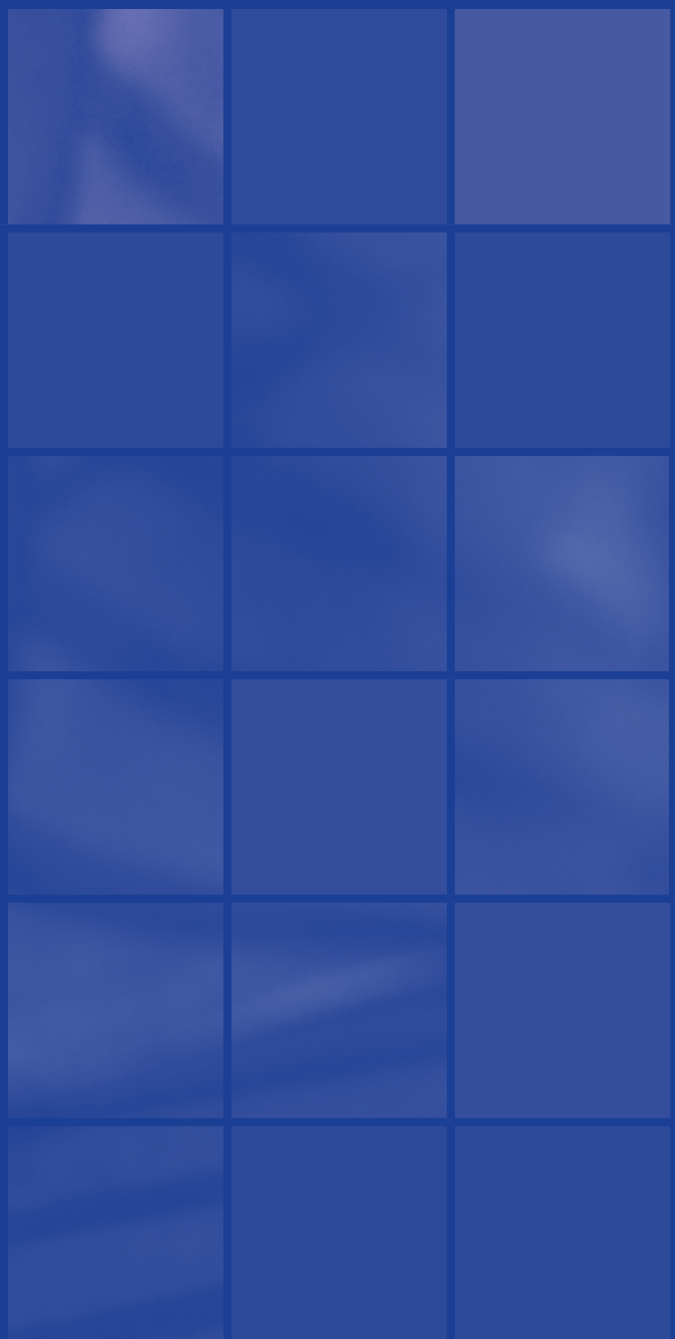
MEDICARE
A PRIMER

MARCH 2007



THE HENRY J. KAISER FAMILY FOUNDATION

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Medicare: A Primer

March 2007

INTRODUCTION

Established in 1965, Medicare is a social insurance program, like Social Security, that provides health and financial security for individuals age 65 and older and for younger people with permanent disabilities. Prior to 1965, roughly half of all seniors lacked medical insurance; today, virtually all seniors have health insurance under Medicare. Medicare provides health insurance coverage to almost 44 million people – approximately 37 million people age 65 and older and another 7 million people with permanent disabilities who are under age 65. The program helps to pay for many important health care services, including hospitalizations, physician services, and a new prescription drug benefit. Individuals contribute payroll taxes to Medicare throughout their working lives and generally become eligible for Medicare when they reach age 65, regardless of their income or health status.

Comprising 13 percent of the federal budget and 19 percent of total national health expenditures in 2006, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and health care spending in the U.S.[1] 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 Medicare are likely to remain prominent on the nation's agenda in the years to come.

[1] The Medicare share of the federal budget is from Congressional Budget Office (CBO), *Budget and Economic Outlook: Fiscal Years 2008 to 2017,* January 2007. The Medicare share of national health expenditures is projected for 2006, from Christine Borger, et al, "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs Web Exclusive*, 22 February 2006.

MEDICARE: A PRIMER

WHAT IS MEDICARE?

Medicare is the nation's health insurance program for Americans age 65 and older, and for younger adults with permanent disabilities.

Established in 1965 under Title XVIII of the Social Security Act, Medicare was initially established to provide health insurance to individuals age 65 and older, regardless of income or medical history. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities and people suffering from end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with Lou Gehrig's disease. In 2007, nearly 44 million people rely on Medicare for their health insurance coverage: 37 million people age 65 and over and 7 million people under age 65 with disabilities.

Medicare consists of four parts, each covering different benefits.

