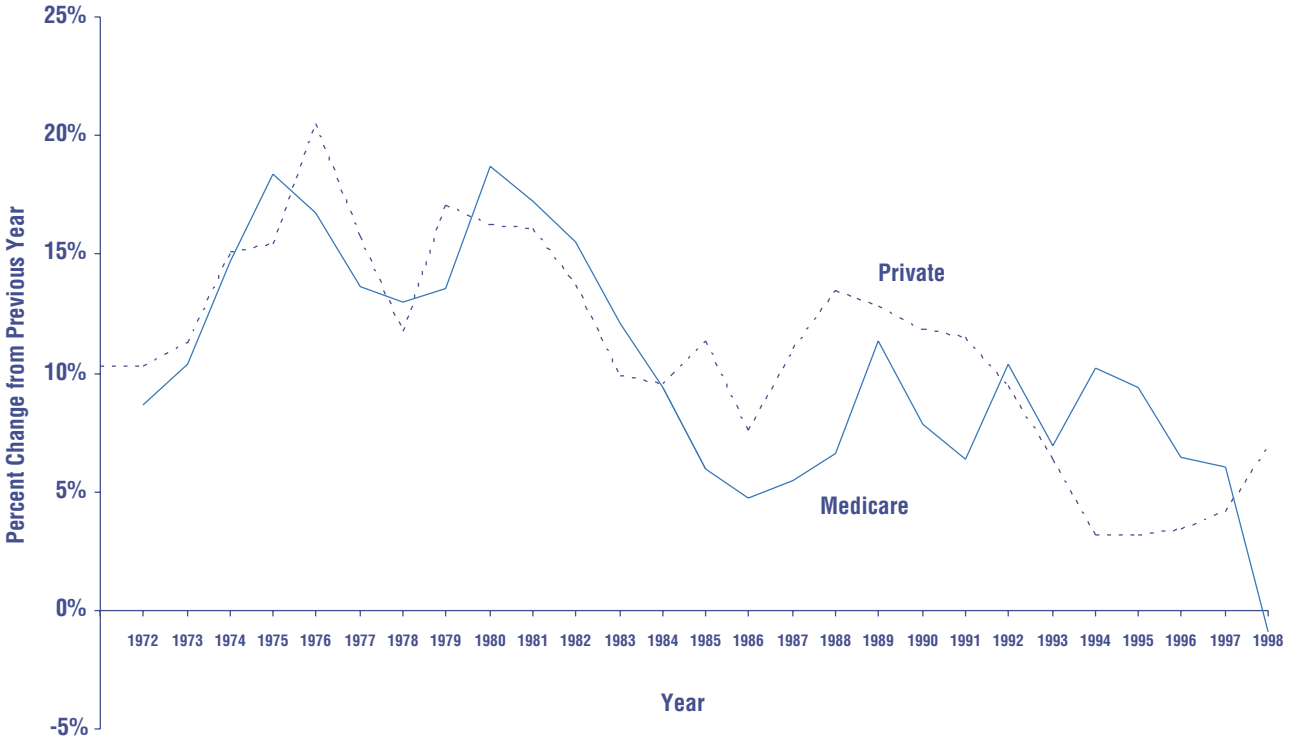
**Other public programs principally include enrollees in the Federal Employees Health Benefits Program (FEHBP) and the health programs of the U.S. Department of Veterans Affairs (VA).

Note: Figure excludes HMO, ESRD, and institutionalized beneficiaries.

SOURCE: M. Moon, The Urban Institute (analysis of 1997 Medicare Current Beneficiary Survey).

The amount that Medicare spends on each beneficiary varies by source of supplemental coverage. Beneficiaries with full Medicaid, QMB/SLMB, or other public insurance have the highest levels of per-beneficiary spending ($6,482, $7,426, and $6,500, respectively). Individuals with insurance from a current employer and those with no insurance to supplement traditional (fee-for-service) Medicare have the lowest Medicare spending ($1,209 and $3,663, respectively). This variation reflects both differences in the average health status of beneficiaries with various sources of supplemental coverage as well as the access to care afforded by their supplemental health insurance.

Figure 26
Annual Per-Capita Rates of Growth in Health Care Spending, 1971–1998

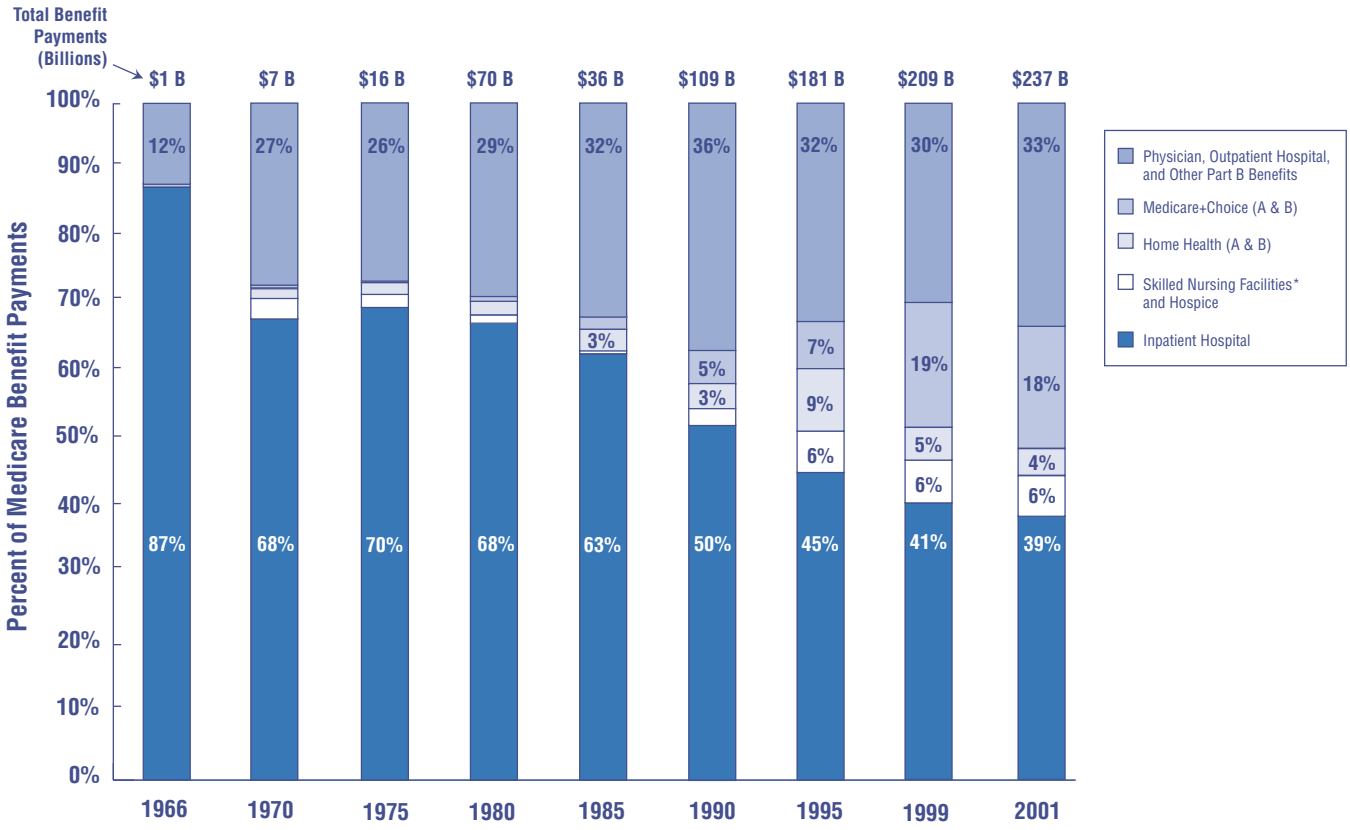


SOURCE: M. Moon, The Urban Institute, May 2001.

Historically, Medicare's costs have generally tracked the growth in private insurance costs. On a per-capita basis, private health insurance grew at an average annual rate of 11.0 percent per year in the period between 1970 and 1998, while Medicare grew at an average rate of 10.2 percent. Between 1984 and 1991, following the enactment of Medicare's prospective payment system for inpatient hospital care, growth in Medicare's per-beneficiary costs was consistently lower than per-capita growth in private health insurance. During the period between 1992 and 1997, Medicare's growth rate was higher.

In the last year for which both private and Medicare data are available, Medicare per-capita spending actually declined (at a rate of -0.9 percent), while private health insurance grew at a rate of just under 7 percent. Growth in Medicare spending is largely influenced by the same factors that have caused growth in health spending in general.

Figure 27
Distribution of Medicare Benefit Payments, 1966–2001



*Skilled Nursing Facilities coverage was effective January 1, 1967.

Note: Figure includes expenditures for ESRD beneficiaries, but excludes administrative payments.

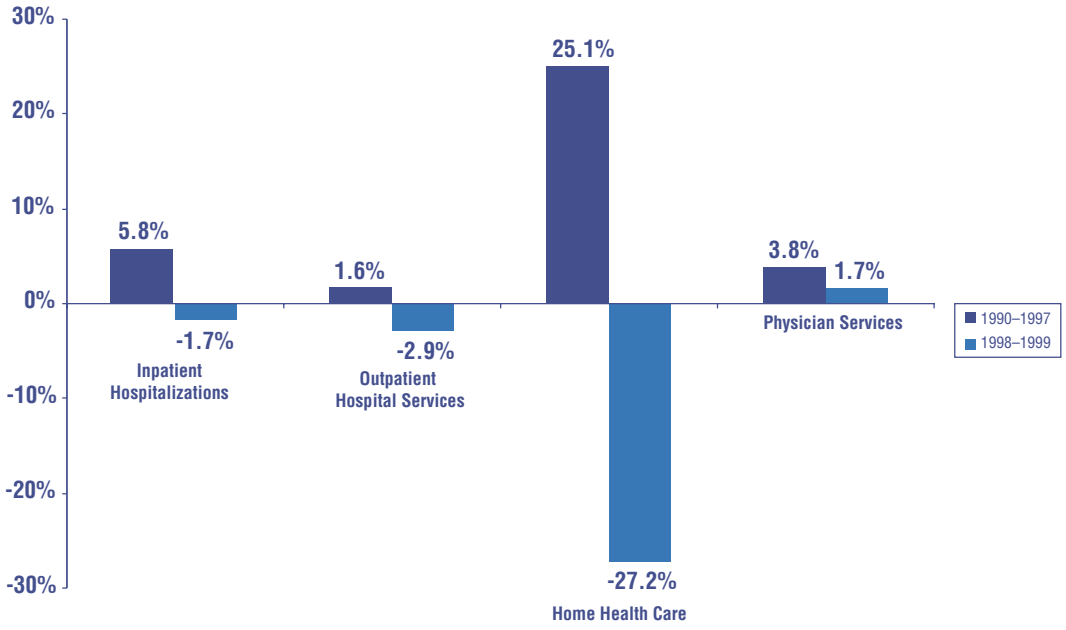
SOURCE: Medicare and Medicaid Cost Estimates Group, Office of the Actuary, Health Care Financing Administration, December 2000; Congressional Budget Office, April 2001 Baseline.

Over the course of Medicare's history, the distribution of benefit payments across different types of services has varied, reflecting changes in both the health-care delivery system and the way in which Medicare pays for services.

While hospitalizations constituted 87 percent of program expenditures in 1966, they represented only 39 percent in 2001. At the same time, expenditures for physician services, outpatient hospital services, and other Part B services increased from 12 percent in 1966 to 33 percent in 2001. Between 1995 and 2001, payments to Medicare HMOs and other Medicare+Choice plans increased from 7 percent to 18 percent of Medicare's total budget. During the same period, home health and skilled nursing care expenditures declined from 15 percent to 10 percent, due primarily to declines in home health payments in the wake of the Balanced Budget Act (BBA) of 1997.

Figure 28

Average Annual Rates of Change in Medicare Spending for Selected Services Before and After the Balanced Budget Act

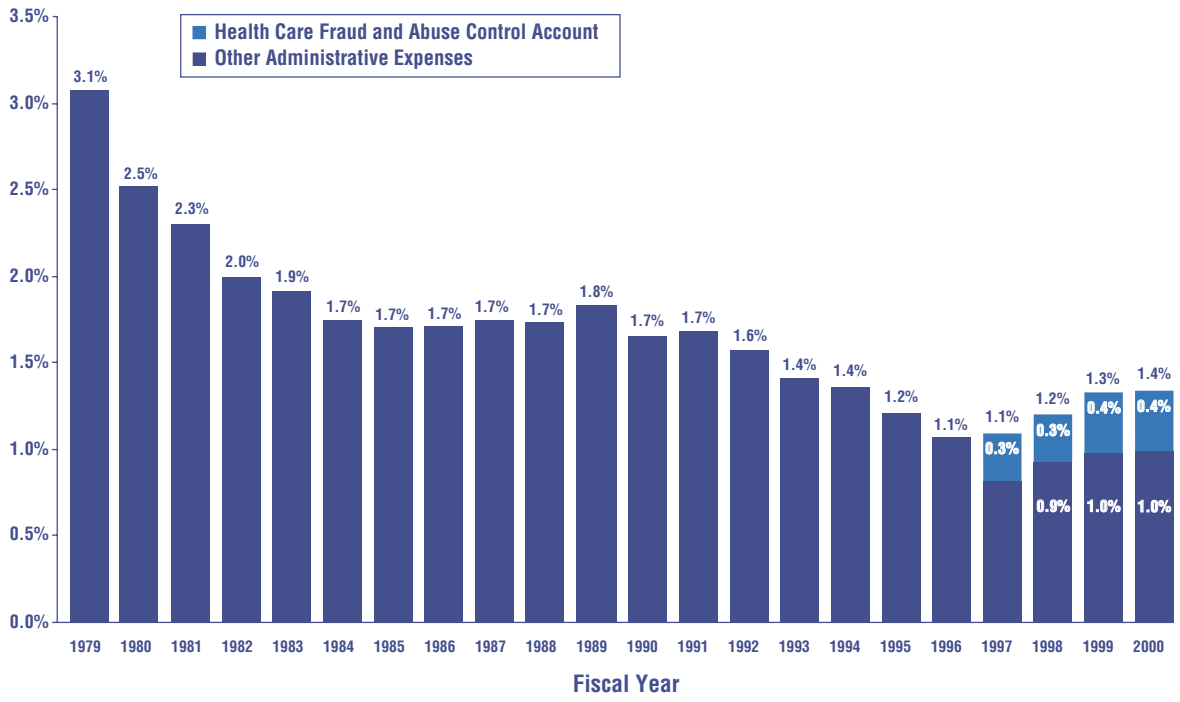


SOURCE: Medicare and Medicaid Costs Estimates Group, Office of the Actuary, Health Care Financing Administration, December 2000.

From year to year, the rates of growth for particular services covered by Medicare can vary substantially in response to changes in program benefits, payment rules, and other features of the program. For example, after a period of rapid growth throughout most of the 1990s, spending on inpatient hospital and home health services dropped dramatically between 1997 and 1999, due to changes in payment formulas enacted as part of the Balanced Budget Act (BBA) of 1997 as well as increased efforts to eliminate waste, fraud, and abuse from the Medicare program.

While home health spending grew substantially at an average annual rate of 25.1 percent between 1990 and 1997, it fell at an average annual rate of 27.2 percent during the subsequent two-year period. During the period between 1997 and 1999, the share of all beneficiaries receiving home health benefits fell from 10.1 to 8.0 percent and the average number of visits per home health user declined from 79 to 45 visits. While spending on inpatient hospitalizations was increasing at an average annual rate of 5.8 percent in the period between 1990 and 1997, spending on these services decreased at an average annual rate of 1.7 percent during the following two years.

Figure 29
Medicare Administrative Expenditures as a Percentage of Medicare Benefit Payments, 1979–2000



Note: Labels are rounded to one decimal place.

SOURCE: Tilson, Congressional Research Service, 2001; Budget of the United States, 1979–2000, Appendix; CBO, 2000.

Medicare's administrative budget is used primarily to fund the fiscal intermediaries and carriers who pay providers' claims and efforts to combat waste, fraud, and abuse. Remaining administrative funds are used for the running of the Centers for Medicare and Medicaid Services (CMS); Medicare research, demonstrations, and evaluations; state survey and certification of health-care facilities serving Medicare, Medicaid, and S-CHIP beneficiaries; and various federal regulatory responsibilities.[1]

Administrative payments now account for less than 2 percent of Medicare benefit payments—a share significantly lower than that among most private insurers. Between 1979 and 2000, Medicare's administrative budget declined from 3.1 percent to 1.4 percent of total benefit spending ($3.0 billion in 2000), despite the complexities of rapidly evolving health-care technologies, more complicated reimbursement rules, and the broader array of delivery options available to beneficiaries. Administrative spending has increased slightly since 1996, due primarily to the creation of a Health Care Fraud and Abuse Control Account in 1997 (now more than one-quarter of all administrative spending). Other sources of this recent increase include funding for Y2K computer needs and the implementation of provisions of the Balanced Budget Act of 1997 (e.g., the Medicare+Choice program and new prospective payment systems). While Medicare benefit payments are classified as mandatory spending, administrative expenditures are discretionary and are thus determined annually through the Congressional appropriations process.

[1]Funding for the Peer Review Organizations (PROs) that monitor Medicare's quality of care ($580 million in FY2000) is not included in these administrative data.

Section III

Supplemental Coverage and Out-of-Pocket Spending

Section III: Supplemental Coverage and Out-of-Pocket Spending

Most Medicare beneficiaries (87 percent) have some form of supplemental insurance to help pay for Medicare's cost-sharing requirements and for benefits not covered by Medicare. Almost all such coverage comes from employer-sponsored insurance, individually purchased Medigap policies, a Medicare+Choice plan, or Medicaid.

Medicare beneficiaries without supplemental insurance tend to experience substantial problems with access to care. For instance, these beneficiaries are five times as likely to report having delayed getting care due to cost and more than three times as likely to report lacking a usual source of care than are those with private supplemental insurance.

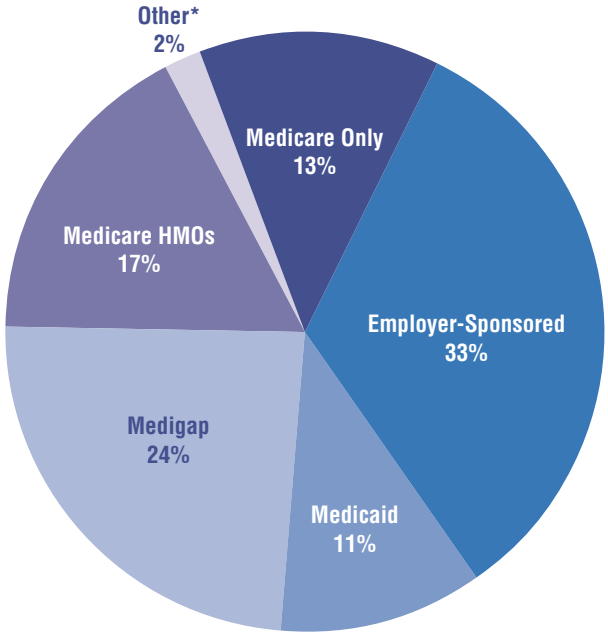
Employer-sponsored coverage is the single most common source of supplemental insurance (held by 33 percent of all non-institutionalized beneficiaries in 1999), followed by Medigap policies (24 percent), Medicare managed care (Medicare+Choice) plans (17 percent), and Medicaid (11 percent). These sources of coverage vary by beneficiaries' poverty status. Almost half (49 percent) of beneficiaries below the federal poverty level have Medicaid coverage, while only 8 percent of this group have employer-sponsored coverage. Poorer beneficiaries are also the most likely to have no coverage at all beyond traditional fee-for-service Medicare. While 16 percent of those below the poverty level rely solely on Medicare, only 4 percent of those with incomes above 250 percent of poverty lack supplemental insurance.

In recent years, supplemental coverage from both employers and Medicare+Choice has eroded as health-care costs have risen, particularly for prescription drugs. Since the early 1990s, the share of employers offering retiree health benefits has declined. In addition, employers have made other changes in the benefits they offer to retirees, by capping the financial value of coverage, requiring higher age or longer service for eligibility, and by requiring greater retiree cost-sharing.

Medigap policies vary widely in the services they cover and their premiums have risen rapidly as well. Although federal legislation in 1990 limited Medigap coverage to ten standard policies, a third of all policies still held are non-standard because they were issued prior to the reform. Policies C and F are the most common, representing 26 and 37 percent of all standard Medigap policies, respectively. Although most popular among beneficiaries, neither of these policies includes prescription drug coverage.

Of the 13 percent of beneficiaries who are dually eligible for Medicare and Medicaid, the majority (83 percent) receive full Medicaid benefits, which include most services not paid for by Medicare, such as prescription drugs and long-term care, and assistance with Medicare's cost-sharing requirements. The remaining 17 percent—Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs)—get assistance with Medicare premiums, if they meet income and asset tests. QMBs are also eligible to receive assistance with Medicare's other cost-sharing requirements.

Figure 30
Sources of Supplemental Coverage Among Non-Institutionalized Medicare Beneficiaries, 1999



Total = 34.7 million non-institutionalized Medicare beneficiaries

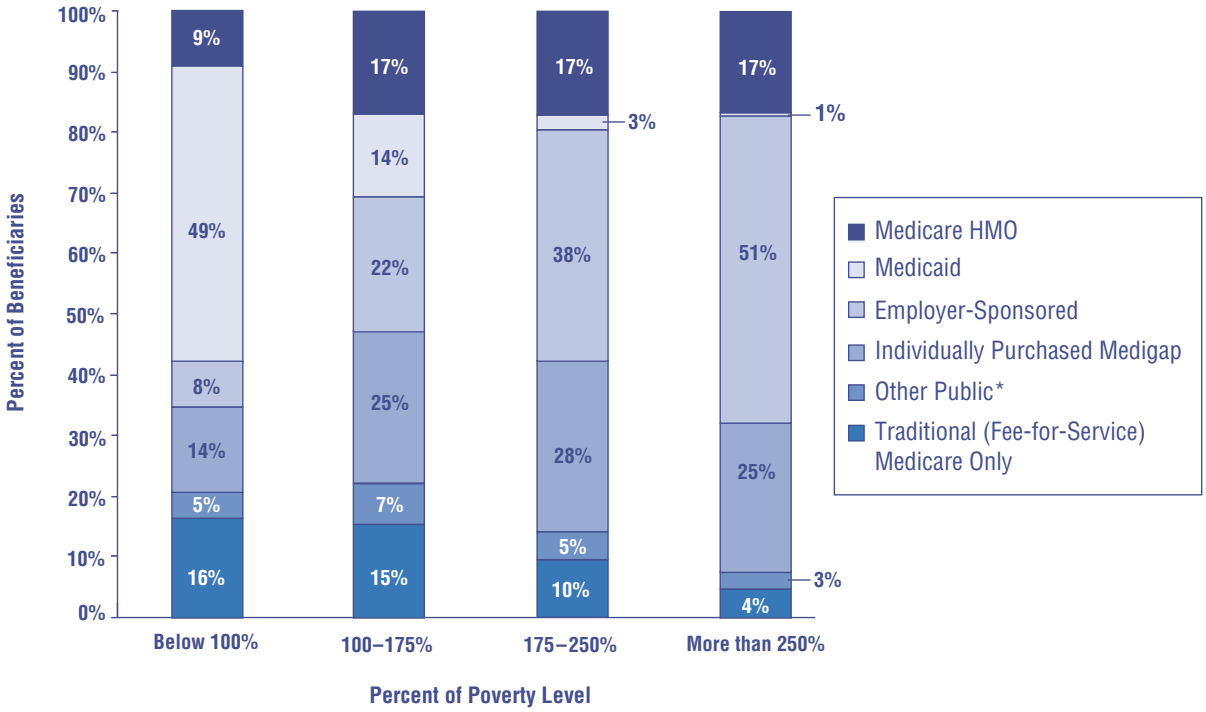
*Includes those receiving coverage from other public programs as well as those in non-risk HMOs.