PART A, also known as the Hospital Insurance (HI) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is funded by a dedicated tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). In 2006, Part A accounted for approximately 40 percent of Medicare benefit spending.[2] An estimated 43.4 million people are entitled to Part A in 2007.

PART B, the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, home health, and preventive services. Part B is funded by general revenues and beneficiary premiums ($93.50 per month in 2007). In 2006, Part B accounted for 35 percent of benefit spending.[3] Beginning in 2007, Medicare beneficiaries who have annual incomes over $80,000 ($160,000 per couple) pay a higher, income-related Part B premium. Part B is voluntary; some beneficiaries (such as the working aged who receive employer-sponsored health care) delay enrollment until they retire. An estimated 40.6 million people are enrolled in Part B in 2007.

PART C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed, and accounted for 14 percent of benefit spending in 2006. As of January 2007, 8.3 million beneficiaries are enrolled in Medicare Advantage plans.

PART D is the outpatient prescription drug benefit, delivered through private plans that contract with Medicare, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. Authorized by the Medicare Modernization Act of 2003 (MMA) and launched in 2006, Part D plans are required to provide a "standard" benefit (or one that is equivalent) and may provide enhanced benefits. Individuals with modest income and assets are eligible for additional assistance with premiums and cost-sharing amounts. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 8 percent of benefit spending in 2006. As of January 2007, nearly 24 million beneficiaries are enrolled in a Part D plan.

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[2] CBO, Medicare Baseline, March 2006.
[3] Id.

WHO IS ELIGIBLE FOR MEDICARE?

Most people age 65 and older are automatically entitled to PART A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years (40 quarters).

Individuals age 65 and over qualify for Medicare if they are U.S. citizens or permanent legal residents. Individuals do not need to meet an income or asset test to qualify for Medicare. Adults under age 65 with permanent disabilities who receive Social Security Disability Income (SSDI) payments for 24 months are eligible for Medicare before they turn 65, even if they have not made payroll tax contributions for 40 quarters. People with end-stage renal disease (ESRD) or Lou Gehrig's disease are eligible for Medicare benefits as soon as they begin receiving SSDI payments, without having to wait 24 months. Individuals entitled to Part A do not pay premiums for covered services. Individuals age 65 and over who are not entitled to Part A benefits, such as those who did not pay enough Medicare taxes during their working years, can pay a monthly premium to enroll.

Individuals entitled to Part A and others age 65 and older may elect to enroll in PART B.

Part B is voluntary, but about 95 percent of beneficiaries with Part A are also enrolled in Part B. For most individuals who become entitled to Part A benefits, enrollment in Part B is automatic unless the individual declines enrollment. Individuals age 65 and older who are not entitled to Part A benefits may enroll in Part B. With the exception of the working aged who may delay enrollment because they receive employment-based coverage, those who do not sign up for Part B when they are first eligible typically pay a penalty for late enrollment, in addition to the regular monthly premium, for the duration of their enrollment in Part B.

Individuals are eligible for PART C, or Medicare Advantage, if they are entitled to Part A and enrolled in Part B.

Beneficiaries may generally elect to enroll in a Medicare Advantage plan on an annual basis between November 15 and March 31 of the following year.

Individuals are eligible for prescription drug coverage under a PART D plan if they are entitled to benefits under Part A and/or enrolled in Part B.

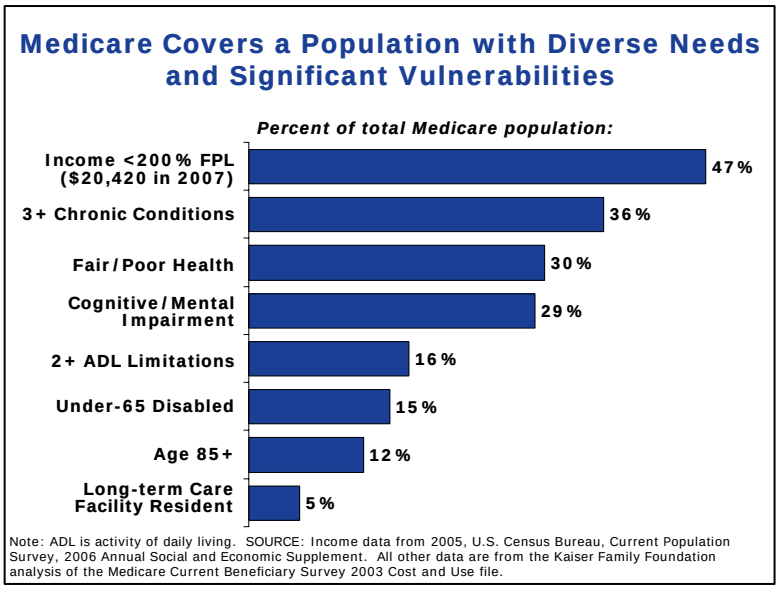
To get Part D benefits, beneficiaries may enroll in a stand-alone prescription drug plan or Medicare Advantage prescription drug plan. The enrollment period for stand-alone prescription drug plans runs from November 15 to December 31 of each year. Individuals can enroll in a Medicare Advantage plan from November 15 through March 31 of the following year. Similar to Part B, there is a permanent premium penalty for late enrollment for individuals who go for an extended period of time without drug coverage that is at least comparable to the Part D standard benefit (known as "creditable coverage").