SOURCE: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

Most Medicare beneficiaries (87 percent) have supplemental health insurance to help pay Medicare's cost-sharing requirements and pay for services not covered by Medicare. Such coverage comes from a range of sources, including: employer-sponsored insurance (covering 33 percent of all beneficiaries), individually purchased Medigap policies (24 percent), Medicaid (11 percent), or a Medicare HMO (Medicare+Choice) plan (17 percent). In recent years, as health-care costs have risen—particularly in the area of prescription drugs—coverage has eroded, with benefits becoming less available, more expensive, and less generous across a range of coverage sources.

There are also significant differences between aged and disabled beneficiaries in terms of the distribution of supplemental coverage. For instance, while only 10 percent of elderly beneficiaries lacked supplemental coverage altogether in 1999, 28 percent of the non-institutionalized disabled population were without it in that year. At the same time, 35 percent of elderly beneficiaries had employer-sponsored coverage, compared to 21 percent of the under-65 disabled.

Figure 31
Primary Source of Supplemental Coverage Among Medicare Beneficiaries, by Poverty Status, 1997



*'Other Public' includes mainly VA and FEHBP enrollees.

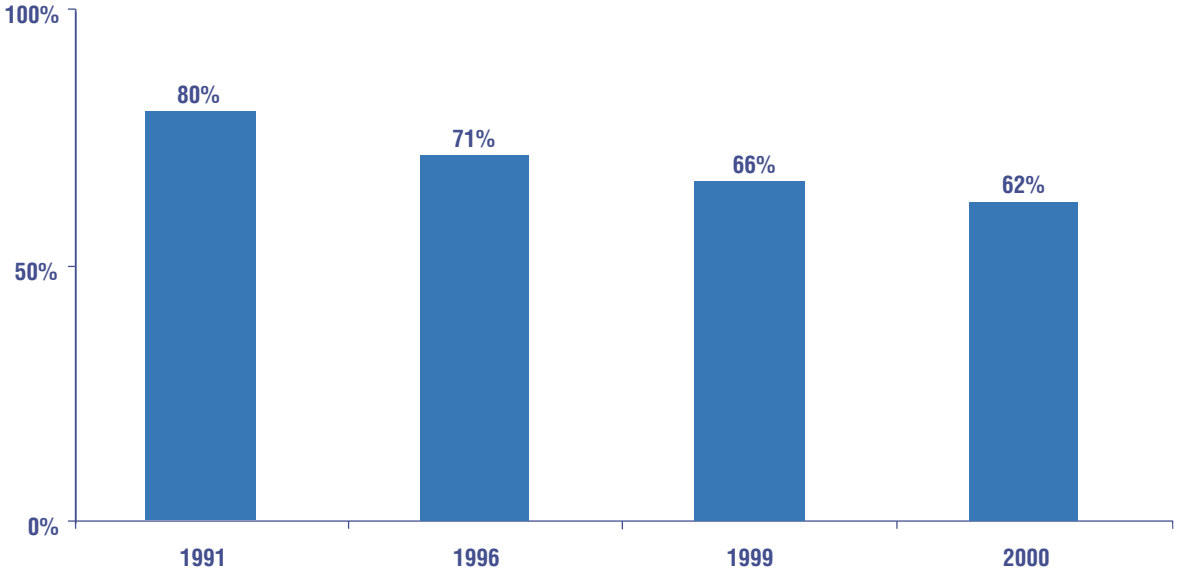
Note: The 1997 federal poverty level was $7,890 for an individual and $10,610 for a couple.

SOURCE: M. Moon, The Urban Institute (analysis of 1997 Medicare Current Beneficiary Survey).

Supplemental coverage varies significantly by beneficiaries' poverty status. The poor and near-poor elderly are at highest risk of having no insurance to supplement Medicare. Although 16 percent of elderly beneficiaries below poverty and 15 percent of those with incomes between 100 and 175 percent of poverty lacked supplemental insurance in 1997, only 4 percent of those with incomes above 250 percent of poverty were without it. While some of those below poverty without supplemental insurance may qualify for Medicaid but not be enrolled, the near-poor are at particular financial risk since they are less likely to qualify for any Medicaid subsidies.

By contrast, the role of employer-sponsored supplemental health insurance increases with income. While only 8 percent of elderly Medicare beneficiaries with incomes of 100 percent of poverty or less had employer-sponsored health insurance in 1997, 51 percent of beneficiaries with incomes above 250 percent of poverty had such supplemental coverage.

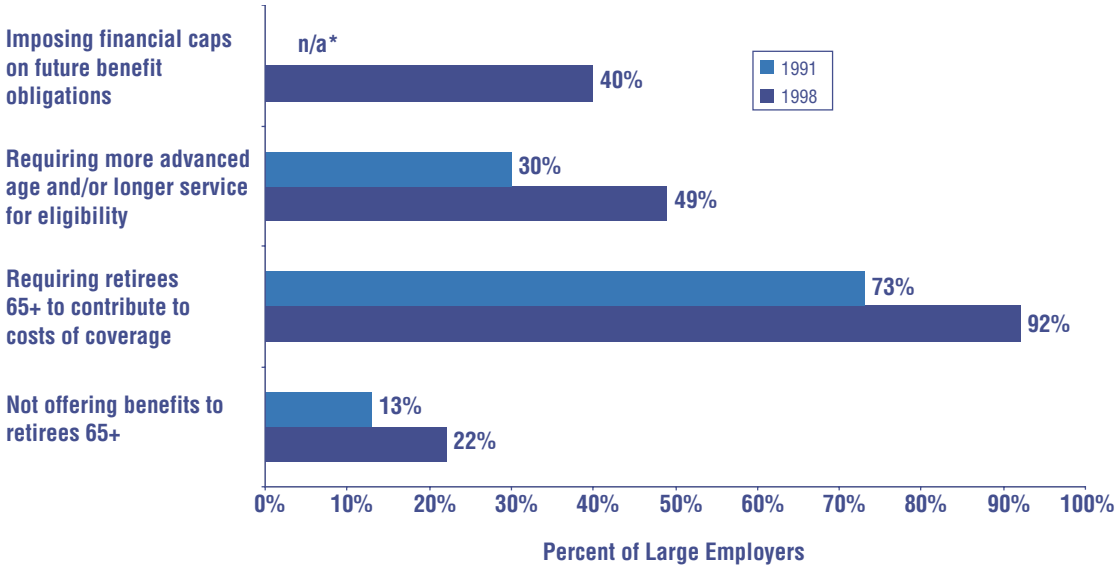
Figure 32
Percentage of Large Employers Providing Retiree Health Benefits, 1991–2000



SOURCE: Hewitt Associates database of 1,006 large employers in selected years.

Over the past decade, the share of large employers providing health insurance to their retirees has decreased, reflecting increasing health-care costs and changes in how firms must account for such liabilities in their financial records. Between 1991 and 2000, the share of large employers offering health benefits to their retirees declined from 80 percent to 62 percent.

Figure 33
Trends in Selected Retiree Health Benefits Among Large Employers, 1991 and 1998



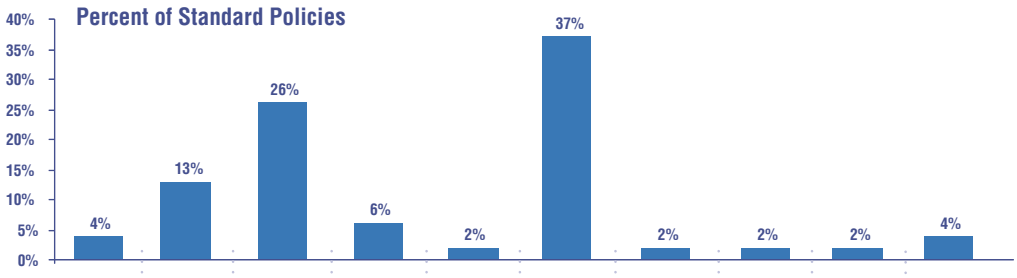
*n/a = not asked in 1991

SOURCE: Hewitt Associates analysis for The Henry J. Kaiser Family Foundation, 1999.

The past 10 years have seen an increase in the share of large firms placing financial caps on future benefits, raising the eligibility age for retiree benefits, increasing the length of service necessary for eligibility, requiring retirees to contribute towards their coverage, and not offering retiree benefits at all. The percentage of firms offering their retirees coverage through a Medicare+Choice plan also increased, a trend that may be viewed as a shift toward more tightly controlled benefits.

The generosity of retiree health coverage is projected to decline even further over the next several years, with many large employers expected to require beneficiaries to pay for a larger share of their medical coverage, to shift to a defined contribution plan that limits the employer's financial obligations, and to use a range of other strategies to rein in the costs of retiree benefits.

Figure 34
Medigap Policies, by Plan Type and Numbers of Policies Purchased, 1999



Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F [a]	Plan G	Plan H	Plan I	Plan J [a]
Coverage for: - Part A coinsurance - 365 additional hospital days during lifetime - Part B coinsurance - Blood products	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B balance billing [b]						X	X		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
Home health care				X			X		X	X
Prescription drugs								X [c]	X [c]	X [c]
Preventive medical care				X						X

[a] Plans F and J also have a high-deductible option that requires the beneficiary to pay $1,580 before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs in Plan J ($250 per year) and foreign travel emergency ($250 per year for plans F and J), which are required in these plans with or without the high-deductible option.

[b] Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payment rate. Plan G pays 80 percent of balance billing; plans F, I, and J cover 100 percent of these charges.

[c] Plans H and I pay 50 percent of drug charges up to $1,250 per year and have a $250 annual deductible. Plan J pays 50 percent of drug charges up to $3,000 per year and has a $250 annual deductible.

SOURCE: General Accounting Office analysis of NAIC Data, July 2001.

Many Medicare beneficiaries purchase supplemental insurance—known as "Medigap"—to help pay for cost-sharing requirements and services not covered by Medicare. Two-thirds of all currently held Medigap policies were purchased after 1990 and conform to one of ten standard benefit packages (Plans A–J). The remaining one-third are considered "pre-standard" and little is known about the specific benefits they offer (e.g., whether they cover any prescription drug costs).

Of the ten standard Medigap plans, C and F are the most prevalent, constituting 26 and 37 percent of all standard Medigap policies in 1999, respectively. These policies pay most of Medicare's cost-sharing requirements, but do not cover outpatient prescription drugs. Among standard policies, only Plans H, I, and J include drug benefits. Together, these represent only about 8 percent of all standard Medigap policies currently held.

Figure 35
Medicaid's Role for Medicare Beneficiaries

Program	Who's Eligible?	What Does Medicaid Pay?	Entitlement?
Full Medicaid Benefits	≤ 73% of poverty* (SSI eligibility level)	Wrap-around benefits, Medicare Part B premium and cost-sharing	Yes
Qualified Medicare Beneficiaries (QMB)	≤ 100% of poverty	Medicare Part B premium and cost-sharing**	Yes
Specified Low-Income Medicare Beneficiaries (SLMB)	100–120% of poverty	Medicare Part B premium	Yes
Qualifying Individuals 1 (QI-1)	120–135% of poverty	Medicare Part B premium	No
Qualifying Individuals 2 (QI-2)	135–175% of poverty	A portion of the Medicare Part B premium	No

*Some states (209b) are permitted to set lower eligibility levels; states also have the option of raising eligibility to 100% of poverty.

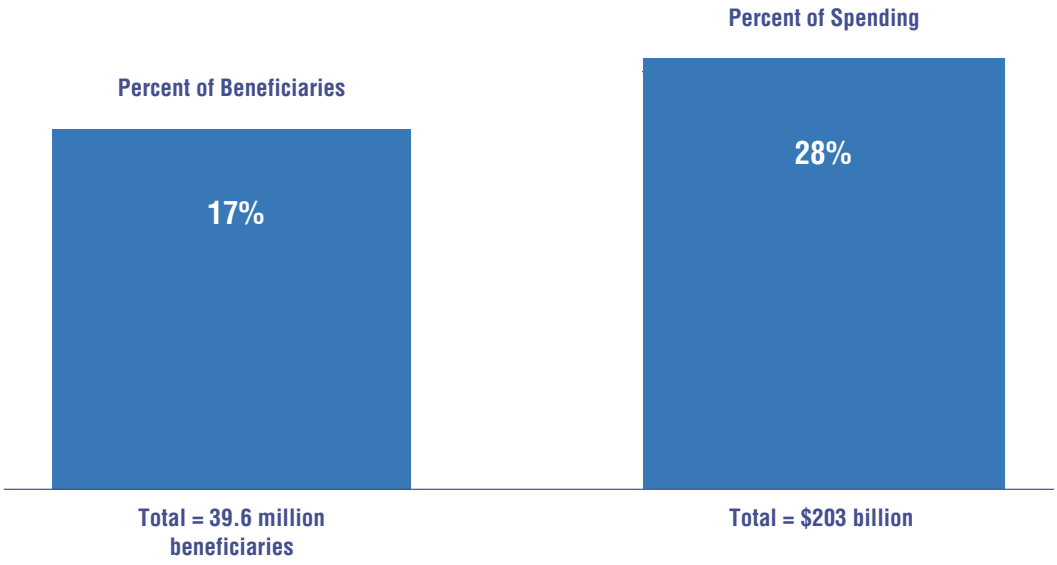
**States are not required to cover all cost-sharing for services if Medicare payment is equal to or greater than what Medicaid pays for the same services.

Note: Individuals must have limited assets (below $4,000 for an individual). Full Medicaid, QMB, and SLMB benefits are available to all who qualify; QI-1 and QI-2 benefits are available on a first-come, first-served basis.

Low-income Medicare beneficiaries who qualify for both Medicare and Medicaid are often referred to as "dual eligibles." There are several categories of dual eligibles that vary in terms of eligibility criteria and the benefits received. In 1997, 83 percent of dually eligible Medicare beneficiaries qualified for full Medicaid benefits (e.g., coverage for outpatient prescription drugs and all of Medicare's premiums and cost-sharing requirements) according to the criteria established by the federal government and their state of residence. The remaining dual eligibles—generally those with slightly higher incomes—were eligible for Medicaid subsidies to assist with some portion of Medicare's cost-sharing requirements. The two primary programs of this type are the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs.

Many low-income Medicare beneficiaries are eligible for some degree of Medicaid assistance, but are not enrolled in the program. States are currently employing a range of outreach and enrollment strategies to increase participation, particularly among those eligible for QMB and SLMB benefits. These strategies include making outreach and enrollment materials and eligibility screening available in locations other than state welfare offices, simplifying application forms, and screening all Medicaid applicants for QMB and SLMB eligibility.

Figure 36
Distribution of Dual Eligibles as a Share of Medicare Beneficiaries and Spending, 1997

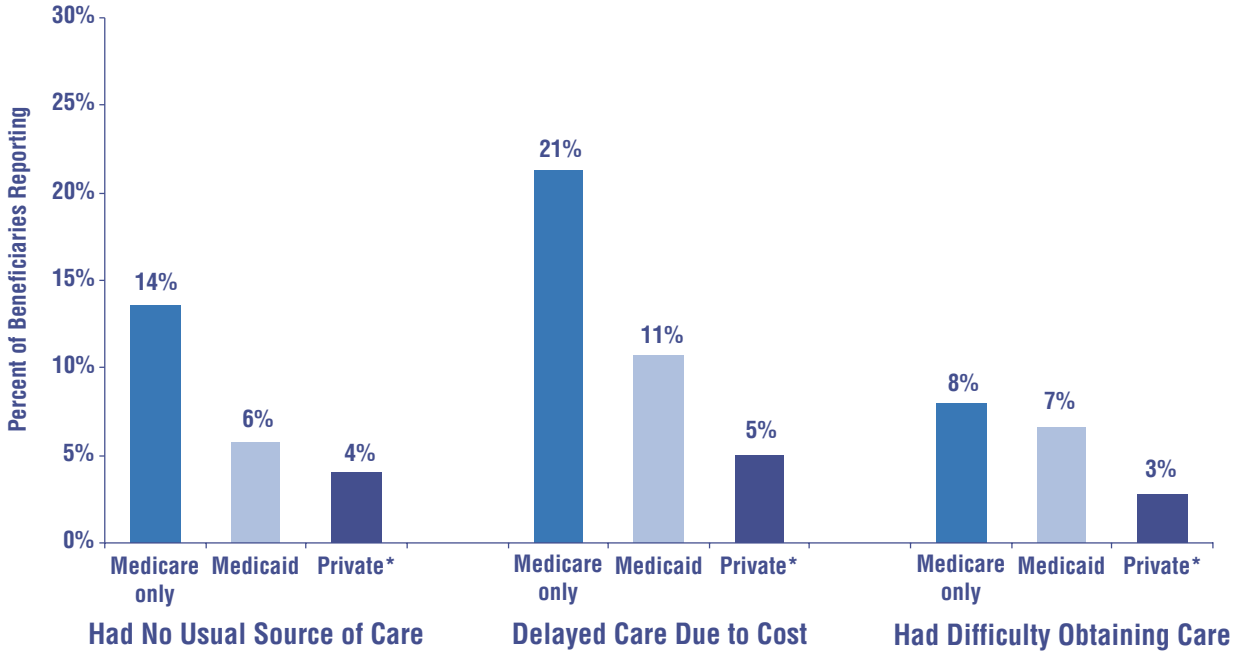


SOURCE: Clark and Hulbert, 1998.

Dual eligibles account for 17 percent of the Medicare population, but incur 28 percent of program expenditures ($56.7 billion in 1997). At the same time, while dual eligibles comprise almost one-fifth (19 percent) of the Medicaid population, they account for more than one-third (35 percent) of Medicaid spending ($56.0 billion in 1997).

The disproportionate share of program payments spent on dually eligible beneficiaries reflects the fact that low-income Medicare beneficiaries are almost twice as likely to be in fair or poor health than are those with higher incomes.

Figure 37
Access to Care Among Non-Institutionalized Medicare Beneficiaries, by Source of Supplemental Coverage, 1999



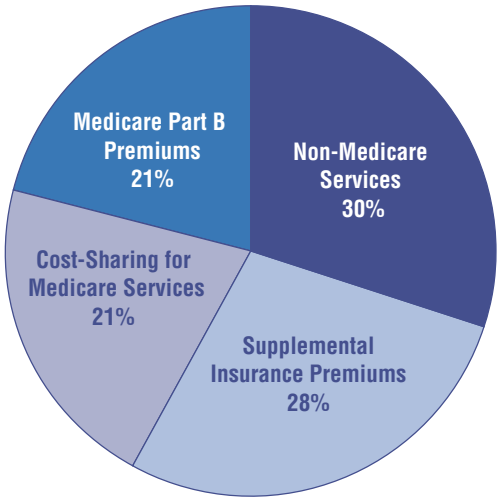
*'Private' includes individually purchased insurance and employer-sponsored coverage.

Note: Includes only community residents.

SOURCE: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

Supplemental insurance dramatically improves beneficiaries' access to care. Beneficiaries without any supplemental coverage are significantly more likely than are those with Medicaid or private supplemental insurance to report having no usual source of care, having delayed care due to cost, and having had some difficulty obtaining care in the previous year. Those without supplemental insurance are also less likely to receive the services not covered under traditional Medicare, including prescription drugs.

Figure 38
Distribution of Out-of-Pocket Expenditures Among Elderly Fee-for-Service Beneficiaries, 2000



Note: Because these data exclude institutionalized beneficiaries, a large portion of out-of-pocket spending on long-term care services not covered by Medicare is not included here.

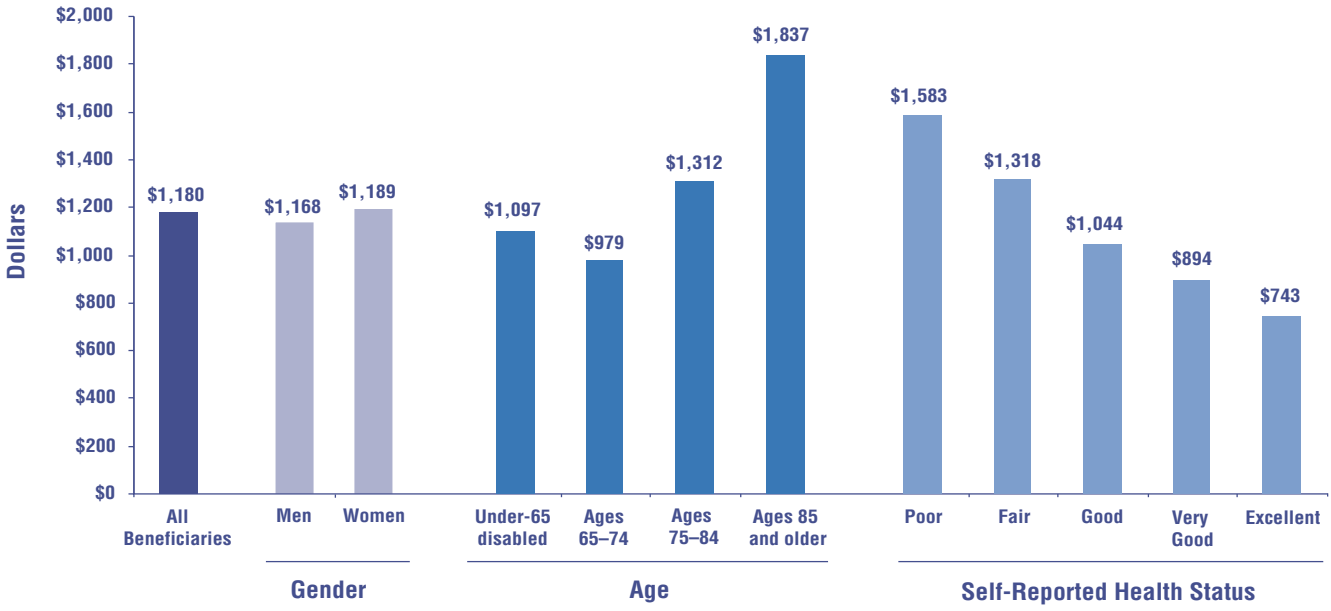
SOURCE: Maxwell, Moon, and Segal, January 2001.

Medicare pays 56 percent of its beneficiaries' total personal health-care expenditures, with the remainder paid out-of-pocket or by other insurers. Medicare beneficiaries face four types of out-of-pocket health-care expenditures: (1) health-care services not covered by Medicare (e.g., prescription drugs), (2) premiums and other cost-sharing for insurance to supplement Medicare, (3) deductibles and co-insurance requirements for services covered by Medicare, and (4) Medicare Part B premiums.

These out-of-pocket costs vary as a function of beneficiaries' health status and supplemental insurance. Individuals with greater health-care needs are more likely to incur payments for deductibles, co-insurance, and services not covered by Medicare. Out-of-pocket costs are likely to be lower, on the other hand, for individuals with relatively comprehensive supplemental insurance, particularly Medicaid or employer-sponsored coverage.

Figure 39

Out-of-Pocket Spending Among Non-Institutionalized Medicare Beneficiaries, by Gender, Age, and Health Status, 1997



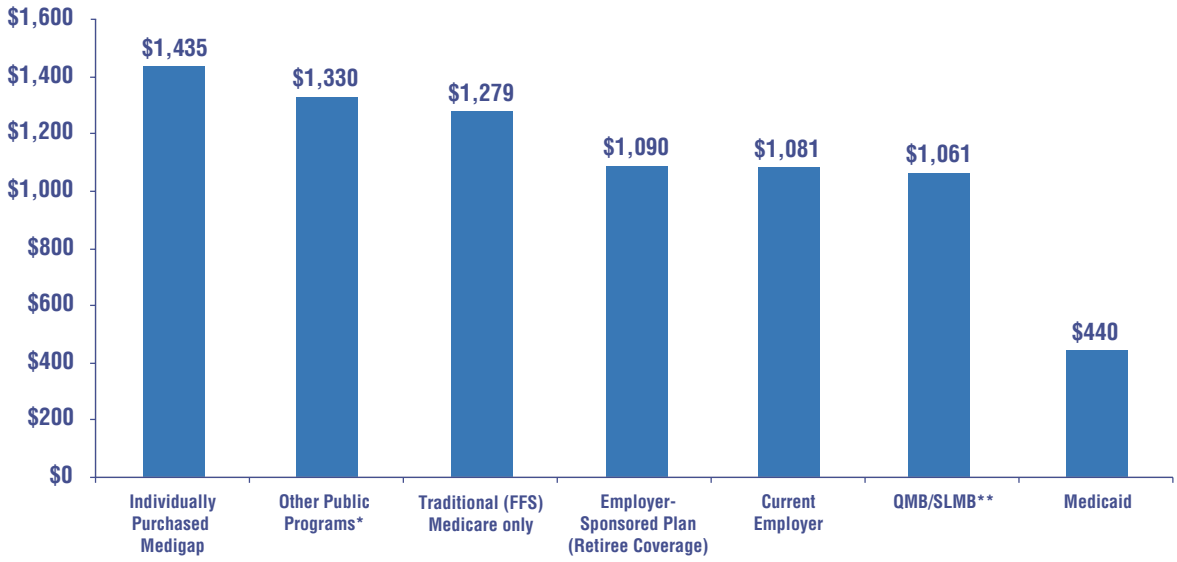
Note: Drug share of total out-of-pocket spending is multiplied by 1.11 to correct for underreporting. Figure excludes HMO, ESRD, and institutionalized beneficiaries.

SOURCE: M. Moon, The Urban Institute (analysis of the 1997 Medicare Current Beneficiary Survey).

Out-of-pocket spending on health care increases with declining health status and advancing age. Beneficiaries in poor health spent 50 percent more out-of-pocket on their health care in 1997 than did those in good health, and more than twice as much as those in excellent health. Those ages 85 and older had out-of-pocket expenditures of $1,837 in 1997—nearly twice as much as those of beneficiaries ages 65–74. Average out-of-pocket spending among the under-65 disabled population is also higher than out-of-pocket spending among elderly beneficiaries ages 65–74, reflecting the unique health needs of disabled beneficiaries.

Figure 40

Out-of-Pocket Spending Among Non-Institutionalized Medicare Beneficiaries, by Primary Source of Supplemental Coverage, 1997



*'Other public programs' include the Federal Employees Health Benefits Program (FEHBP) and the health programs of the U.S. Department of Veterans Affairs (VA).

**Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs.

Note: Figure excludes HMO, ESRD, and institutionalized beneficiaries.

SOURCE: M. Moon, The Urban Institute (analysis of the 1997 Medicare Current Beneficiary Survey).

Out-of-pocket expenses vary across Medicare beneficiaries by type of supplemental coverage. Medicare beneficiaries with Medicaid generally face the lowest out-of-pocket costs ($440 on average in 1997) largely because they incur fewer costs for uncovered services such as prescription drugs and they do not pay deductibles, co-insurance, or premiums for Medicare Part B or their supplemental coverage.

Individuals purchasing individual Medigap policies pay the highest average out-of-pocket costs ($1,435 on average in 1997), reflecting relatively high premiums, the fact that only a small portion of Medigap enrollees have policies that cover outpatient prescription drugs, and limited coverage for other benefits.

Section IV

Medicare+Choice

Section IV: Medicare+Choice

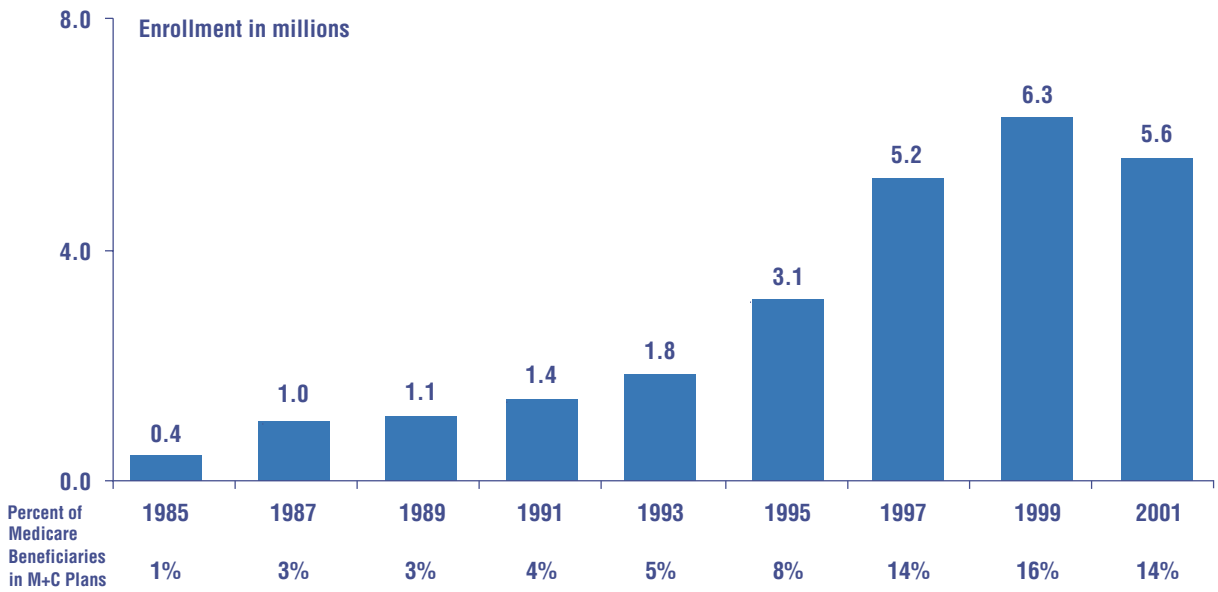
While most Medicare beneficiaries (86 percent) have their health-care bills paid directly by the traditional fee-for-service program, one in seven (14 percent) is covered under a Medicare+Choice (M+C) plan, primarily Health Maintenance Organizations (HMOs) in 2001. For each enrollee, Medicare pays M+C plans a fixed monthly amount to cover all Medicare benefits.

Since the 1970s, private health plans have been allowed to contract with Medicare on a cost-reimbursement basis. Since passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982, risk-based plans have been an option under Medicare. The Balanced Budget Act (BBA) of 1997 established the M+C program, allowing beneficiaries to enroll in a variety of private plans in addition to HMOs. Preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs), coupled with high-deductible insurance plans are all permitted to contract with Medicare to provide health benefits to beneficiaries. To date, with the exception of one PSO and one PFFS plan, HMOs remain the primary alternative to traditional Medicare.

In recent years, there has been a rapid decline in the number of Medicare HMOs participating in Medicare, from 346 plans in 1998 to 179 in 2001. Withdrawals and service area reductions over the past three years have lead to a decline in enrollment and have disrupted coverage for some 1.5 million people on Medicare, disproportionately affecting beneficiaries residing outside of major urban areas. In September 2001, another 58 plans (covering 536,000 beneficiaries) announced their intention to withdraw from the Medicare market or reduce their service area, beginning in 2002. Declining plan participation has been largely attributed to changes in Medicare payments to plans enacted under the BBA, increased administrative responsibilities, low market penetration, provider turnover in managed care networks, and other business concerns.

Managed care is likely to continue to have an important role in Medicare, but the future of the current M+C program seems somewhat uncertain. While the Administration has set a goal of increasing M+C enrollment, the recent withdrawals and service area reductions by many plans and the decrease in highly desired additional benefits (especially prescription drug coverage) offered by many remaining plans may make Medicare+Choice a less attractive option for Medicare beneficiaries. Striking the right balance between the goals of controlling spending growth, setting payments to plans fairly, providing greater stability for plans and beneficiaries, and meeting the health needs of aging beneficiaries will be an ongoing challenge for Medicare managed care.

Figure 41
Enrollment in Medicare HMOs and Other Medicare+Choice Plans, 1985–2001



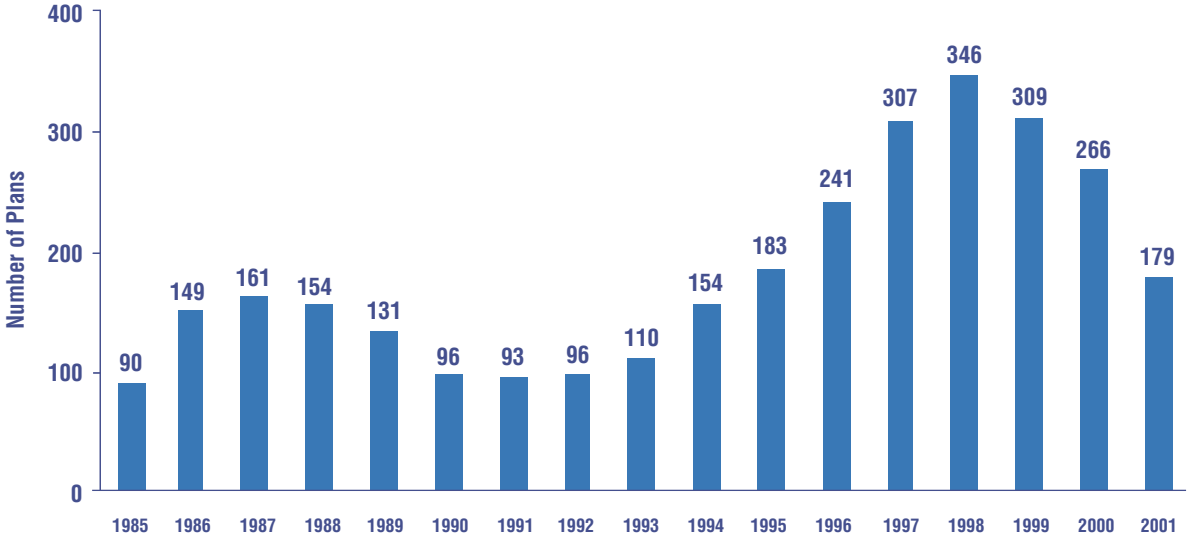
Note: All data are as of December of the given year. 2001 data are for June.

SOURCE: Health Care Financing Administration, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report, June 2001.

Risk-based managed-care plans have been an option under the Medicare program since 1982. In 1985, there were over 440,000 Medicare beneficiaries enrolled in Medicare HMOs, doubling to more than 1 million beneficiaries nationwide by 1987. Over the next four years, Medicare HMO enrollment grew modestly, despite a 40 percent drop in plan participation.

Between 1993 and 1998, Medicare HMO enrollment grew rapidly, due largely to increased plan participation. However, beginning in 1998, enrollment began to level off as plans began to withdraw from the Medicare market and reduce their service areas in certain parts of the country. Between 2000 and 2001, Medicare HMO enrollment declined by 10 percent—the first time enrollment dropped since Medicare HMOs began participating in the Medicare program. The Congressional Budget Office projects enrollment to reach 18 percent of the total Medicare population (8.7 million beneficiaries) by 2011, growing at a substantially slower rate than previously expected.

Figure 42
Medicare HMOs and Other Private Health Plans Participating in Medicare, 1985–2001



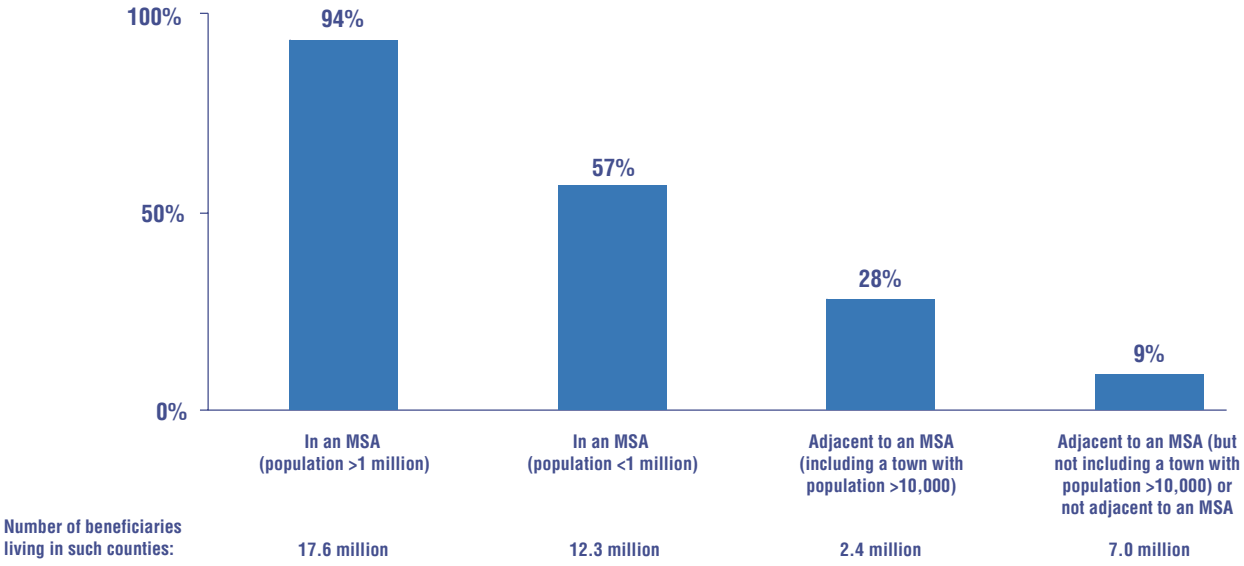
Note: All data are as of December of the given year. 2001 data are for September.

SOURCE: Health Care Financing Administration, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report, June 2001.

In 1985, 90 health plans contracted with the Medicare program to provide care to enrolled beneficiaries. After a rapid increase in plan participation between 1985 and 1987, over 40 percent of participating plans withdrew from the Medicare market over the next four years. Not until 1992 did the number of Medicare HMOs begin to climb again, reaching a high of 346 in 1998. Since then, the number of plans participating in Medicare has declined to 179 in 2001, disrupting coverage for more than 1.5 million beneficiaries. In September 2001, another 58 plans (covering 536,000 beneficiaries) announced their intention to withdraw from the Medicare market or reduce their service area, beginning in 2002. Declining plan participation has been attributed to changes in Medicare payments to plans enacted in 1997 under the Balanced Budget Act (BBA), new administrative requirements, and provider turnover.

A number of changes have been adopted since 1997 to encourage plans to stay in the Medicare market. For example, both the Balanced Budget Reconciliation Act (BBRA) of 1999 and the Medicare, Medicaid, and S-CHIP Benefits Improvement and Protection Act (BIPA) of 2000 provided increased payments to Medicare+Choice plans. In addition, many administrative requirements have been eased by the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)), in an effort to discourage plan withdrawals.

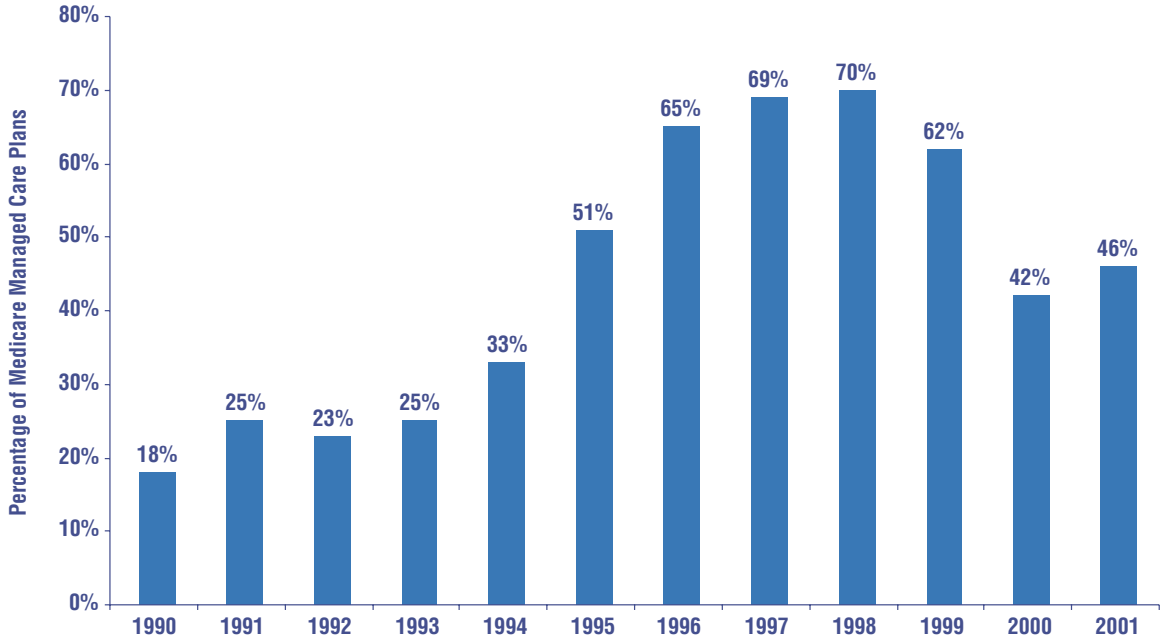
Figure 43
Percentage of Beneficiaries Offered a Medicare+Choice Plan, by Type of County, 2001



Note: "MSA" refers to metropolitan statistical area as defined by the U.S. Office of Management and Budget.
SOURCE: Medicare Payment Advisory Commission, June 2001.

Medicare beneficiaries in highly populated metropolitan statistical areas (MSAs) are more likely to have a Medicare+Choice plan available in their area than are those in less-populated areas. For example, Medicare beneficiaries residing in MSAs with greater than 1 million people are more than 10 times as likely as beneficiaries living in rural areas to have a Medicare+Choice health plan option in their county in 2001 (94 percent versus 9 percent), where rural is defined as counties adjacent to an MSA, but not including a town with at least 10,000 people, or counties not adjacent to an MSA at all.

Figure 44
Percentage of Medicare Managed Care Plans with Zero Premiums, 1990–2001



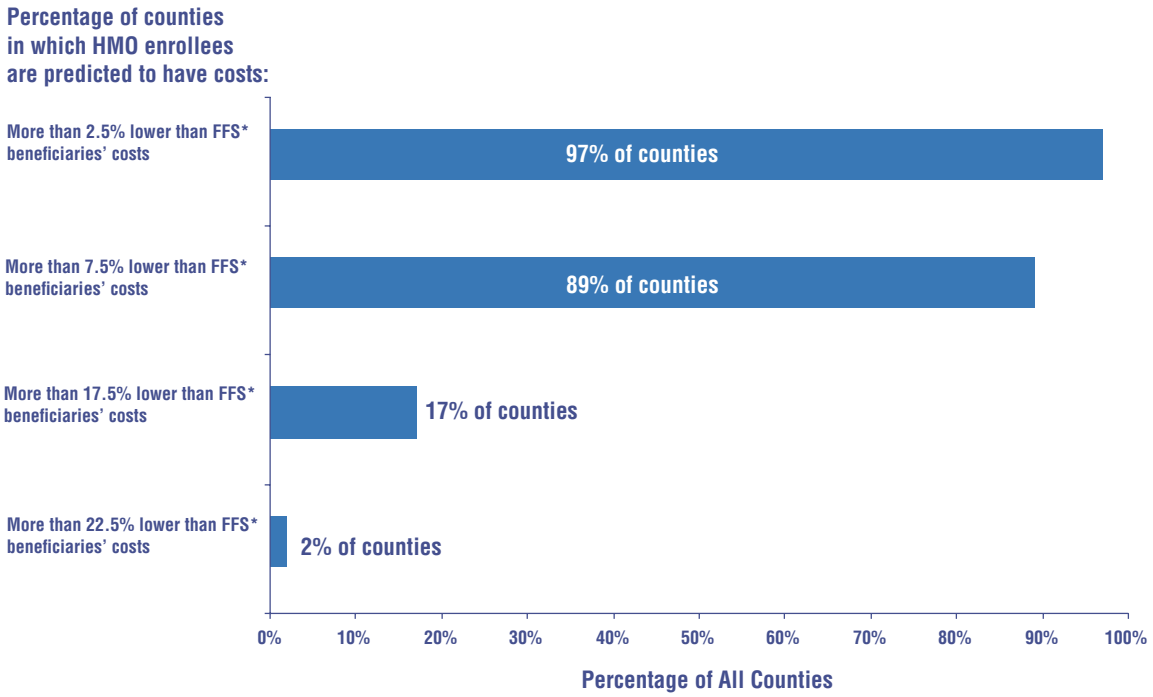
SOURCE: Cassidy and Gold, 2000; Gold, 2001.

Medicare pays Medicare HMOs and other M+C plans a fixed monthly amount for each enrollee to cover all Medicare benefits. Health plans that contract with Medicare are generally required to provide benefits covered under the traditional Medicare program without imposing additional out-of-pocket costs on enrollees. Plans with expenses below the Medicare payment level are required by law to distribute savings to beneficiaries in the forms of lower plan premiums and copayments or additional benefits, or they must return excess payments to Medicare.

Generous plan payments during the 1990s enabled participating Medicare HMOs to offer additional benefits to Medicare enrollees for no additional premium (the "zero-premium option").[1] Although 70 percent of plans offered a zero-premium option in 1998, less than half of all Medicare+Choice plans do so today, due in part to reductions in payments to plans. Between 1999 and 2001, the share of enrollees paying a monthly premium of $50 or more rose from 3 percent to 19 percent, and average monthly premiums (among those plans imposing a premium) increased from $32.11 to $42.52.

[1]Medicare beneficiaries enrolled in Medicare HMOs and other Medicare+Choice plans continue to pay the monthly Medicare Part B premium, which is $50.00 in 2001.

Figure 45
Measures of Favorable Selection in Medicare+Choice Plans, 1997–1998



*FFS: Fee-for-Service.

Note: Analysis based on inpatient encounter data for services provided between July 1997 and June 1998 in the 428 counties with at least 1,000 Medicare managed care enrollees.

SOURCE: Greenwald, Levy, and Ingber, 2000.

One of the major challenges facing the Medicare+Choice program is establishing payment amounts that reflect enrollees' health needs. Many studies suggest that Medicare managed care enrollees are in better health and thus have lower than average medical costs than do those in the traditional program. For example, between 1997 and 1998, Medicare+Choice enrollees in 89 percent of all counties had average predicted costs that were more than 7.5 percent lower than those of their fee-for-service counterparts. This implies that managed care may have resulted in increased Medicare spending, rather than savings, because capitated payments to plans do not reflect the better health of this population overall.

Recognizing the need for risk-adjusted payments that more accurately reflect the health needs of enrollees in order to help prevent financial losses to the program, Medicare has recently begun to phase in a new risk-adjustment system based on beneficiary inpatient hospital stays during the previous year. A more comprehensive risk adjuster using both inpatient and ambulatory data is expected to be fully in place by 2007.

Section V

Medicare and Prescription Drugs

Section V: Medicare and Prescription Drugs

Medicare generally does not cover the cost of outpatient prescription drugs. Despite the growing use of pharmaceuticals in medical practice, 27 percent of beneficiaries lacked drug coverage throughout 1998. The remainder had coverage for at least part of the year through employer-sponsored plans (33 percent), Medicare+Choice plans (15 percent), Medicaid (12 percent), and Medigap (10 percent). In addition, many low-income seniors in 23 states now receive help with drug costs through state-sponsored pharmacy assistance programs already in operation. Of the approximately 10 million beneficiaries without drug coverage in 1998, one-half had incomes below 175 percent of the federal poverty level. Those without prescription drug coverage tend to fill fewer prescriptions and have higher out-of-pocket drug expenses than do those with drug coverage.

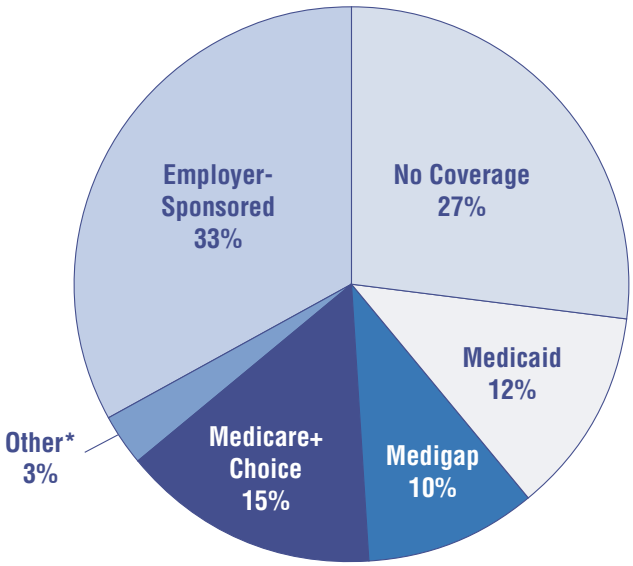
Existing sources of supplemental coverage appear to be eroding due in large part to the high and rising costs of prescription drugs. The share of large employers offering retiree benefits has declined, while the cost-sharing requirements for those with drug coverage and other retiree benefits have increased. Of the 3.9 million beneficiaries with Medicare+Choice drug coverage in 2001, 37 percent faced an annual limit on their drug benefit of less than $750, and another 24 percent had a limit of between $750 and $1,500. Medigap drug benefits are capped at $1,250 or $3,000 on top of a $250 deductible. Many states are also introducing changes in their Medicaid drug benefits in an effort to constrain spending.

Prescription drugs have been the fastest-growing component of health-care spending over the 1990s, a trend that is attributable primarily to increases in the number of prescriptions dispensed and the shift to newer, higher-cost drugs. This increased spending is projected to continue through the coming decade.

Drug spending is concentrated among a relatively small share of Medicare beneficiaries. In 2001, 10 percent of beneficiaries are estimated to have drug expenditures of $4,000 or more, with 4 percent having expenditures in excess of $6,000. Almost half (49 percent) are estimated to have expenditures of less than $1,000, with about 12 percent of beneficiaries consuming no prescription drugs in 2001. Medicare beneficiaries' out-of-pocket drug expenses are also skewed. About 17 percent of all Medicare beneficiaries are projected to have no out-of-pocket drug spending in 2001, with 13 percent having out-of-pocket expenses of $2,000 or more.

Out-of-pocket expenditures for drugs also vary by the type of supplemental insurance beneficiaries hold, ranging from an average of $237 for Medicaid enrollees to $609 for those with Medigap policies.

Figure 46
Prescription Drug Coverage Among Non-Institutionalized Medicare Beneficiaries, 1998



Total = 38.1 Million Medicare Beneficiaries, 1998

*Includes other public programs such as Veterans Affairs, Department of Defense, and State Pharmaceutical Programs for low-income elderly, as well as non-risk health maintenance organizations (HMOs).

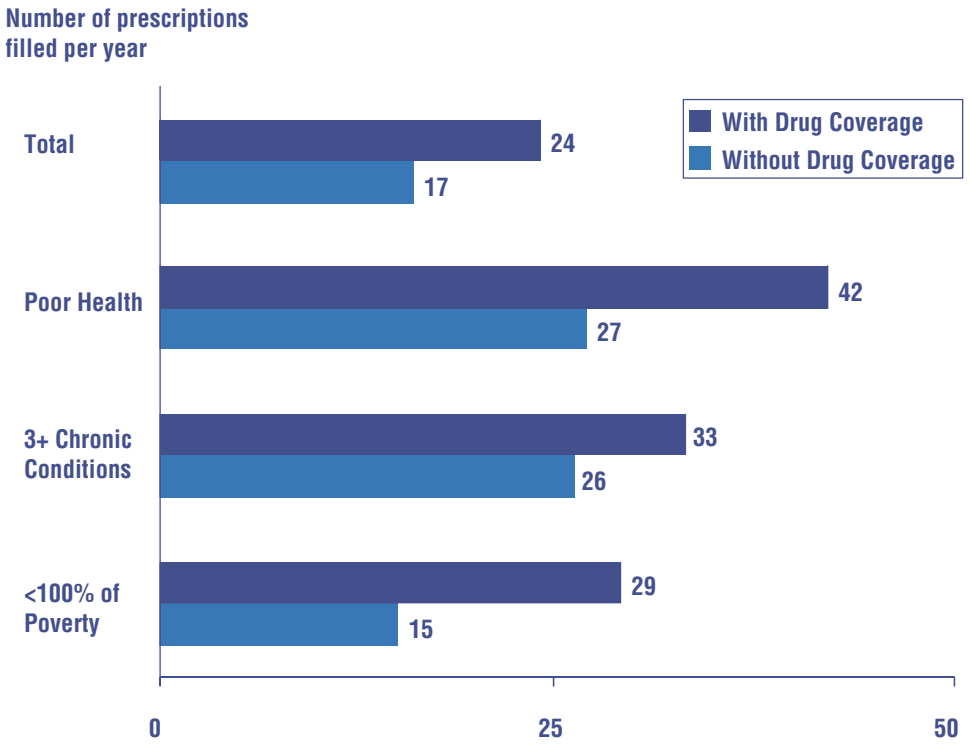
Note: Excludes institutionalized beneficiaries.

SOURCE: Poisal and Murray, 2001.

While more than a quarter (27 percent) of Medicare beneficiaries lacked any prescription drug coverage throughout the year in 1998, approximately half of the Medicare population either had gaps in their drug coverage or lacked it altogether over the course of the year. Medicare beneficiaries have coverage for prescription drug expenses through a variety of sources: Employer-sponsored plans (33 percent), Medicare managed care (Medicare+Choice) plans (15 percent), Medicaid (12 percent), individually purchased Medigap policies (10 percent), and other public and private sources (3 percent).

Figure 47

Average Number of Prescriptions Filled by Non-Institutionalized Medicare Beneficiaries With and Without Drug Coverage, 1998

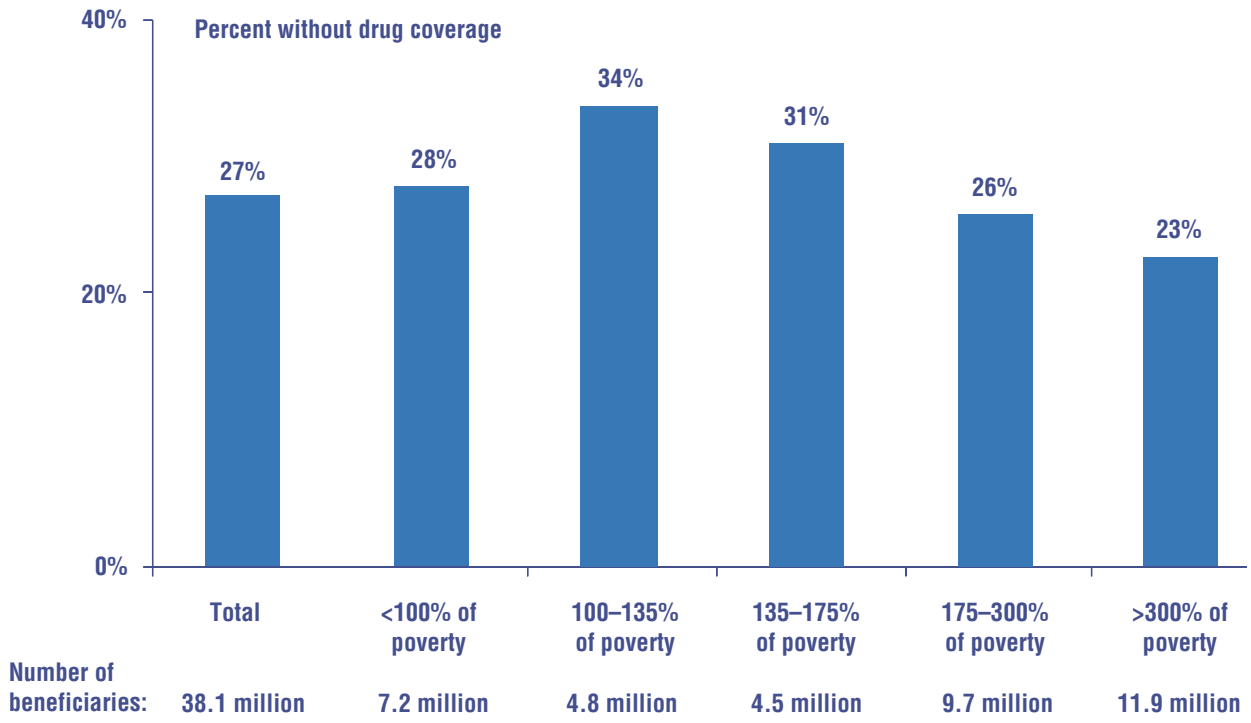


Note: 1998 poverty thresholds were as follows: Aged/Living alone—$7,818; Aged/Two-person household—$9,862; Disabled/Living alone—$8,480; Disabled/Two-person household—$10,972.

SOURCE: Poisal and Murray, 2001.

Beneficiaries without prescription drug coverage fill one-third fewer prescriptions, on average, than do those with some form of prescription drug coverage. Across a range of beneficiary characteristics, those with prescription drug coverage generally fill more prescriptions in a given year than do those without such coverage. This gap persists among those in poor health and those reporting having three or more chronic conditions. Beneficiaries with drug coverage who describe their health as poor filled an average of 42 prescriptions per year in 1998, versus 27 among those of the same health status who lacked coverage. (A similar gap exists among those reporting their health as excellent between those with and without drug coverage.) Beneficiaries living under the poverty level without coverage fill only about half as many prescription as do equally poor beneficiaries who do have drug coverage. These disparities have important implications for beneficiaries as evidence indicates that going without needed prescriptions is associated with poor health outcomes.

Figure 48
Lack of Prescription Drug Coverage Among Non-Institutionalized Medicare Beneficiaries, by Poverty Status, 1998

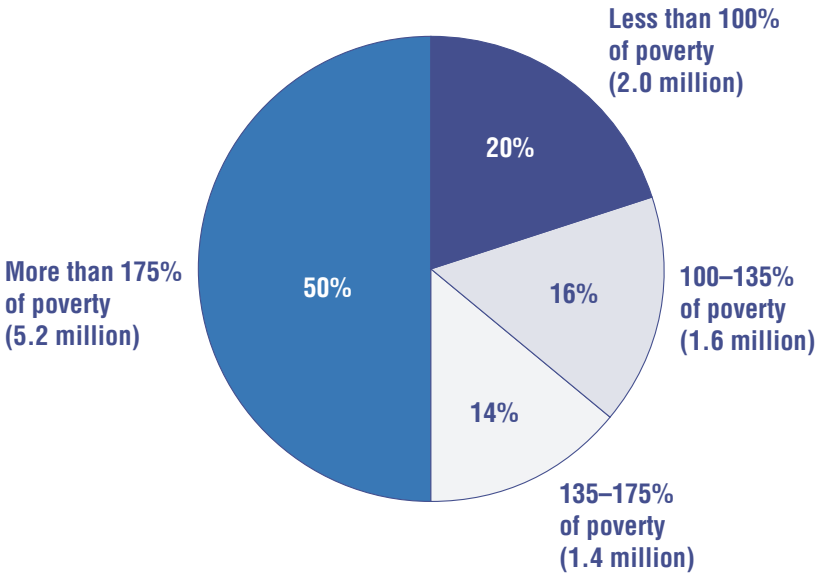


Note: 1998 poverty thresholds were as follows: Aged/Living alone—$7,818; Aged/Two-person household—$9,862; Disabled/Living alone—$8,480; Disabled/Two-person household—$10,972.

SOURCE: Poisal and Murray, 2001.

Although lack of prescription drug coverage affects beneficiaries of all income levels, the poor and near-poor are less likely to have access to prescription drug coverage than are those with higher incomes. Beneficiaries with incomes between 100 and 135 percent of the federal poverty level are more likely than those with incomes below poverty to lack drug coverage due to Medicaid's role in insuring the lowest-income beneficiaries. Lower-income beneficiaries are also less likely to have employer-sponsored coverage and to be able to afford a Medigap policy that includes drug coverage.

Figure 49
Distribution of Non-Institutionalized Medicare Beneficiaries Without Prescription Drug Coverage, by Poverty Status, 1998



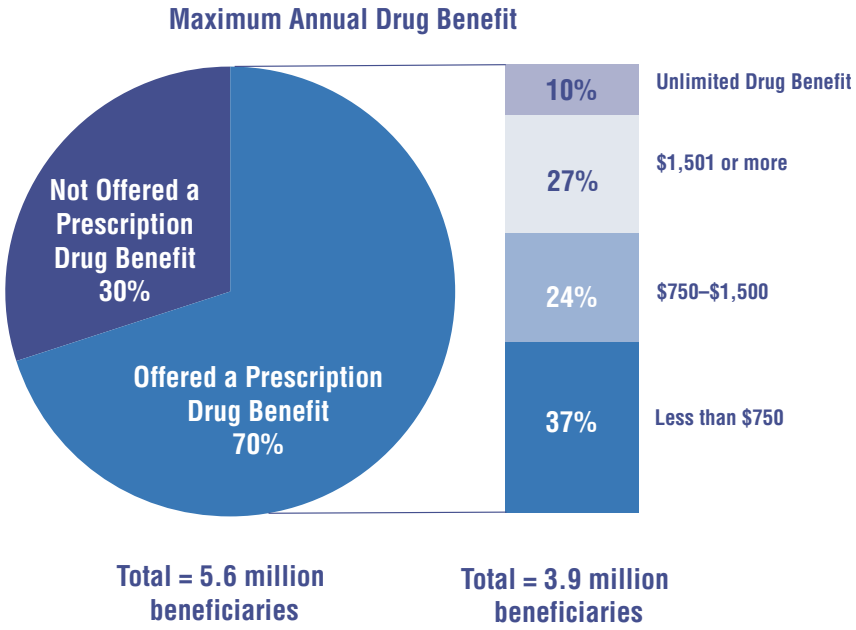
Total = 10.2 million beneficiaries without drug coverage, 1998

Note: 1998 poverty thresholds were as follows: Aged/Living alone—$7,818; Aged/Two-person household—$9,862; Disabled/Living alone—$8,480; Disabled/Two-person household—$10,972.

SOURCE: Poisal and Murray, 2001.

Although poor beneficiaries are more likely than higher-income beneficiaries to lack prescription drug coverage, half of all Medicare beneficiaries without prescription drug coverage have incomes above 175 percent of poverty.

Figure 50
Distribution of Medicare Managed Care Enrollees, by Annual Drug Benefit Limit, 2001



Note: Numbers may not total to 100% due to rounding.

SOURCE: Gold and Achman, March 2001.

Throughout the 1990s, Medicare+Choice plans were increasingly viewed as a promising source of prescription drug coverage. During the mid-1990s, enrollment in these plans grew rapidly, primarily because many offered highly valued benefits such as prescription drug coverage for little or no additional cost to beneficiaries. With the recent withdrawal of many Medicare+Choice plans from the Medicare market, access to these benefits is eroding and plans remaining in the market are implementing a variety of strategies to limit their prescription drug liabilities.

Of the 5.6 million beneficiaries enrolled in Medicare+Choice plans in 2001, 3.9 million (70 percent) received prescription drug coverage through basic plans, down from 84 percent in 1999. Of Medicare+Choice enrollees with prescription drug coverage through basic plans, only 10 percent had an unlimited drug benefit, while 37 percent had a cap on their drug benefit of $750 or less. In 1999, just 21 percent faced drug benefit caps of this amount.

Figure 51
State Senior Pharmaceutical Assistance Programs

Type of Program	Program Description	States with Program
Direct Benefit	• Assists with prescription drug costs • Generally targeted toward low-income elderly without drug coverage • Variable cost-sharing, often income-related	AZ, AK, CT, DE, FL, IL, IN, KS, ME, MD, MI, MN, NJ, NY, NC, PA, RI, SC, TX, VT, WY
Insurance	• Assists with prescription drug costs • Eligibility not necessarily limited to low-income • Premium generally subsidized for low-income • Variable cost-sharing, often income-related • Administered by private entities or the state	MD, MA, NV
Price Reduction	• Sets limits on the drug prices charged to Medicare beneficiaries; no state subsidy required • Affects retail and/or wholesale prices • Eligibility not necessarily limited to low-income	CA, CT, FL, ME, MD, VT, WV
Buying Pool	• Uses group purchasing to obtain price discounts for those without drug coverage • No state subsidy required • Private entities negotiate prices	IA, ME, MA, NH, WA, VT
Tax Credit	• Provides refundable tax credit to elderly with high drug costs • Eligibility generally limited to low-income	MI, MO

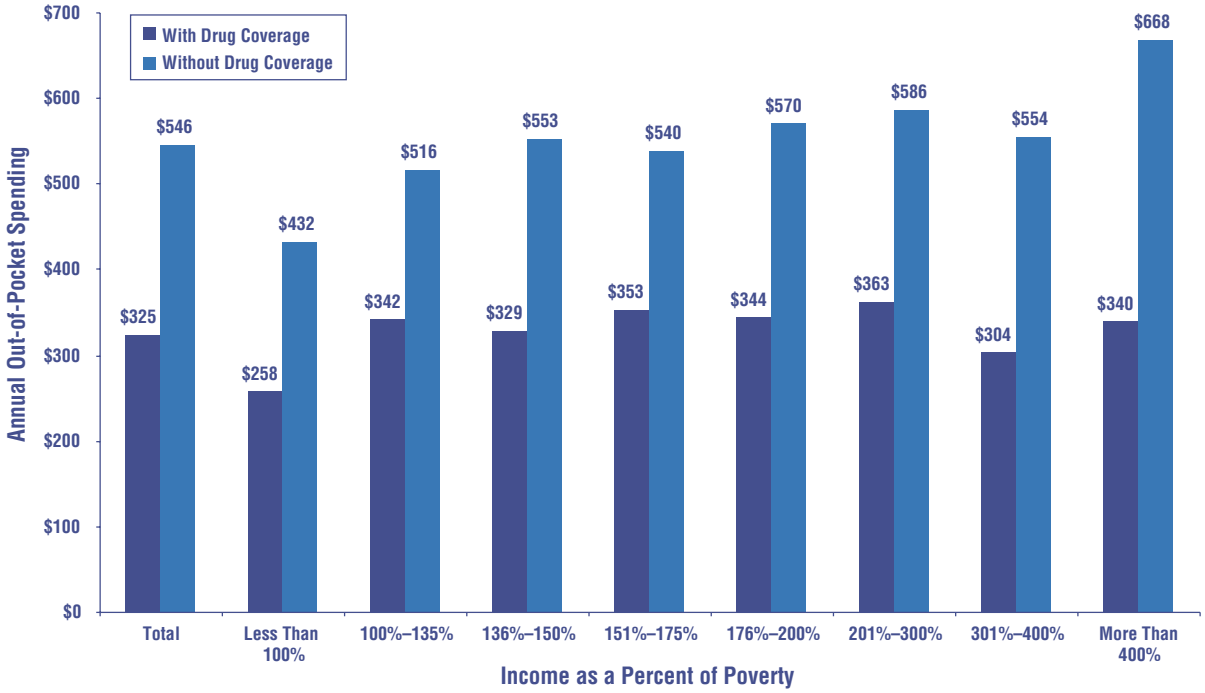
Note: Some states have more than one type of program in operation and are thus listed multiple times.
SOURCE: AARP, 2001 (analysis of data obtained from the National Conference of State Legislatures).

As of July 2001, 29 states had adopted some type of program to assist Medicare beneficiaries with the cost of prescription drugs, with some states having more than one program already in operation. These programs fall into one of five categories: direct benefit programs (21 states), insurance programs (3 states), price reduction programs (7 states), buying pools (6 states), and tax credit programs (2 states).

These programs vary in their approaches to lowering the prices beneficiaries pay for prescription medications, their eligibility criteria, and the extent to which they require funding from the state.

Figure 52

Out-of-Pocket Drug Spending Among Non-Institutionalized Beneficiaries With and Without Drug Coverage, by Poverty Status, 1998



Note: 1998 poverty thresholds were as follows: Aged/Living alone—$7,818; Aged/Two-person household—$9,862; Disabled/Living alone—$8,480; Disabled/Two-person household—$10,972.

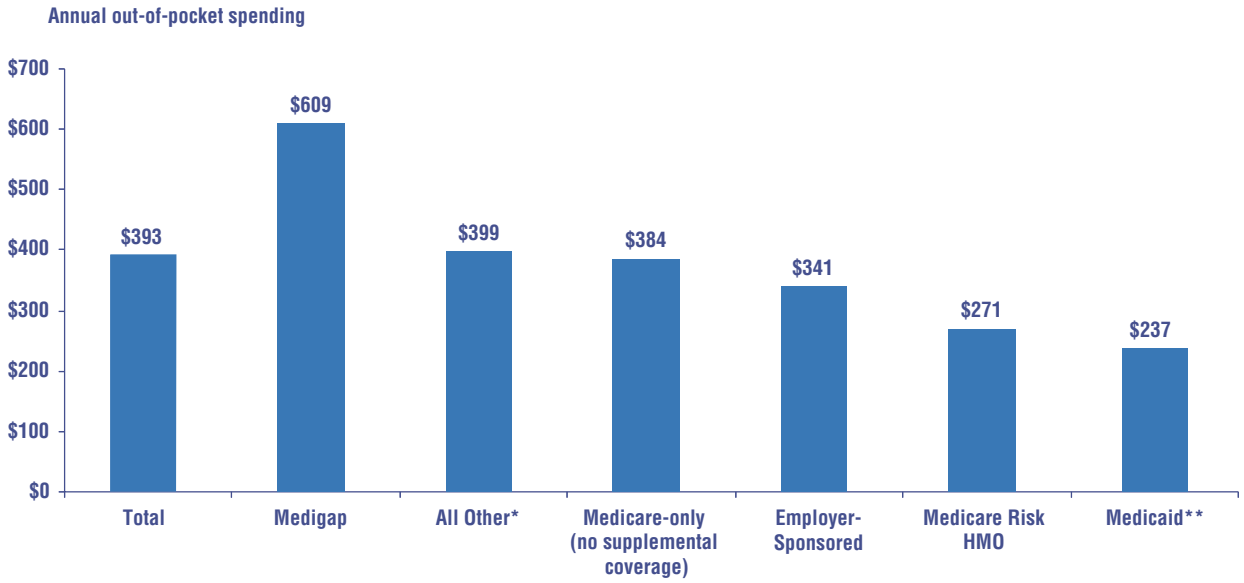
SOURCE: Poisal and Murray, 2001.

Prescription drug coverage has a significant impact on Medicare beneficiaries' out-of-pocket drug spending. Despite the fact that those without drug coverage fill fewer prescriptions than do those with it, they spend more out-of-pocket on prescription drugs.

Beneficiaries with drug coverage spent on average $325 on drugs compared with $546 among those without it in 1998. This disparity persists among Medicare beneficiaries of all income levels. Among beneficiaries with incomes below the federal poverty level, those without drug coverage had average out-of-pocket drug expenses of $432, compared to $258 among low-income beneficiaries with drug coverage. Among those with incomes above 400 percent of poverty, those with drug coverage had average out-of-pocket drug expenses of $340, while those without coverage spent $668. Rising drug costs could widen these disparities even further.

Figure 53

Out-of-Pocket Drug Spending Among Non-Institutionalized Medicare Beneficiaries, by Primary Source of Supplemental Coverage, 1998



*Includes other public programs such as Veterans Affairs, Department of Defense, State Pharmaceutical Assistance Programs, and non-risk HMOs.

**Includes those receiving full Medicaid benefits, as well as QMBs and SLMBs.

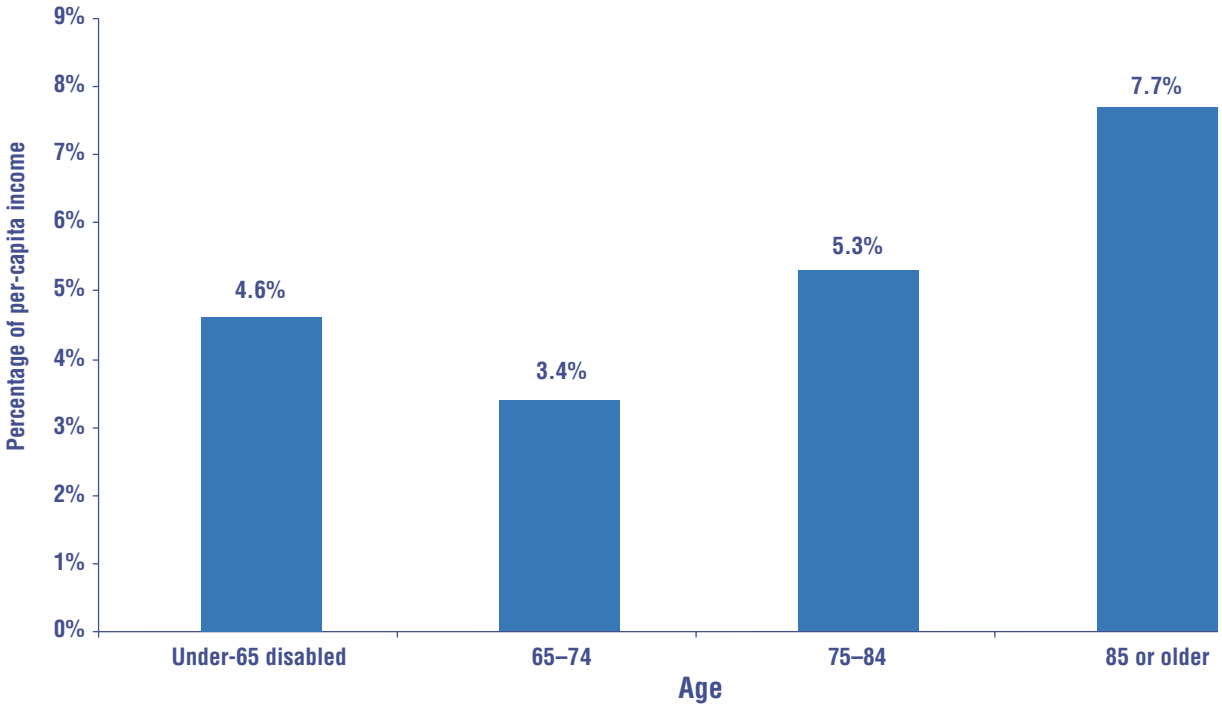
Note: Data based on the noninstitutionalized population and include beneficiaries with and without drug coverage.

SOURCE: Poisal and Murray, 2001.

Out-of-pocket drug spending among Medicare beneficiaries varies by source of supplemental coverage, reflecting differences in the generosity of benefits and potential variations in the health-care needs of those with different sources of coverage. Across all non-institutionalized Medicare beneficiaries, average annual out-of-pocket spending on drugs was $393 per beneficiary in 1998, ranging from $237 among beneficiaries also enrolled in Medicaid to $609 among those with Medigap coverage (many of whom do not have prescription coverage). Beneficiaries with no supplemental coverage spent an average of $384 on prescription drugs in 1998.

Figure 54

Out-of-Pocket Drug Spending Among Non-Institutionalized Medicare Beneficiaries as a Share of Income, by Age, 1997



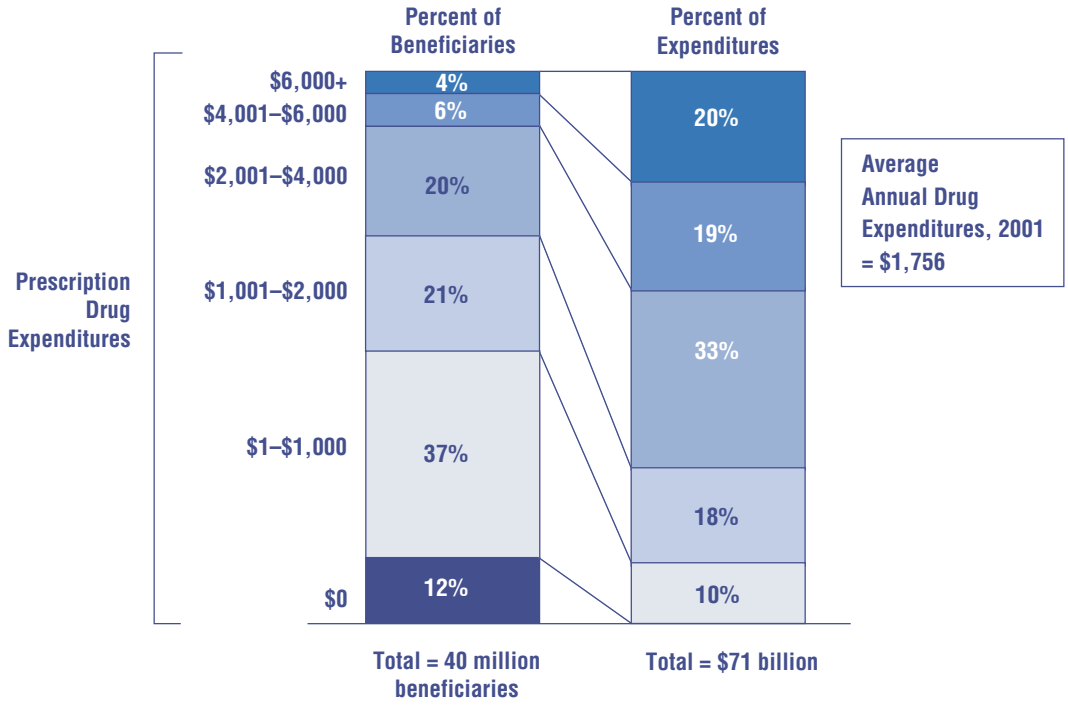
Note: Figure excludes HMO, ESRD, and institutionalized beneficiaries.

SOURCE: M. Moon, The Urban Institute (analysis of the 1997 Medicare Current Beneficiary Survey).

Beneficiaries dedicate an increasingly large share of their incomes to spending on prescription drugs as they age. This increase is due to changes in health-care needs, coverage, and income, as out-of-pocket spending on prescription drugs does not necessarily increase in absolute terms over the life span (average spending actually drops among those ages 85 and over).

In 1997, the share of elderly beneficiaries' incomes devoted to prescription drugs rose from 3.4 percent among those ages 65–74 to 7.7 percent among those 85 or older. Under-65 disabled beneficiaries spent 4.6 percent of their incomes on average on drugs.

Figure 55
Distribution of Medicare Beneficiaries and Prescription Drug Expenditures, 2001

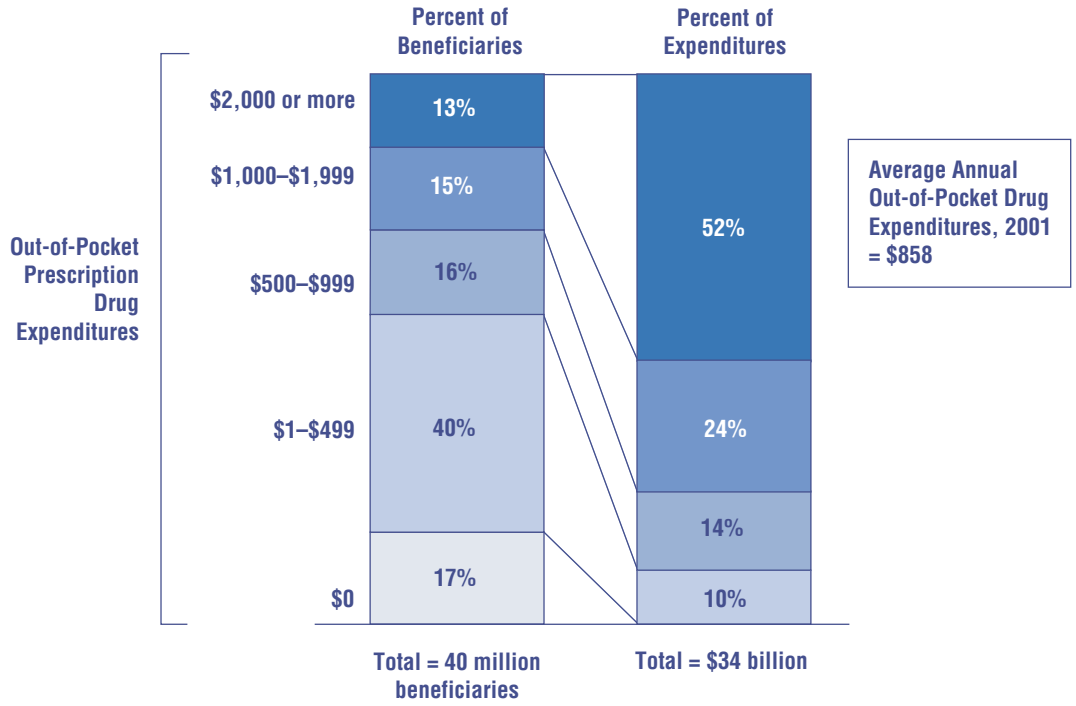


SOURCE: Congressional Budget Office, 2001 (revised estimates of drug spending based on January 2001 baseline).

Average per-capita drug spending among the Medicare population is projected to be $1,756 in 2001. However, as with health-care expenditures for the Medicare population in general, drug spending is highly skewed and is concentrated among a relatively small share of beneficiaries.

About 12 percent of beneficiaries currently have no drug expenses and almost half (49 percent) of beneficiaries will have either no expenses or expenses of less than $1,000. At the upper end of expenditures, just 10 percent of beneficiaries will have expenditures of $4,000 or more, and 4 percent will have expenditures in excess of $6,000. Together, these two groups constitute 39 percent of all drug expenditures on behalf of Medicare beneficiaries.

Figure 56
Distribution of Medicare Beneficiaries and Out-of-Pocket Drug Expenditures, 2001

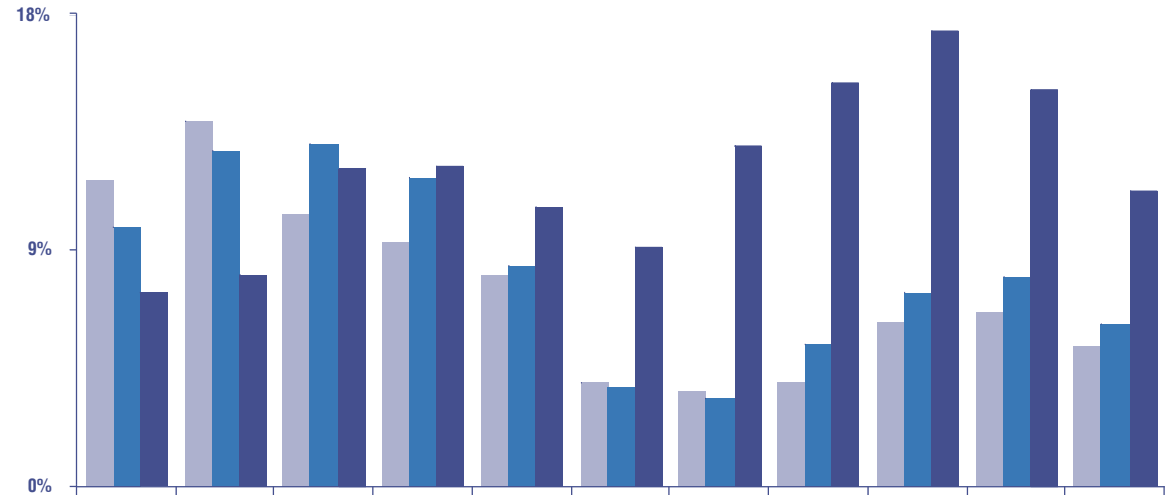


SOURCE: Actuarial Research Corporation for the Kaiser Family Foundation, 2001 (using CBO's revised estimates of drug spending based on January 2001 baseline).

Average per-capita out-of-pocket spending on prescription drugs among Medicare beneficiaries is projected to be $858 in 2001. Out-of-pocket drug expenditures among Medicare beneficiaries reflect a distribution similar to that of total drug expenditures, although the expenses incurred are on average substantially lower due to the presence of insurance for a majority of beneficiaries.

About 17 percent of beneficiaries are projected to have almost no out-of-pocket drug expenses in 2001, while 73 percent of beneficiaries will have either no out-of-pocket drug expenses or expenses of less than $1,000. Those with the highest out-of-pocket drug expenses (of more than $2,000) account for 13 percent of beneficiaries, but 52 percent of total out-of-pocket drug spending among the Medicare population.

Figure 57
Annual Growth in Selected National Health Expenditures, 1970–2010



	1970	1980	1985	1990	1992	1994	1996	1998	2000*	2002*	2010*
Hospital Care	11.7%	13.9%	10.4%	8.9%	8.1%	3.9%	3.6%	3.4%	6.3%	6.6%	5.4%
Physician Services	9.9%	12.8%	13.1%	11.8%	8.4%	3.8%	3.3%	5.4%	7.4%	8.0%	6.2%
Prescription Drugs	7.4%	8.1%	12.1%	12.2%	10.7%	9.1%	13.0%	15.4%	17.4%	15.1%	11.3%

*Projected

Note: Growth calculated as average annual percent change over 10-year period from 1970–1980; over 5-year periods from 1980-1990; and 1-year intervals between 1991 and 2010.

SOURCE: National Health Statistics Group, Office of the Actuary, Health Care Financing Administration, 2000; Heffer, 2001.

Prescription drugs were the fastest-growing component of health-care spending throughout the 1990s, a trend that is projected to continue through the coming decade. This rapid growth may be attributed to price increases among existing drugs and changes in utilization stemming from both the rising number of prescriptions dispensed and the increased use of newer, higher-cost drugs.

Annual increases in spending for prescription drugs have outpaced increases for hospital care and physician services since 1990. Since 1995, spending on prescription drugs has grown at a rate of more than 10 percent per year, with increases of more than 15 percent per year at the end of the decade. By contrast, spending for hospital and physician services has grown at rates of less than 10 percent since the early 1990s. The annual growth in prescription drug spending is projected to be about 11 percent by 2010.

Section VI

Financing Medicare

Section VI: Financing Medicare

Part A services are financed out of the Hospital Insurance (HI) Trust Fund, which receives the bulk of its income from payroll taxes—1.45 percent from employers and 1.45 percent from employees. This tax rate has remained the same since 1986, although Congress eliminated the cap on the level of wages subject to the Medicare payroll tax and raised the maximum share of Social Security benefits subject to taxation to 85 percent in 1993, thus increasing revenue to the Trust Fund.

Part B services are funded out of the Supplementary Medical Insurance (SMI) Trust Fund. The SMI program is financed by a combination of premiums paid by beneficiaries (25 percent of annual program costs) and general tax revenues (almost all of the remainder).

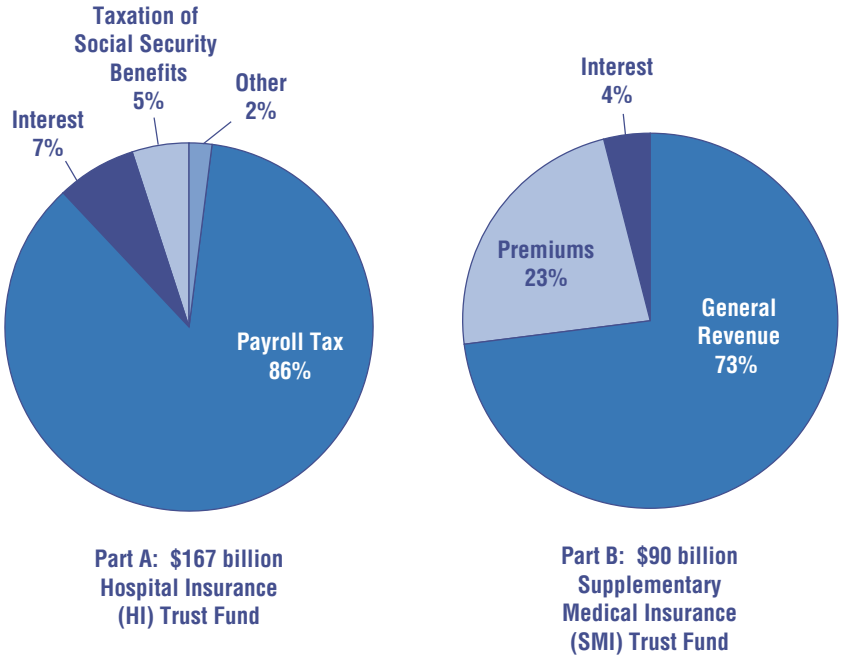
Because the Hospital Insurance (HI) Trust Fund can theoretically become insolvent, its status has become a proxy for Medicare's overall financial health. Each year, as part of an assessment of Medicare's financial outlook, the Trustees of the program project how long the HI Trust Fund will remain solvent. Such projections vary from year to year due to changes in underlying economic conditions, expectations about future health-care costs, and Congressional changes to the Medicare program. In 1994 through 1996, the Trustees estimated that the HI Fund would become insolvent by 2001. In 2001, however, they projected the longest period of HI solvency in Medicare's history—through 2029.

The SMI Trust Fund, in contrast to HI, cannot become insolvent because income from premiums and general revenues is set annually at a level sufficient to pay benefits. However, SMI costs are rising faster than are those of the HI Trust Fund. These increases will require higher premiums from beneficiaries and more general tax revenues in coming years, more than doubling from $50 per month in 2001 to $110 in 2011, according to Congressional Budget Office projections.

Looking at the Medicare program as a whole, over half of revenues in 2000 came from payroll taxes (56 percent). General revenues accounted for 26 percent, premiums represented just under 9 percent, and the remaining 9 percent came from various other sources, including interest and taxes paid on Social Security benefits.

Over the long term, Medicare will face significant financial challenges as the Baby Boom generation retires, beginning in 2010. The number of beneficiaries will almost double between 2001 and 2030, from 40 million to 77 million. The growth rate will be particularly significant among the oldest-old (i.e., beneficiaries ages 85 and over). In addition, the number of workers paying payroll taxes will not be keeping pace with the increase in the number of beneficiaries. The number of workers per beneficiary will fall from 4.0 in 1999 to 2.3 in 2030. As a result of all of these factors, Medicare spending is expected to double from 2.2 percent of the economy (GDP) in 2000 to 4.5 percent in 2030.

Figure 58
Sources of Medicare Revenue, Parts A and B, 2000



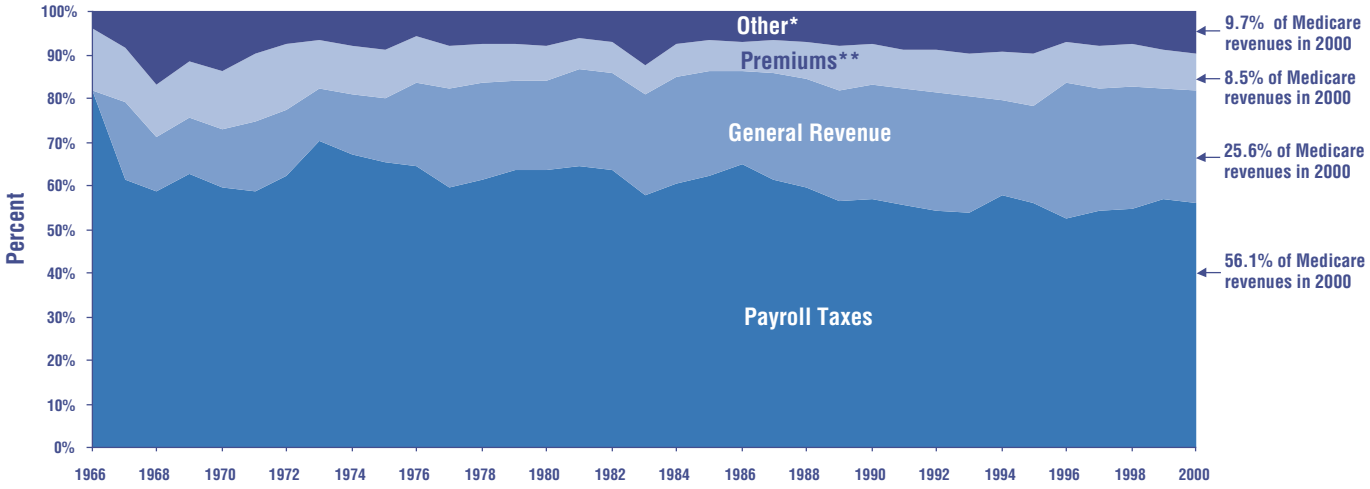
SOURCE: Annual Reports of the Trustees of the Medicare Hospital Insurance Trust Fund and the Medicare Supplementary Medical Insurance Trust Fund, April 2001.

Medicare Parts A and B are financed very differently. Part A, which is paid for by the Hospital Insurance (HI) Trust Fund, is financed primarily through a 1.45 percent payroll tax paid by both employees and their employers. (This tax rate has remained the same since 1986, although Congress eliminated the cap on the level of wages subject to the Medicare payroll tax after 1993 thus increasing revenues to the Trust Fund.) These taxes account for 86 percent of the Trust Fund, with the remainder coming from interest, taxation of Social Security benefits, and other sources.

Part B is financed by the Supplementary Medical Insurance (SMI) Trust Fund, which is funded by general revenues (73 percent), beneficiary premiums (23 percent), and interest (4 percent). Since Medicare's implementation, the primary sources of income for the SMI Trust Fund—premiums and general revenues—have been set each year at a level sufficient to pay benefits.

Figure 59

Income of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds, by Source, 1966–2000



*"Other" includes income from taxation of Social Security benefits, railroad retirement account transfers, reimbursement for uninsured persons, payments for military wage credits, recoveries of amounts reimbursed from the Trust Fund that are not obligations of the Trust Fund, amounts from the fraud and abuse control system, interest, and a small amount of miscellaneous income.

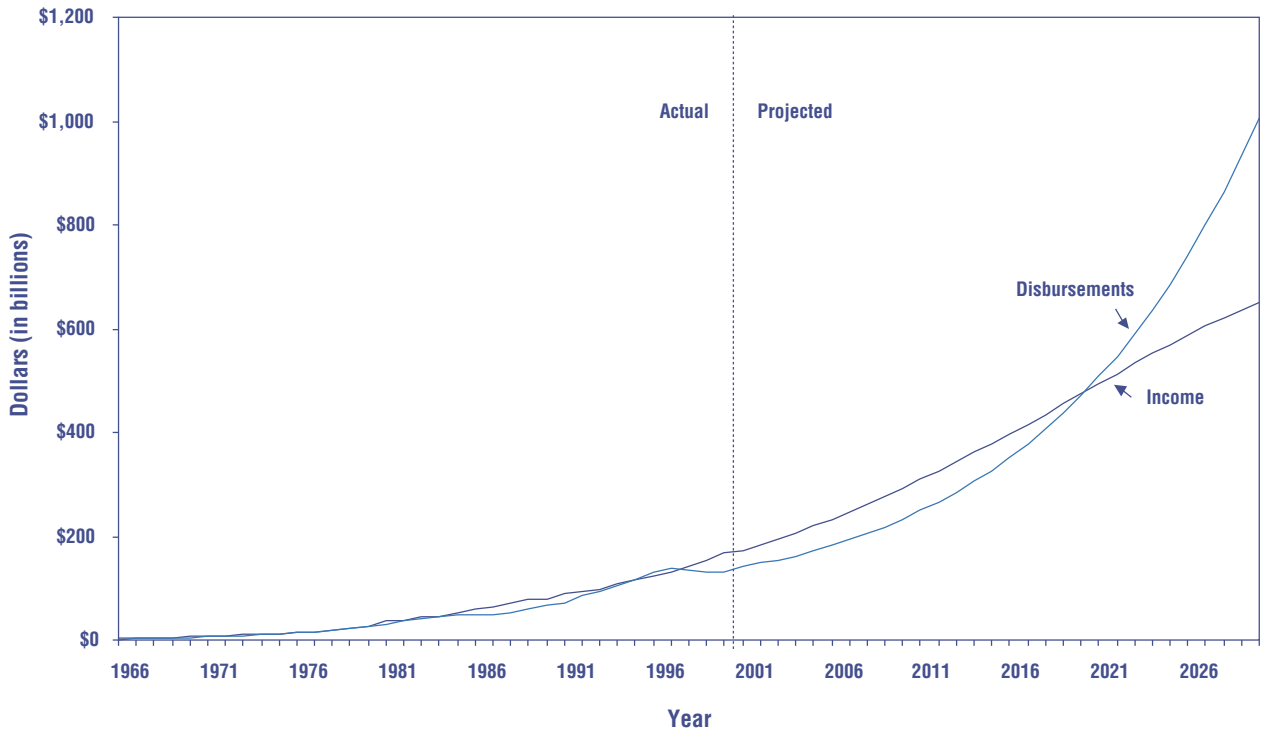
**"Premiums" include premiums from voluntary HI enrollees and all SMI enrollees.

SOURCE: Annual Reports of the Trustees of the Medicare Hospital Insurance (HI) Trust Fund and the Medicare Supplementary Medical Insurance (SMI) Trust Fund, April 2001.

Looking at sources of income for the HI and SMI Trust Funds combined, the relative role of payroll taxes has generally decreased since the early 1970s. In 2000, payroll taxes accounted for 56 percent of all Medicare revenues.

In 1997, Congress permanently set premiums to equal 25 percent of expected Part B costs. In 2000, both Part B premiums and Part A premiums paid by those not automatically eligible for Part A constituted slightly less than 9 percent of total Medicare revenues.

Figure 60
Operations of the Hospital Insurance (HI) Trust Fund, 1966–2030

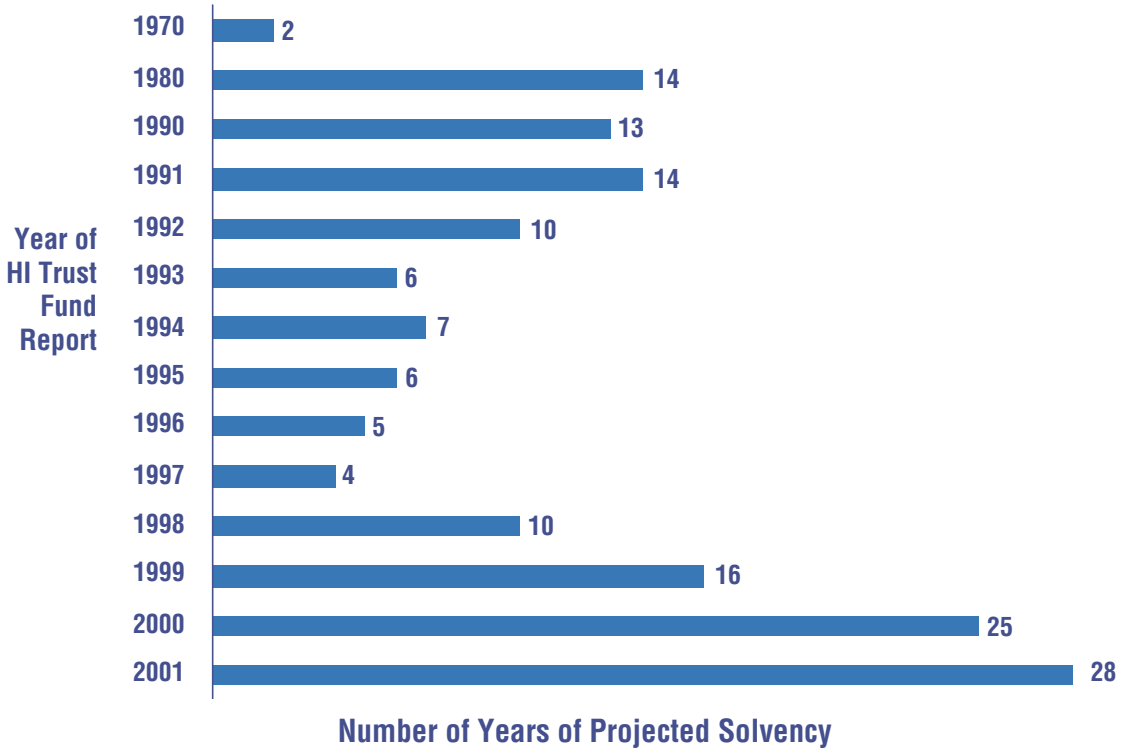


SOURCE: Medicare and Medicaid Cost Estimates Group, Office of the Actuary, Health Care Financing Administration, March 2001; Annual Report of the Trustees of the Medicare Hospital Insurance Trust Fund, April 2001.

Each year, the Medicare Trustees (the Secretaries of Treasury, Labor, and Health and Human Services; and two public Trustees of different parties selected by the President and confirmed by the Senate) issue a report on the current and projected status of the HI Trust Fund.

After rising relative to income in recent years, the growth in disbursements from the Trust Fund has been below that in income due to: (1) the robust economy; (2) more aggressive efforts to fight waste, fraud, and abuse; and (3) changes in payments legislated in the Balanced Budget Act (BBA) of 1997. While income from all sources is expected to continue to exceed disbursements in the short run, spending will begin to exceed revenues in 2021, according to the Trustees' intermediate assumptions.

Figure 61
Projected Years of Hospital Insurance (HI) Trust Fund Solvency, 1970–2001



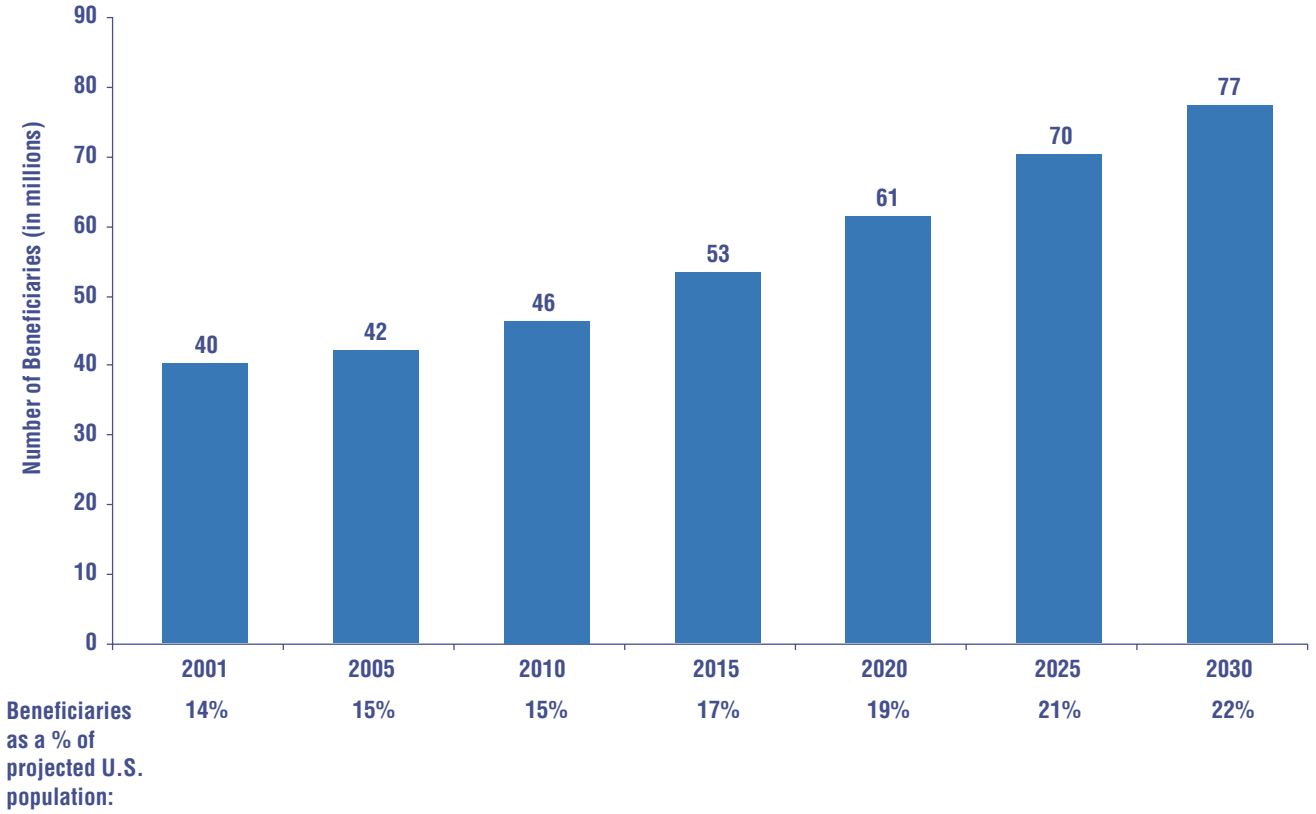
Note: No specific projections made for 1973–1975 and 1989. For all other years not displayed, the HI Trust Fund was projected to remain solvent for 17 or fewer years

SOURCE: Intermediate projections from HI Trustees' reports, 1970–2001.

The Trustees' assessment of the financial outlook for Medicare has varied significantly from year to year due to changes in underlying economic conditions, expectations about future health-care costs, and Congressional changes in the Medicare program. For example, the number of years through which the Trustees have projected the HI Trust Fund to have sufficient funds to pay benefits has ranged from 4 to 28 over the last decade alone. In 1994 through 1996, the Trustees estimated that the HI Trust Fund would become insolvent by 2001.

By 2001, however, they reported the longest period of projected HI solvency in Medicare's history, estimating that funds would be sufficient to pay benefits through 2029. Many factors, including the state of the economy and general trends in health-care spending, will have a direct impact on whether current solvency projections are realized.

Figure 62
Projected Number of Medicare Beneficiaries, 2001–2030



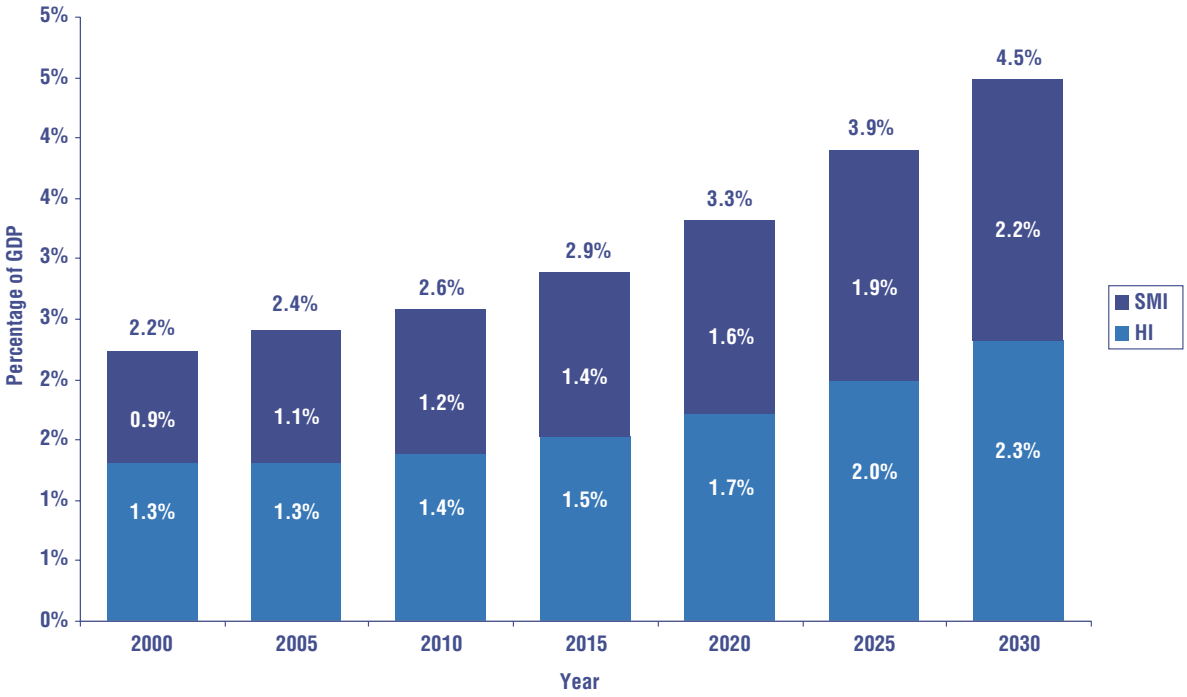
SOURCE: Office of the Actuary, Health Care Financing Administration, November 2000; Population Division, U.S. Census Bureau, May 2001.

Over the long term, Medicare will face significant financing challenges. Among these challenges is the aging of the American population. The first of the "Baby Boom" generation will turn 65 and become eligible for Medicare in 2010. Between 2001 and 2030, the number of Medicare beneficiaries is projected to almost double, rising from 40 million to 77 million.

The number of beneficiaries over age 85 (the "oldest-old") is projected to grow from 4.3 million individuals today to about 8.5 million in 2030. As this population is more likely to need health-care services than are younger beneficiaries, these projections raise particular concerns for Medicare's long-term financing challenges.

The aging of the population also has significant implications for Medicare financing. Because the HI Trust Fund is financed primarily through payroll taxes, its income is directly related to the number of individuals in the workforce. The number of workers is not projected to rise as rapidly as is the number of Medicare beneficiaries, thus increasing the implicit burden on each worker over the next generation. While there were 4 workers for every beneficiary in 1999, there are projected to be only 2.3 workers per beneficiary in 2030.

Figure 63
Projected Medicare Spending as a Percentage of Gross Domestic Product (GDP), 2000–2030



SOURCE: Annual Report of the Trustees of the Medicare Hospital Insurance Trust Fund, April 2001.

With the aging of the population and expected increases in overall health-care costs due largely to new and more expensive medical technologies, Medicare spending is projected to grow at a rate significantly higher than that of the overall economy. Between 2000 and 2030, Medicare's share of the overall economy (GDP) is estimated to more than double from 2.2 percent to 4.5 percent.

Section VII

TABLES

Table A
Medicare's Cost-Sharing Requirements, 1966–2001

	Part A					Part B	
Year	Inpatient Hospital Deductible	Daily Coinsurance (61st-90th Day)	Daily Coinsurance (60 Lifetime Reserve Days)	SNF Daily Coinsurance (21st-100th Day)*	Full Part A Monthly Premium**	Monthly Premium***	Annual Deductible
1966	$40	$10	—	—	—	$3.00	$50
1971	$60	$15	$30	$7.50	—	$5.60	$50
1976	$104	$26	$52	$13.00	$45	$7.20	$60
1981	$204	$51	$102	$25.50	$89	$11.00	$60
1987	$520	$130	$260	$65.00	$226	$17.90	$75
1988	$540	$135	$270	$67.50	$234	$24.80	$75
1989	$560	NA*	NA*	$25.50	$156	$31.90	$75
1990	$592	$148	$296	$74.00	$176	$28.60	$75
1991	$628	$157	$314	$78.50	$177	$29.90	$100
1992	$652	$163	$326	$81.50	$192	$31.80	$100
1993	$676	$169	$338	$84.50	$221	$36.60	$100
1994	$696	$174	$348	$87.00	$245 ($184)	$41.10	$100
1995	$716	$179	$358	$89.50	$261 ($183)	$46.10	$100
1996	$736	$184	$368	$92.00	$289 ($188)	$42.50	$100
1997	$760	$190	$380	$95.00	$311 ($187)	$43.80	$100
1998	$764	$191	$382	$95.50	$309 ($170)	$43.80	$100
1999	$768	$192	$384	$96.00	$309 ($170)	$45.50	$100
2000	$776	$194	$388	$97.00	$301 ($166)	$45.50	$100
2001	$792	$198	$396	$99.00	$300 ($165)	$50.00	$100

*In 1989, the SNF coinsurance was on days 1–8 of the 150 days allowed annually; for the other years, it is on days 21–100 of the 100 days allowed per benefit period.

**People ages 65 and older are automatically entitled to Medicare if they (or their spouse) worked for 40 quarters or more. Those who have not worked 40 quarters may be able to get Part A coverage by paying a monthly premium. Figures in parentheses are for persons who have paid Medicare taxes during at least 30 of the 40 quarters required to be fully insured.

***Part B premium was originally 50% of projected costs. Congress set it at 25% permanently in the Balanced Budget Act of 1997.

Note: NA = not applicable. SNF = skilled nursing facility.

SOURCE: Health Care Financing Administration.

Table B
Characteristics of the Medicare Population, 1999

		Total Community	Aged—Community (No ESRD)	Disabled—Community (No ESRD)	ESRD—* Community	Total Facility**
Number of Beneficiaries		34,752,952	30,240,786	4,302,484	197,939	1,900,670
Gender	Male	44.2%	42.2%	57.3%	58.1%	29.8%
	Female	55.8%	57.8%	42.7%	41.9%	70.2%
Age	Under 65	12.8%	N/A	100.0%	63.7%	16.4%
	65–74	45.1%	51.7%	N/A	22.1%	10.7%
	75–84	32.9%	37.8%	N/A	11.6%	27.4%
	85 and over	9.2%	10.5%	N/A	2.6%	45.5%
Living Arrangement	Lives alone	31.3%	32.5%	23.8%	17.3%	N/A
	Lives with spouse	52.1%	53.8%	39.7%	52.7%	N/A
	Lives with children	9.0%	8.8%	10.5%	8.6%	N/A
	Lives with others	7.6%	4.9%	26.0%	21.3%	N/A
	Lives in long-term care facility	N/A	N/A	N/A	N/A	100.0%
Race/ Ethnicity	White	81.2%	83.0%	69.6%	45.8%	86.7%
	Black, not Hispanic	9.0%	7.6%	17.3%	36.9%	8.2%
	Hispanic	7.3%	6.7%	10.9%	14.6%	4.0%
	Other	2.6%	2.7%	2.2%	2.8%	1.0%
Marital Status	Married	53.4%	55.2%	40.8%	53.7%	12.8%
	Widowed	29.7%	33.1%	7.2%	11.7%	58.5%
	Divorced/Separated	10.0%	8.0%	23.8%	16.8%	6.1%
	Never Married	6.9%	3.8%	28.1%	17.8%	22.7%
Lives in a Metropolitan Area	Yes	76.0%	76.4%	72.7%	85.1%	73.8%
	No	24.0%	23.6%	27.3%	14.9%	26.2%
Education	8th grade or less	16.5%	16.4%	17.4%	18.5%	30.7%
	Some high school	17.1%	16.6%	20.9%	20.7%	32.9%
	High school graduate	29.3%	28.9%	32.1%	28.2%	13.6%
	Some college or 2-year degree	22.3%	22.3%	22.3%	19.8%	15.3%
	College graduate or more	14.7%	15.8%	7.3%	12.8%	7.5%

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Table B *(continued)*
Characteristics of the Medicare Population, 1999

		Total Community	Aged—Community (No ESRD)	Disabled—Community (No ESRD)	ESRD—* Community	Total Facility**
Number of Beneficiaries		34,752,952	30,240,786	4,302,484	197,939	1,900,670
Income	Less than $10,000	24.7%	21.5%	46.0%	29.6%	54.6%
	$10,000–20,000	28.8%	29.0%	26.8%	33.0%	24.1%
	$20,001–30,000	17.8%	18.9%	11.0%	11.9%	9.5%
	$30,001–40,000	11.1%	11.8%	6.7%	3.0%	5.1%
	More than $40,000	17.7%	18.9%	9.6%	22.4%	6.7%
Supplemental Insurance	No supplemental coverage	12.5%	10.2%	28.4%	13.7%	14.8%
	Private coverage	74.7%	80.4%	35.6%	53.3%	26.0%
	Employer-sponsored	33.1%	34.8%	20.9%	††	††
	Medicare HMO	17.3%	18.7%	8.8%	††	††
	Medigap	24.3%	27.0%	5.9%	††	††
	Medicaid	10.9%	7.7%	32.2%	28.3%	58.8%
	Other	1.9%	1.6%	3.8%	4.7%	0.5%
Self-Reported Health Status	Poor	8.6%	5.7%	27.3%	32.3%	15.6%
	Fair	18.9%	16.7%	33.7%	33.5%	41.3%
	Good	31.4%	32.3%	25.2%	28.0%	29.6%
	Very good	26.4%	29.1%	9.1%	4.6%	10.6%
	Excellent	14.7%	16.2%	4.8%	1.7%	2.9%

SOURCE: All data are from the 1999 Medicare Current Beneficiary Survey (MCBS), except for data on "cognitive/mental impairment," which were derived from an Urban Institute analysis of the 1997 MCBS and are not available in all columns (†).

*ESRD includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD. Unweighted n = 99 respondents.

**While the percentages for beneficiaries living in a facility are shown, they may not be reliable due to the high number of missing values. Out of 1,266 beneficiaries who lived in a facility when the survey was conducted, 566 had missing values for education level and 598 had missing values for income level.

***The count for Chronic Conditions includes Stroke, Diabetes, Emphysema, Heart Disease, Hypertension, Arthritis, Osteoporosis, Broken Hip, Parkinson's Disease, and Urinary Incontinence.

††Cell size insufficiently large to be significant.

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Table B *(continued)*
Characteristics of the Medicare Population, 1999

		Total Community	Aged (No ESRD)	Disabled (No ESRD)	Ages 65–84 (No ESRD)	Ages 85+ (No ESRD)	ESRD—* Community	Total Facility**
Number of Beneficiaries		34,752,952	30,240,786	4,302,484	27,058,668	3,182,118	197,939	1,900,670
					Percentage of Beneficiaries with Health Condition			
Presence of Chronic Conditions	No Chronic Conditions***	12.6%	11.8%	18.1%	12.4%	6.8%	3.3%	14.1%
	1 Chronic Condition	22.0%	22.3%	20.5%	22.8%	18.1%	15.7%	24.5%
	2+ Chronic Conditions	65.4%	65.9%	61.5%	64.8%	75.1%	81.0%	61.4%
	Hypertension	54.6%	55.4%	46.4%	55.2%	57.5%	93.4%	35.6%
	Emphysema	14.9%	13.8%	22.6%	14.1%	10.7%	15.2%	7.7%
	Diabetes	17.0%	16.5%	19.5%	16.8%	13.2%	50.5%	16.2%
	Arthritis	56.6%	57.4%	52.1%	56.4%	65.7%	38.0%	18.6%
	Osteoporosis/Broken Hip	15.6%	15.9%	12.9%	15.1%	23.4%	17.1%	14.4%
	Parkinson's Disease	1.1%	1.2%	0.8%	1.1%	2.0%	1.0%	6.1%
	Pulmonary Disease	36.9%	37.5%	32.0%	36.5%	46.0%	55.8%	27.8%
	Stroke	10.3%	10.0%	12.5%	9.3%	15.6%	15.1%	11.0%
	Alzheimer's Disease	2.0%	2.1%	1.2%	1.5%	7.3%	0.9%	15.0%
	Skin Cancer	16.3%	17.8%	5.6%	17.3%	22.8%	11.5%	0.6%
	Other Types of Cancer	16.8%	17.4%	12.4%	17.3%	18.6%	13.4%	5.2%
	Urinary Incontinence	18.6%	18.4%	19.7%	17.1%	29.8%	9.6%	62.0%
	1+ Limitations in Activities of Daily Living (ADLs)	30.5%	27.8%	48.7%	25.0%	51.4%	41.7%	N/A
	Cognitive/Mental Impairment†	—	18.8%	51.4%	—	—	—	—

SOURCE: All data are from the 1999 Medicare Current Beneficiary Survey (MCBS), except for data on "cognitive/mental impairment," which were derived from The Urban Institute's analysis of the 1997 MCBS and are not available in all columns (†).

*ESRD includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD. Unweighted n = 99 respondents.

**While the percentages for beneficiaries living in a facility are shown, they may not be reliable due to the high number of missing values. Out of 1,266 beneficiaries who lived in a facility when the survey was conducted, 566 had missing values for education level and 598 had missing values for income level.

***The count for Chronic Conditions includes Stroke, Diabetes, Emphysema, Heart Disease, Hypertension, Arthritis, Osteoporosis, Broken Hip, Parkinson's Disease, and Urinary Incontinence.

Table C
Characteristics of the Medicare Population, by State, Selected Years

State	Total Number of Medicare Beneficiaries (1998)	Projected State Population Age 65+ as a Percentage of State Population (2025)	Medicare Beneficiaries Age 65+ as a Percentage of State Medicare Population (1998)	Disabled Medicare Beneficiaries Under Age 65 as a Percentage of State Medicare Population (1998)	Medicare Beneficiaries Residing in Rural Areas as a Percentage of State Medicare Population (1998)	Medicare Beneficiaries With Income <100% of Poverty as a Percentage of State Medicare Population (1997–1999)	Medicare Beneficiaries With Income 100%–199% of Poverty as a Percentage of State Medicare Population (1997–1999)	Medicare Beneficiaries With Medicaid as a Percentage of State Medicare Population (1998)	Beneficiaries in Medicare+Choice Plans as a Percentage of State Medicare Population (1998)	Total Medicare Spending Per Beneficiary (1998)
United States Total	38,976,551 (14.4% of U.S. population)	18.5% of U.S. Population	85.9% of U.S. Medicare population	14.1% of U.S. Medicare Population	23.2% of U.S. Medicare Population	11.8% of U.S. Medicare population	29.9% of U.S. Medicare population	13.2% of U.S. Medicare population	15.3% of U.S. Medicare Population	$5,465
Alabama	688,085 (15.8% of state population)	20.5% of state population	81.2% of state Medicare population	18.8% of state Medicare population	35.8% of state Medicare population	16.5% of state Medicare population	31.3% of state Medicare population	17.8% of state Medicare population	6.54% of state Medicare population	$5,376
Alaska	33,321 (5.4%)	10.4%	80.8%	19.2%	60.4%	9.8%	27.6%	21.8%	N/A (No plans offered)	$4,374
Arizona	661,577 (14.2%)	21.3%	86.8%	13.2%	13.9%	10.1%	28.1%	7.8%	38.7%	$4,691
Arkansas	445,398 (17.5%)	23.9%	81.3%	18.7%	60.5%	14.1%	33.6%	17.6%	3.1%	$4,475
California	3,903,432 (11.9%)	13.0%	87.1%	12.9%	4.9%	10.7%	26.9%	20.0%	37.1%	$6,035
Colorado	463,640 (11.7%)	20.1%	84.8%	15.2%	18.0%	7.9%	25.9%	11.3%	30.0%	$5,150
Connecticut	521,900 (15.9%)	17.9%	88.3%	11.7%	3.1%	13.4%	25.6%	9.9%	20.0%	$6,159
Delaware	110,583 (14.9%)	19.2%	86.4%	13.6%	27.1%	11.8%	30.1%	8.2%	10.4%	$3,834
District of Columbia	79,106 (15.1%)	14.0%	86.5%	13.5%	N/A (No rural areas)	18.5%	24.6%	18.5%	8.6%	$11,801
Florida	2,803,554 (18.8%)	26.3%	88.7%	11.3%	7.9%	10.8%	30.3%	11.3%	26.7%	$6,564
Georgia	911,435 (11.9%)	16.9%	81.1%	18.9%	39.6%	13.3%	24.1%	18.7%	4.1%	$4,931
Hawaii	163,738 (13.7%)	15.9%	90.7%	9.3%	27.4%	11.7%	27.5%	11.8%	N/A (No plans offered)	$4,092
Idaho	162,984 (13.3%)	21.5%	86.8%	13.2%	66.6%	9.5%	34.4%	9.2%	N/A (No plans offered)	$3,854

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Table C *(continued)*
Characteristics of the Medicare Population, by State, Selected Years

State	Total Number of Medicare Beneficiaries (1998)	Projected State Population Age 65+ as a Percentage of State Population (2025)	Medicare Beneficiaries Age 65+ as a Percentage of State Medicare Population (1998)	Disabled Medicare Beneficiaries Under Age 65 as a Percentage of State Medicare Population (1998)	Medicare Beneficiaries Residing in Rural Areas as a Percentage of State Medicare Population (1998)	Medicare Beneficiaries With Income <100% of Poverty as a Percentage of State Medicare Population (1997–1999)	Medicare Beneficiaries With Income 100%–199% of Poverty as a Percentage of State Medicare Population (1997–1999)	Medicare Beneficiaries With Medicaid as a Percentage of State Medicare Population (1998)	Beneficiaries in Medicare+Choice Plans as a Percentage of State Medicare Population (1998)	Total Medicare Spending Per Beneficiary (1998)
Illinois	1,674,480 (13.9%)	16.6%	87.1%	12.9%	21.1%	12.8%	29.0%	8.8%	9.2%	$5,234
Indiana	863,940 (14.6%)	19.2%	85.6%	14.4%	30.7%	10.9%	31.3%	9.3%	1.7%	$5,104
Iowa	486,705 (17.0%)	22.6%	88.9%	11.1%	63.0%	5.7%	33.8%	10.3%	0.6%	$3,804
Kansas	397,584 (15.1%)	19.5%	88.2%	11.8%	52.4%	8.5%	25.8%	9.9%	5.0%	$4,667
Kentucky	628,611 (16.0%)	21.3%	78.5%	21.5%	56.2%	13.9%	37.2%	17.0%	3.4%	$4,808
Louisiana	616,597 (14.1%)	18.4%	81.5%	18.5%	26.9%	17.7%	35.6%	18.7%	16.6%	$7,246
Maine	216,426 (17.4%)	21.4%	83.0%	17.0%	46.3%	12.2%	29.2%	15.4%	N/A (No plans offered)	$3,818
Maryland	643,419 (12.5%)	16.4%	87.8%	12.2%	9.8%	13.2%	22.7%	9.6%	13.9%	$5,876
Massachusetts	977,729 (15.9%)	18.1%	85.5%	14.5%	1.6%	12.8%	28.7%	14.4%	22.1%	$6,132
Michigan	1,418,415 (14.4%)	18.1%	85.0%	15.0%	21.4%	8.8%	29.1%	9.7%	3.8%	$5,630
Minnesota	660,763 (14.0%)	19.9%	88.3%	11.7%	40.9%	8.1%	26.9%	8.8%	8.6%	$4,377
Mississippi	423,573 (15.4%)	19.6%	78.4%	21.6%	70.2%	17.7%	34.5%	25.1%	N/A (No plans offered)	$5,440
Missouri	873,114 (16.1%)	20.1%	85.1%	14.9%	37.4%	12.9%	26.5%	9.4%	12.0%	$5,557
Montana	137,835 (15.7%)	24.4%	85.8%	14.2%	76.0%	8.3%	30.7%	8.6%	N/A (No plans offered)	$4,014
Nebraska	257,736 (15.5%)	21.0%	89.1%	10.9%	60.8%	11.9%	34.2%	7.0%	4.3%	$4,301
Nevada	227,425 (13.0%)	21.0%	86.3%	13.7%	14.5%	9.8%	30.2%	7.6%	20.4%	$5,171
New Hampshire	168,759 (14.2%)	19.0%	85.7%	14.3%	34.2%	9.5%	30.1%	3.8%	9.8%	$4,003
New Jersey	1,218,599 (15.0%)	17.3%	88.3%	11.7%	N/A (No rural areas)	10.1%	31.6%	11.6%	14.5%	$5,843
New Mexico	232,164 (13.4%)	16.9%	84.4%	15.6%	46.6%	17.7%	26.8%	15.0%	18.3%	$3,752

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Table C *(continued)*
Characteristics of the Medicare Population, by State, Selected Years

State	Total Number of Medicare Beneficiaries (1998)	Projected State Population Age 65+ as a Percentage of State Population (2025)	Medicare Beneficiaries Age 65+ as a Percentage of State Medicare Population (1998)	Disabled Medicare Beneficiaries Under Age 65 as a Percentage of State Medicare Population (1998)	Medicare Beneficiaries Residing in Rural Areas as a Percentage of State Medicare Population (1998)	Medicare Beneficiaries With Income <100% of Poverty as a Percentage of State Medicare Population (1997–1999)	Medicare Beneficiaries With Income 100%–199% of Poverty as a Percentage of State Medicare Population (1997–1999)	Medicare Beneficiaries With Medicaid as a Percentage of State Medicare Population (1998)	Beneficiaries in Medicare+Choice Plans as a Percentage of State Medicare Population (1998)	Total Medicare Spending Per Beneficiary (1998)
New York	2,749,385 (15.1%)	16.5%	85.8%	14.2%	8.8%	12.7%	30.7%	13.3%	15.0%	$6,436
North Carolina	1,123,635 (14.9%)	21.4%	82.6%	17.4%	39.2%	15.2%	32.2%	18.8%	2.6%	$4,933
North Dakota	105,167 (16.5%)	22.8%	89.4%	10.6%	66.9%	14.2%	34.4%	5.3%	N/A (No plans offered)	$4,675
Ohio	1,732,371 (15.5%)	19.6%	86.1%	13.9%	19.3%	11.8%	30.0%	10.4%	14.2%	$5,249
Oklahoma	513,876 (15.4%)	21.9%	85.8%	14.2%	47.4%	11.7%	33.7%	12.3%	8.4%	$4,773
Oregon	492,890 (15.0%)	24.2%	87.6%	12.4%	35.2%	10.9%	29.5%	10.7%	25.4%	$3,840
Pennsylvania	2,132,903 (17.8%)	21.0%	88.7%	11.3%	16.4%	8.9%	33.9%	8.7%	23.6%	$6,324
Rhode Island	173,827 (17.6%)	18.8%	85.9%	14.1%	N/A (No rural areas)	9.3%	39.2%	10.2%	29.0%	$6,035
South Carolina	561,822 (14.6%)	20.7%	81.1%	18.9%	33.7%	12.6%	34.0%	18.8%	N/A (No plans offered)	$4,793
South Dakota	121,238 (16.4%)	21.7%	88.3%	11.7%	73.5%	12.1%	31.2%	10.6%	N/A (No plans offered)	$4,270
Tennessee	830,508 (15.3%)	20.3%	81.5%	18.5%	37.5%	13.0%	31.2%	20.8%	3.3%	$5,935
Texas	2,253,872 (11.4%)	16.1%	86.4%	13.6%	23.3%	16.0%	31.2%	15.1%	13.6%	$6,781
Utah	203,455 (9.7%)	17.2%	87.3%	12.7%	28.1%	6.7%	27.5%	7.3%	8.2%	$4,548
Vermont	88,951 (15.1%)	20.4%	84.4%	15.6%	74.4%	7.8%	29.2%	14.8%	N/A (No plans offered)	$3,380
Virginia	879,315 (12.9%)	17.9%	84.7%	15.3%	32.1%	14.8%	25.2%	12.3%	3.9%	$4,305
Washington	737,168 (13.0%)	20.2%	86.5%	13.5%	22.4%	9.1%	24.2%	12.1%	24.7%	$4,069
West Virginia	343,413 (19.0%)	24.9%	80.1%	19.9%	58.9%	13.3%	32.7%	12.3%	N/A (No plans offered)	$4,586
Wisconsin	794,789 (15.2%)	20.5%	87.5%	12.5%	37.2%	5.4%	34.1%	9.4%	2.9%	$4,241
Wyoming	65,339 (13.6%)	20.9%	86.5%	13.5%	68.2%	13.5%	36.2%	9.2%	N/A (No plans offered)	$3,487

SOURCE: L. Green, et al., *Medicare State Profiles: State and Regional Data on Medicare and the Population It Serves*, The Henry J. Kaiser Family Foundation, September 1999; M. Moon, The Urban Institute, from the 1997–1999 Current Population Survey; and Health Care Financing Administration, May 2001.

Section VIII

Data Sources and References

Data Sources

The charts presented in this publication draw data from several sources. The primary source of data about the Medicare population is the Medicare Current Beneficiary Survey (MCBS), which is used to assist the Centers for Medicare and Medicaid Services (CMS) in the administration, monitoring, and evaluation of the Medicare program. The MCBS is a continuous survey of a nationally representative sample of more than 16,000 Medicare beneficiaries, which consists of two data files. The "Access to Care" file includes demographic information and beneficiary responses to questions about health status, access to care, and satisfaction with that care. These data have been collected since 1991. Since 1992, the MCBS has also produced a "Cost and Use" file that includes estimates of beneficiaries' total personal health care use and expenditures as well as their sources of payment. Once data collection is complete, there is typically a delay of a few years before the files are made publicly available, with the "Access to Care" file released before the "Cost and Use" data.

In producing this Chart Book, we made every effort to obtain and use the most current available data. In many instances—particularly in describing the characteristics of the Medicare population—we were able to obtain data from the 1999 MCBS through analysis conducted for the Foundation by the Barents Group of KPMG Consulting. In other cases, we rely on analyses of data from the 1998 and 1997 MCBS. (The 1997 data and some of the 1998 data were analyzed for the Foundation by Marilyn Moon of the Urban Institute.)

Data on Medicare program spending—past, present, and future—come from the CMS Office of the Actuary and the Congressional Budget Office (CBO). The Office of the Actuary collects data on actual spending and publishes them in an annual Statistical Supplement to the *Health Care Financing Review.* At the time of this publication, the most recent year for which the Office had actual spending data available was 1998.

Some data on program revenues, projected spending, and the state of the Medicare Trust Funds come from the Office of the Actuary and the annual reports of the Medicare and Social Security Trustees. As part of its work to support the Congressional budget process, CBO prepares periodic estimates of federal spending for the preceding and current years (referred to as the "baseline" estimate). As these estimates of Medicare spending are often more recent than are those provided by CMS, some of the charts in Section II rely on the CBO baseline. In other cases, we use slightly earlier data from the Office of the Actuary because they provide greater detail about the nature of Medicare spending.

Other data sources for this Chart Book include the Current Population Survey (CPS), a nationally representative annual household survey administered by the Census Bureau that collects economic and demographic information; and several published reports and academic papers that we consider the most appropriate and up-to-date sources on particular topics. Individual charts and the following list of References include more detailed citations.

References

AARP, Public Policy Institute. "State Pharmacy Assistance Programs 2001: An Array of Approaches." Issue Brief Number 50, July 2001.

Annual Reports of the Trustees of the Medicare Hospital Insurance (HI) Trust Fund and the Medicare Supplementary Medical Insurance (SMI) Trust Fund, April 2001.

The Budget and Economic Outlook: Fiscal Years 2002–2011. Congressional Budget Office, 2001.

Cassidy, A, and M Gold. "Medicare+Choice in 2000: Will Employees Spend More and Receive Less?" Mathematica Policy Research, Inc., July 2000.

Clark, WD, and M Hulbert. "Research Issues: Dually Eligible Medicare and Medicaid Beneficiaries, Challenges and Opportunities." *Health Care Financing Review* (Winter 1998): 1–10.

The Faces of Medicare: Profiles of a Diverse Population. The Henry J. Kaiser Family Foundation, 1999.

General Accounting Office. "Medigap Insurance: Plans Are Widely Available But Have Limited Benefits and May Have High Costs." GAO-01-941. July 31, 2001.

Gold, M. "Medicare+Choice: An Interim Report Card." *Health Affairs* (July/August 2001): 120–138.

Gold, M, and L Achman. "Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001." Issue Brief prepared for The Commonwealth Fund, April 2001.

Greenwald, L, J Levy, and M Ingber. "Favorable Selection in the Medicare+Choice Program: New Evidence." *Health Care Financing Review* (Spring 2000): 127–134.

Health Care Financing Review. Medicare and Medicaid Statistical Supplement, 1999.

Heffer, S, et al., "Health Spending Growth Up in 1999; Faster Growth Expected in the Future." *Health Affairs* (March/April 2001): 193–203.

Income of the Population 55 or Older. Social Security Administration, March 2000.

Maxwell, S, M Moon, and M Segal. "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries." Report prepared for The Commonwealth Fund, December 2000.

Medicare and You 2001. Health Care Financing Administration, 2001.

Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report. Health Care Financing Administration, June 2001.

Medicare State Profiles: State and Regional Data on Medicare and the Populations It Serves. Report prepared by The Barents Group for The Henry J. Kaiser Family Foundation, September 1999.

National Conference of State Legislatures. Data on State Senior Pharmaceutical Assistance Programs (www.ncsl.org/programs/health/drugaid.htm), July 2001.

Poisal, JA, and L Murray. "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage." *Health Affairs* (March/April 2001): 74–85.

Report to the Congress: Medicare in Rural America. The Medicare Payment Advisory Commission, June 2001.

Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits. Report prepared by Hewitt Associates for The Henry J. Kaiser Family Foundation, October 1999.

Tilson, S. Memorandum to the Senate Finance Committee on HCFA Budget, Organization, and Staffing Information. Congressional Research Service, January 30, 2001.

Section IX

Fact Sheets

MEDICARE AT A GLANCE

June 2001

What Is Medicare and How Is It Financed?

Medicare is the federal health insurance program that covers 34 million Americans ages 65 and older and another 5 million younger adults with permanent disabilities. Like Social Security, Medicare is a social insurance program. It serves all eligible beneficiaries without regard to income or medical history. Medicare has played a central role in the U.S. health system since it was established in 1965. Today it provides health insurance coverage to one in seven Americans.

Medicare Part A (the Hospital Insurance Program) is financed mainly by a 1.45% payroll tax paid by both employees and employers. Revenue from the payroll tax is held in the Hospital Insurance Trust Fund and used to pay Part A benefits. Part B (the Supplementary Medical Insurance Program) is financed by both beneficiary premiums ($50 per month in 2001) and general revenue. Premiums cover about a quarter of total Part B spending.

Most individuals 65 and older are automatically entitled to Medicare Part A if they or their spouse are eligible for Social Security payments. People under 65 who receive Social Security cash payments because they are disabled generally become eligible for Medicare after a 2-year waiting period. People with end-stage renal disease (ESRD) are entitled to Part A regardless of their age. Part B is voluntary, but 95% of all Part A beneficiaries enroll in Part B.

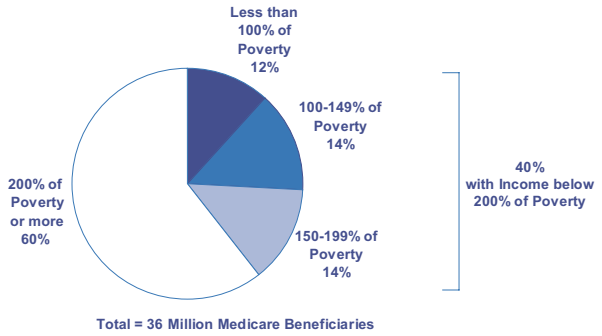
Who Is Covered Under Medicare?

Medicare covers a diverse population:

- Most beneficiaries (76%) are ages 65 to 84, but the under-65 disabled (13%) and those 85+ (11%) are growing rapidly.
- Four in ten beneficiaries (40%) have incomes at or below twice the poverty level ($16,480 for individuals; $22,120 for couples in 1999) (Exhibit 1).

Exhibit 1

The Non-Institutionalized Medicare Population, by Poverty Level, 1999



Note: Reflects income from all household family members. If income from household family members other than spouse were excluded, 17% would have incomes below poverty. The 1999 federal poverty level was $8,240 for individuals; $11,060 for couples.
Source: Urban Institute estimates based on 2000 Current Population Survey.

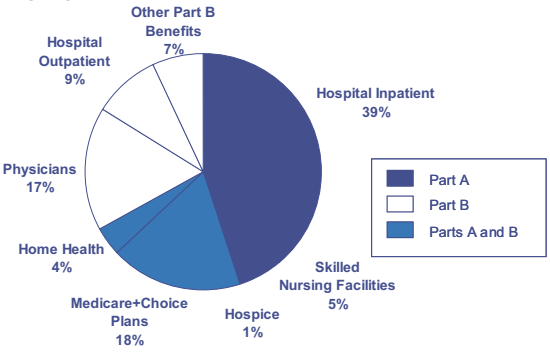
- Nearly one in three (30%) say their health is fair or poor.
- About one in four (23%) have difficulty with mental functioning.

What Benefits Does Medicare Cover?

Medicare provides broad coverage of basic benefits, but does not cover outpatient prescription drugs or long-term care. Medicare Part A, which finances 45% of benefits, covers inpatient hospital services, skilled nursing facility (SNF) benefits, home health visits following a hospital or SNF stay, and hospice care (Exhibit 2). Inpatient hospital services are subject to a deductible ($792 per benefit period in 2001) and a daily coinsurance beginning after the 60th day of a hospital stay. SNF care is limited to 100 days, subject to a 3-day prior hospitalization requirement, with coinsurance ($99 per day in 2001) for days 21-100. No copayments apply to home health services.

Exhibit 2

Estimated Medicare Benefit Payments, by Type of Service, Fiscal Year 2001



* Excludes administrative expenses.
SOURCE: Congressional Budget Office, *April 2001 Baseline: Medicare.*

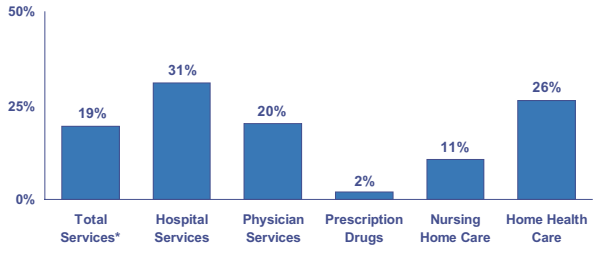
Part B, which accounts for 33% of Medicare benefit spending, covers physician and outpatient hospital services, annual mammography and other cancer screenings, and services such as laboratory procedures and medical equipment. After the $100 Part B deductible, a 20% coinsurance is required for most services.

Medicare+Choice plans contract with Medicare to provide both Part A and B services to enrolled beneficiaries. Medicare+Choice plans account for an estimated 18% of Medicare payments. Home health is also funded under Parts A and B, accounting for 4% of Medicare spending.

Medicare benefit payments are expected to total $237 billion in 2001, accounting for 12% of the federal budget and 19% of total national spending for personal health services. In 1999, Medicare financed 31% of the nation's hospital services and 20% of physician services, but only 2% of outpatient prescription drugs (Exhibit 3).

Exhibit 3

Medicare's Share of National Personal Health Expenditures, by Type of Service, 1999



	(Expenditures in Billions)					
Medicare	$205.9	$121.4	$54.7	$2.0	$9.6	$8.7
Total	$1,057.7	$390.9	$269.4	$99.6	$90.0	$33.1

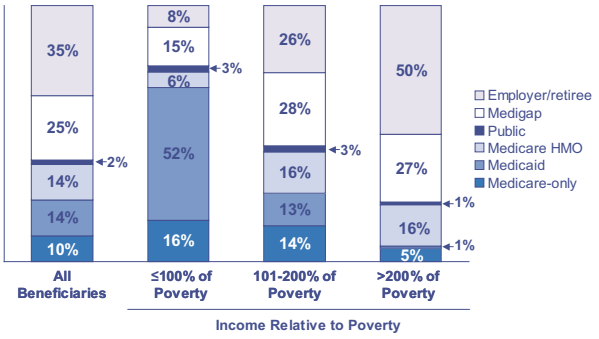
*Total services also include dental care and other professional services.
SOURCE: Health Care Financing Administration, Office of the Actuary, March 2001.

Gaps in Medicare: Implications for Beneficiaries

Medicare does not generally cover outpatient prescription drugs and has high cost-sharing requirements. As a result, most beneficiaries (90%) have some form of supplemental insurance (Exhibit 4). In 1997, over a third had employer-sponsored benefits, a quarter (25%) owned Medigap policies, and 14% had Medicaid, the major public financing program for low-income Americans. Another 14% were enrolled in Medicare HMOs. Those with low incomes are more likely than higher-income beneficiaries to rely on Medicaid or be without supplemental coverage, but less likely to have employer-sponsored retiree health benefits.

Exhibit 4

Health Insurance Coverage of Medicare Beneficiaries, 1997



Note: Columns may not sum to 100%; Employer/retiree includes both beneficiaries who have supplemental insurance from a former employer or union and those who are still working and whose current employer is their primary source of insurance.
Source: Urban Institute analysis of 1997 Medicare Current Beneficiary Survey.

Despite the prevalence of supplemental insurance, 27% of all beneficiaries lacked drug coverage throughout 1998 (Poisal, 2001). With average drug spending at $1,756 in 2001 (CBO, 2001), lack of drug benefits can result in high out-of-pocket spending and under-utilization of needed medications. Retiree health benefits are currently the primary source of drug coverage, followed by Medicare HMOs. However, drug coverage is expected to decline with the predicted erosion of retiree benefits, Medicare HMO withdrawals, and the rise in Medigap premiums.

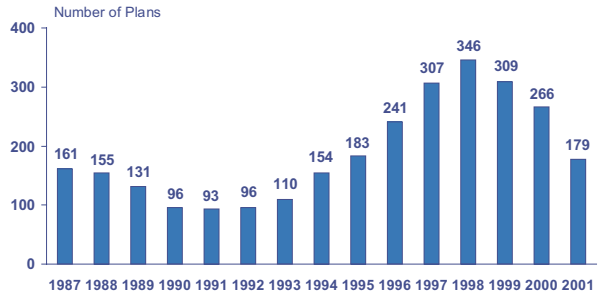
The elderly spent an estimated 22% of their income, on average, for health care services and premiums in 2000. However, seniors in poor health and without supplemental insurance spent about 44% of their income on health care. (Maxwell, et al., 2000).

Medicare+Choice

Medicare HMOs have been an option since the mid-1980s. Beginning in the early 1990s, the number of Medicare HMOs grew rapidly, as did the number of enrollees. Today, 5.6 million Medicare beneficiaries (14%) are enrolled in Medicare HMOs, more than four times the 1990 level, but half a million fewer than the number enrolled in 1999. Enrollment has declined due to a drop in plan participation from 346 in 1998 to 179 in 2001 (Exhibit 5). Declining plan participation has been attributed to administrative requirements, changes in Medicare payments to plans, and other challenges that affect profitability. By 2011, CBO projects enrollment to grow to 18% of the total Medicare population—increasing at a substantially slower rate than was previously anticipated.

Exhibit 5

Medicare HMOs and Other Private Health Plans Participating in Medicare, 1987–2001



Note: All data are from December of the given year, except 2001 (September).
SOURCE: Health Care Financing Administration, Medicare Managed Care Contract Plans Monthly Summary Report.

Medicare's Financial Outlook

Medicare spending has recently grown slowly, increasing by an average of about 1.4% over the last three years (1998-2000) compared with average yearly growth of almost 10% over the preceding decade (1987-1997). This turnaround is associated with changes enacted under the Balanced Budget Act of 1997, intended to slow the growth in payments to providers and plans and to promote provider compliance with payment rules. Combined with a strong economy, this downturn has postponed the expected depletion of the Hospital Insurance Trust Fund to 2029.

While the recent slowdown will produce long-term savings, Medicare spending is expected to grow at a faster pace in coming years. Even with continued improvements in program efficiency, Medicare will face significant financing challenges in the future. A doubling of program enrollment by 2030 coupled with the expected rise in national health care spending will likely necessitate greater resources to maintain current benefits and secure the financial outlook of the program. Additional challenges include improving benefits, particularly prescription drugs; strengthening protections for Medicare's most vulnerable; and stabilizing the Medicare+Choice program. Addressing these challenges will be critical for meeting the needs of the growing number of elderly and disabled on Medicare.

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MEDICARE+CHOICE

September 2001

OVERVIEW

Medicare provides health benefits to 40 million elderly and disabled Americans. Most Medicare beneficiaries (86%) have their health care bills paid directly by the traditional fee-for-service program, while the remaining 14% are covered under Medicare+Choice (M+C) plans.

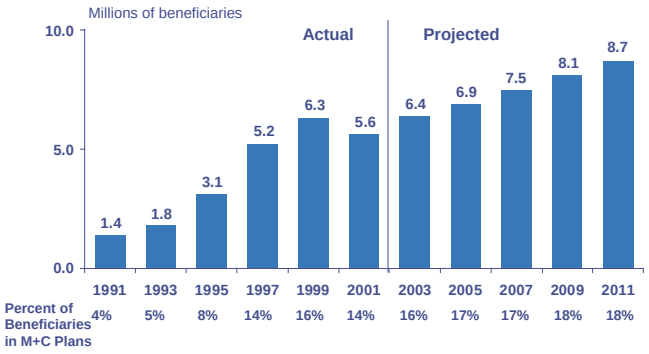
The Balanced Budget Act (BBA) of 1997 established the M+C program allowing beneficiaries to enroll in a variety of private plans in addition to HMOs. Preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans (PFFS), and medical savings accounts (MSAs) coupled with high-deductible insurance plans are permitted to contract with Medicare to provide health benefits to people on Medicare. To date, with the exception of one PSO and one PFFS plan, HMOs remain the primary alternative to traditional Medicare.

ENROLLMENT

Medicare HMO enrollment grew rapidly during the period between 1993 and 1999, climbing from 1.8 million to 6.3 million beneficiaries, or 16% of the total Medicare population (Exhibit 1). Beginning in 1999, enrollment began to level off and has since declined to 5.6 million M+C plan enrollees in 2001. By 2011, CBO projects enrollment to grow to 18% of the total Medicare population, although increasing at a substantially slower rate than was previously projected.

Exhibit 1

Enrollment in Medicare HMOs and Other Medicare+Choice Plans



Note: 2001 data are from June of that year.

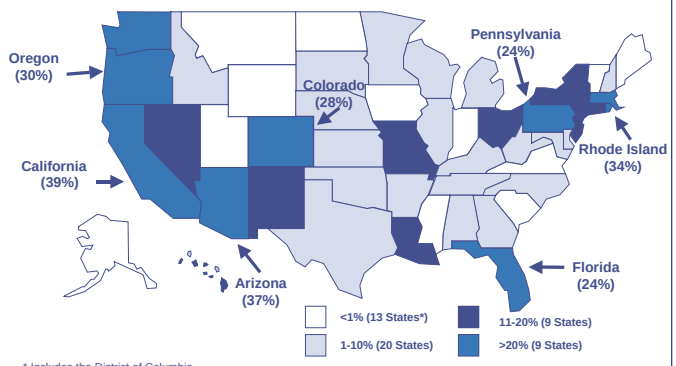
SOURCE: Actual: HCFA/Center for Health Plans and Providers, 2001; Projections: CBO, Medicare Baseline, April 2001.

Although most have a Medicare HMO available in their area, the share of beneficiaries with such an option has recently declined from 72% in 1999 to 64% in 2001. Medicare HMO enrollment remains concentrated in a few states, with over a fourth of Medicare HMO enrollees nationwide residing in California (26%). Only 14% of those living in rural areas have the option of enrolling in a Medicare HMO today.

The share of Medicare beneficiaries enrolled in M+C plans varies widely across states (Exhibit 2). More than a third of all beneficiaries living in California, Arizona, and Rhode Island are enrolled in Medicare HMOs, while in 33 states 10% or fewer are in HMOs. In 13 states, fewer than 1% of Medicare beneficiaries are enrolled in an M+C plan.

Exhibit 2

Medicare+Choice Plan Enrollees as a Percent of Medicare Beneficiaries, by State, 2001



* Includes the District of Columbia

SOURCE: HCFA, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report, June 2001.

PLAN PARTICIPATION

The number of Medicare HMOs available in the 1990s grew rapidly, rising from 96 plans in 1990 to 346 in 1998. In 1999 and each of the following two years, however, the number of plans participating in Medicare declined. Today, 179 M+C plans participate in Medicare. HMO withdrawals and service area reductions during this 3-year period disrupted coverage for 1.5 million beneficiaries, disproportionately affecting beneficiaries residing outside of major urban areas. The under-65 disabled, the oldest-old, and the near-poor experienced the greatest hardship after their HMO withdrew (Laschober, 1999). Declining plan participation has been attributed to changes in Medicare payments to plans that were enacted in 1997, new administrative requirements, provider turnover, and other business concerns that affect profitability.

A number of changes have been adopted since 1997 to encourage plans to stay in the Medicare market. For example, both the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 increased payments to M+C plans. In addition, the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, eased administrative requirements to discourage future terminations.

BENEFITS AND PREMIUMS

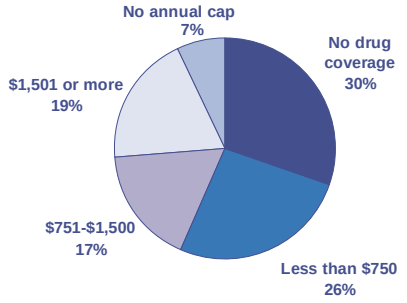
M+C plans are generally required to provide benefits covered under traditional Medicare without imposing additional out-of-pocket costs. Plans with costs below the Medicare payment level are required to distribute savings to beneficiaries in the form of lower plan premiums and copayments or additional benefits, unless they return excess payments to Medicare. As of 2003, M+C plans will be able to offer reduced Part B premiums as an extra benefit.

Most M+C plans offer benefits in addition to those covered by traditional Medicare as part of their basic plan option. However, there has been a decline in the availability of some key benefits, like prescription drugs, preventive dental coverage, and hearing benefits (Mathematica Policy Research, Inc., 2001). The share of M+C enrollees in basic plans with drug coverage declined

from 84% in 1999 to 70% in 2001. In addition, plans are imposing more stringent limits on drug benefits. Today, about one in four Medicare HMO enrollees has an annual prescription drug benefit cap of $750 or less (Exhibit 3).

Exhibit 3

Prescription Drug Coverage and Benefit Caps for Medicare+Choice Enrollees, 2001



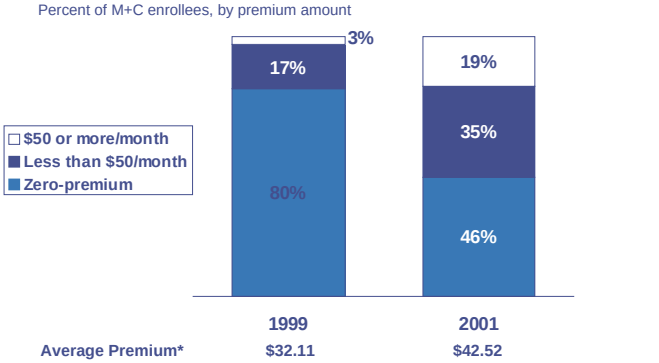
Total = 5.6 million Medicare+Choice enrollees

Note: Benefit caps apply to prescription drug benefits for basic plans in M+C contract segments.
SOURCE: Mathematica Policy Research, Inc. analysis of HCFA's Medicare Compare database 2001 for the Commonwealth Fund.

Until recently, the majority of Medicare HMO enrollees were offered additional benefits without being charged a premium (other than the monthly Part B premium). The share of Medicare HMO enrollees in basic plans with a zero-premium declined from 80% in 1999 to 46% in 2001. The share of enrollees with a monthly premium of $50 or more rose from 3% in 1999 to 19% in 2001. During this period, average monthly premiums (among plans with a premium) increased from $32.11 to $42.52 (Exhibit 4).

Exhibit 4

Monthly Premiums for Medicare+Choice Enrollees, 1999 and 2001



*Average premium charged by basic plans that impose premiums. Columns may not add to 100% due to rounding or missing data.
SOURCE: Mathematica Policy Research, Inc., analysis of HCFA's Medicare Compare database 2001 for the Commonwealth Fund.

Payments to Plans

Medicare pays M+C plans a fixed monthly amount for each enrollee to cover Medicare benefits. Payments are adjusted for age, sex, Medicaid enrollment, and the institutional status of the beneficiary, but payments vary widely throughout the country. Over time, regional variations in payments are expected to decrease as Medicare phases in a system that blends national average costs with county-level costs and raises payments to plans in rural areas and other low-cost counties.

To expand access to plans in rural areas, BIPA 2000 increased minimum monthly payments to $475 for plans serving areas with fewer than 250,000 people and $525 for plans in more populated areas. For counties with rates above the threshold, the minimum payment was raised from 2% to 3% for 2001.

Many studies have cited inadequate adjustment for the health status of enrollees as a problem with Medicare's M+C payment methodology. Managed care has resulted in increased Medicare spending, rather than savings, because managed care enrollees are reportedly in better health than are those in the traditional program and have lower than average medical costs. According to a 2000 GAO report, in 1998, Medicare paid plans an average of 13.2% more than Medicare would have spent if plan enrollees had received care under traditional Medicare. The consensus of the literature is that risk-adjusted payments are needed to more accurately reflect the health needs of enrollees, to prevent financial losses to the program, and to encourage plans to enroll high-cost cases.

In 2000, Medicare began to phase in a new risk-adjustment system based on inpatient hospital stays in the previous year. By 2007, a more comprehensive risk adjuster using both inpatient and ambulatory data is expected to be in place.

Annual Enrollment and Disenrollment Rules

Since the start of the Medicare HMO program, beneficiaries have been permitted to enroll in (provided plans are accepting new enrollees) and disenroll from plans at any time during the year. Beginning in 2002, beneficiaries will be able to do so only during an annual, coordinated enrollment period held in November 2001 and during the first six months of 2002. Beginning in 2003 and thereafter, beneficiaries will be able to enroll or disenroll only during the coordinated enrollment period in November and during the first three months of the calendar year.

Quality of Care

To date, the evidence on quality of care in Medicare HMOs is mixed (Miller and Luft, 2001; Wholey, et al., 1998). For example, a study of elderly cancer patients in HMOs found enrollees more likely to be diagnosed at an early stage than those in fee-for-service (Riley, et al., 1994). Others report that elderly HMO enrollees with chronic illnesses have disparate access to specialists and home health and rehabilitation services, and have poorer health outcomes compared with those in the fee-for-service program (Ware, et al., 1996; Shaughnessy, et al., 1994; Retchin, et al., 1994; Clement, et al., 1994).

Satisfaction studies are also inconclusive (Tudor, et al., 1998). While the majority of Medicare HMO enrollees report being satisfied with their care, those with greater health problems or functional limitations, the under-65 disabled, and the chronically ill are more likely to report problems accessing specialists and other covered services (HHS OIG, 1998; PPRC, 1997).

Future Issues

Managed care is likely to continue to have an important role in Medicare, but the future of the current M+C program seems uncertain. While the Administration has set a goal of increasing M+C enrollment, the recent withdrawals and service area reductions by many plans—and the decrease in prescription drug and other supplemental benefits by many remaining plans—may make M+C a less attractive option for Medicare beneficiaries. Striking the right balance between the goals of controlling spending growth, setting payments to plans fairly, providing greater stability for plans and beneficiaries, and meeting beneficiaries' health care needs will be an ongoing challenge for Medicare managed care.

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MEDICARE AND PRESCRIPTION DRUGS

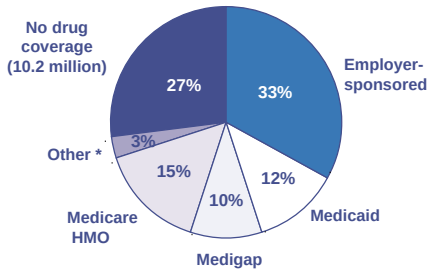
May 2001

Overview

Prescription drug use increases with age along with the prevalence of chronic and acute health problems. However, many elderly people do not have prescription drug coverage because Medicare—the federal health insurance program that covers 40 million elderly and disabled Americans—does not cover outpatient prescription drugs. More than a quarter of all Medicare beneficiaries (10 million) had no drug coverage in 1998, the most recent year for which national data are available (Figure 1).

Figure 1

Sources of Prescription Drug Coverage for Medicare Beneficiaries, 1998



Total = 38.1 million Medicare beneficiaries

*Includes those receiving coverage from other public programs as well as those in non-risk HMOs.
Note: Data are based on the non-institutionalized population.
Source: Poisal, J.A., and L. Murray. *Health Affairs,* March/April 2001.

National spending for drugs has tripled in the last decade and is expected to more than double between 2000 and 2010, from an estimated $117 billion to $366 billion, according to the Health Care Financing Administration. These trends pose challenges for Medicare beneficiaries, who account for 14% of the U.S. population, but 43% of the nation's total drug expenditures. Beneficiaries are now increasingly exposed to the rising costs of pharmaceuticals.

Sources of Prescription Drug Coverage

Almost three-quarters of all Medicare beneficiaries had some drug coverage for at least part of the year in 1998, but access to these benefits is declining, as is the scope of existing coverage.

Employer-sponsored plans, the leading source of drug coverage for seniors, assist 33% of the Medicare population with drug costs. In 2000, employers were estimated to spend nearly $15 billion on retiree drug benefits. During the past decade, there has been a steady erosion of retiree health benefits with the share of large employers offering coverage to those 65+ declining from 80% in 1991 to 66% in 1999. According to Hewitt Associates, with the rapid increase in retiree drug costs, employers are expected to take more stringent steps to control spending in the future.

Medigap provides prescription drug benefits to approximately 10% of all Medicare beneficiaries. About two-thirds of those with Medigap coverage are enrolled in 1 of 10 standard policies (Plans A – J), 3 of which (Plans H – J) cover some prescription drug costs. Plans H and I have a $250 deductible and cover 50% of drug costs up to $2,500; Plan J covers 50% up to $6,000. In 1999, only about 537,000 (9%) of the 6 million beneficiaries with standard Medigap policies had drug coverage (Chollet and Kirk, 2001). Premiums for policies that cover drug costs have increased dramatically in recent years.

Medicaid provides drug coverage for 12% of the Medicare population, generally those with very low incomes. Only half of all Medicare beneficiaries with incomes below the federal poverty level are covered by Medicaid. Medicare beneficiaries are eligible for Medicaid assistance with drug costs if they receive cash assistance under the Supplemental Security Income (SSI) program or if they "spend down" their income and assets to qualify as medically needy. Although all state Medicaid programs cover prescription drugs, there is considerable variation in drug benefits across states. In 1998, Medicaid spent, on average, $893 per elderly beneficiary for pharmaceuticals. With rising drug costs, many states may look for ways of curtailing spending on prescription drugs in the future.

Medicare HMOs assisted 15% of all beneficiaries with their drug costs in 1998, although this share dropped to about 10% in 2001. In recent years, many HMOs have been able to offer supplemental benefits like drug coverage because Medicare requires plans with costs below the Medicare payment level to return savings to beneficiaries. However, the share of Medicare+Choice enrollees with prescription drug coverage declined from 84% in 1999 to 67% in 2001. While 11% of Medicare+Choice enrollees with some drug coverage have no annual cap on drug benefits, 38% are now subject to a cap of $750 or less (Mathematica Policy Research, 2000).

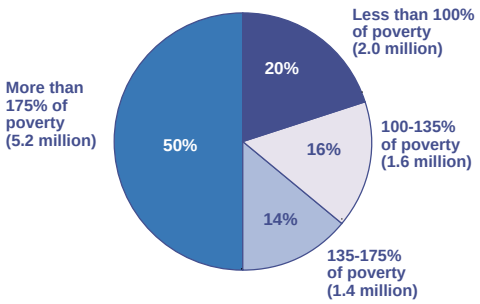
State Pharmacy Assistance Programs provide some assistance to many low-income Medicare beneficiaries who are not eligible for Medicaid. These programs vary widely in terms of structure, eligibility, and benefits. While most provide a direct subsidy to low-income seniors, other approaches include discount programs, tax credits, and private-insurance models. Twenty-six states have authorized a pharmacy assistance program and 24 programs are now in operation.

Who Lacks Drug Coverage?

Of the more than 10 million Medicare beneficiaries without any form of prescription drug coverage in 1998, about half (5 million) had incomes below 175% of poverty, which was $15,033 for an individual in 2001 (Figure 2). More than a quarter of those without drug coverage (almost 3 million) were in fair or poor health.

Figure 2

Medicare Beneficiaries *without* Prescription Drug Coverage, by Poverty Level, 1998



Total = 10.2 million beneficiaries, 1998

Source: Poisal, J.A., and L. Murray. *Health Affairs,* March/April 2001.
Note: The federal poverty level was $8,050 for individuals and $10,850 for couples in 1998.

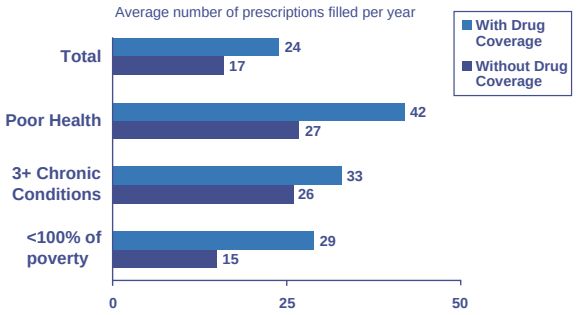
Lack of drug coverage disproportionately affects beneficiaries living in rural areas, the near-poor, and the oldest-old (Poisal and Murray, 2001). In 1998, those in rural areas were more likely than others to be without drug coverage (37% vs. 23%). Thirty-four percent of beneficiaries with incomes between 100%-150% of poverty lacked coverage, compared to 23% of those with incomes above 300% of poverty and 28% of those below the poverty level, about half of whom received drug coverage under Medicaid. More than a third (34%) of beneficiaries ages 85+ lacked drug coverage, compared to a quarter (25%) of those ages 65 to 74.

Why Does Drug Coverage Matter?

Virtually all Medicare beneficiaries use pharmaceuticals on a regular basis, filling 22 prescriptions on average in 1998. Beneficiaries *without* drug coverage averaged nearly seven fewer prescriptions per year than those *with* coverage. Among those in poor health, those who lacked coverage averaged 15 fewer medications than their insured counterparts (Figure 3).

Figure 3

Average Prescriptions Filled by Medicare Beneficiaries, w*ith* and *without* Drug Coverage, by Selected Characteristics, 1998



Source: Poisal, J.A., and L. Murray, *Health Affairs,* March/April 2001.
Note: ADL = Activity of Daily Living

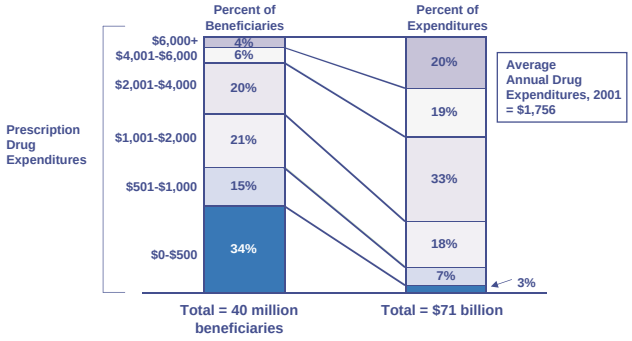
Lower drug utilization levels among those without drug coverage may negatively affect health outcomes and result in increased utilization of other services such as physician and hospital care. For example, beneficiaries with hypertension who lack drug coverage are 40% less likely to purchase antihypertensive medications (Blustein, 2000).

Total and Out-of-Pocket Drug Spending

According to the Congressional Budget Office's recently revised estimates, total drug spending for the Medicare population is expected to be $71 billion in 2001 and to total $1.5 trillion over 2001-2011. Over the past five years, average annual per capita drug spending for the Medicare population has approximately doubled, reaching an estimated $1,756 in 2001 (CBO, 2001) (Figure 4). Spending is highly skewed across the population: About a third of all beneficiaries are expected to incur less than $500 in drug expenses in 2001, while 10% will have drug expenses of at least $4,000, and account for almost 40% of drug spending.

Figure 4

Distribution of Medicare Beneficiaries and Prescription Drug Expenditures, 2001



Source: CBO, 2001 (revised estimates of drug spending based on January 2001 baseline).

Out-of-pocket spending for pharmaceuticals is related to many factors, including beneficiaries' health needs, their access to drug coverage, the generosity of that coverage, and the prices of the drugs they need. In 1998, those *without* drug coverage spent on average 68% more for their medications than did those *with* coverage ($546 vs. $325). Among those in poor health, disparities in out-of-pocket spending were even wider ($820 vs. $490) (Poisal and Murray, 2001).

In 2001, average annual out-of-pocket spending for drugs among Medicare beneficiaries is estimated to be about $858, with 27% of beneficiaries expected to spend more than $1,000 (Actuarial Research Corporation, 2001). Prescription drug spending—including out-of-pocket spending—is projected to rise even further in the near future due to the introduction of more new, high-priced drugs; increases in direct-to-consumer advertising; patent extensions for brand-name drugs; and more limited drug coverage.

Outlook for the Future

The lack of drug coverage for more than one in four Medicare beneficiaries, the erosion of drug coverage for many others, and the continued increase in drug expenditures have led to a variety of proposals to assist Medicare beneficiaries with these costs. Complex and controversial issues have yet to be resolved. For example, should drug coverage be provided directly under Medicare or primarily through private, risk-bearing plans? Should new benefits be targeted to the poor or be universally available to all Medicare beneficiaries? What strategies should be used to control drug costs? How should new benefits be financed? The outcome of this debate will have significant implications for the nation's aging population.

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