WHAT ARE THE CHARACTERISTICS OF PEOPLE WITH MEDICARE?

Medicare covers a population with diverse needs and circumstances. While many beneficiaries enjoy good health, a quarter or more have serious health problems and live with multiple chronic conditions, including cognitive and functional impairments.

Many Medicare beneficiaries live on modest incomes and most depend on Social Security as their primary source of income.

Almost half of all Medicare beneficiaries (47 percent) had an income below 200 percent of poverty ($20,420/individual and $27,380/couple in 2007), and 12 percent had an income below 100 percent of the poverty level.



There is a high prevalence of chronic conditions, cognitive impairments, and functional limitations among the Medicare population.

About a third (36 percent) of all Medicare beneficiaries live with three or more chronic conditions. Among the most common are hypertension and arthritis.

More than a quarter (29 percent) of all beneficiaries have a cognitive or mental impairment that limits their ability to function independently.

Approximately one in six (16 percent) beneficiaries have functional limitations as defined as two or more limitations in activities of daily living, such as eating or bathing.

Although the majority of the Medicare population is over age 65, about 15 percent are under age 65 and permanently disabled.

These individuals tend to have lower incomes than other beneficiaries. About 40 percent are dually eligible for both Medicare and Medicaid. Because of their disabilities, they tend to have relatively high rates of health problems, including functional limitations and cognitive impairments.

Most beneficiaries live at home, but 5 percent live in a long-term care setting.

Five percent (2.2 million) of Medicare beneficiaries live in a long-term care setting, such as a nursing home or assisted living facility, with higher rates for beneficiaries ages 85+ (20 percent).[4] More than two-thirds of beneficiaries living in long-term care settings are women.

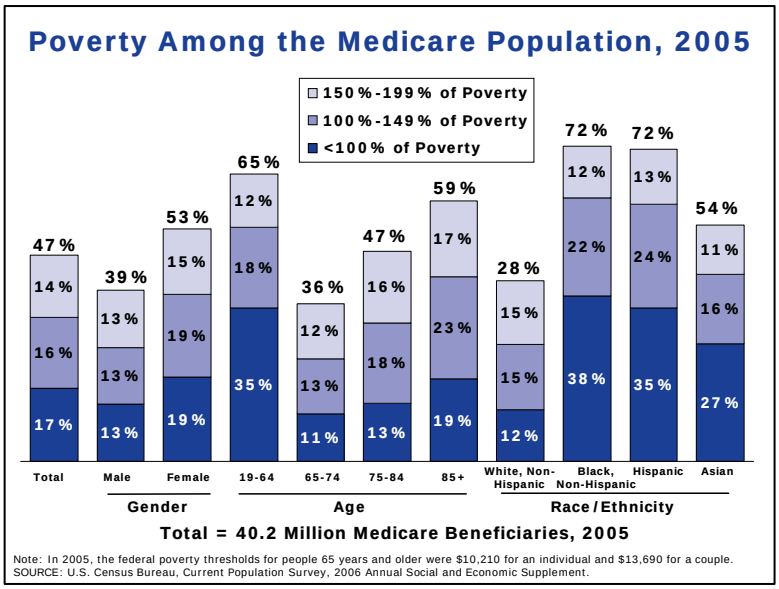
[4] Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2003 Cost and Use file.

Nearly half of all Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL), but poverty rates are especially high among those in racial/ethnic minority groups, women, people under-65 with disabilities, and those ages 85 and older.

More than 70 percent of African American and Hispanic beneficiaries live on an income below twice the poverty level, and more than a third of these beneficiaries have incomes below the poverty level. By contrast, 28 percent of White beneficiaries have an income below twice the poverty level and 12 percent have incomes below poverty.

Nearly two-thirds of all under age 65 beneficiaries with disabilities live on income below twice the poverty rate, and more than a third live in poverty. Among seniors, poverty rates tend to rise with age. Close to six in ten beneficiaries age 85 and older live on income below twice the poverty level.

Poverty rates are substantially higher among women on Medicare than men. More than half of all female Medicare beneficiaries live on income below twice the poverty rate, substantially higher than the rate for men on Medicare.



Note: In 2005, the federal poverty thresholds for people 65 years and older were $10,210 for an individual and $13,690 for a couple.
SOURCE: U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement.

WHAT DOES MEDICARE COVER AND HOW MUCH DO BENEFICIARIES PAY FOR BENEFITS?

Medicare provides coverage of basic health services including care in hospitals and other settings, physician services, diagnostic tests, preventive services and, as of 2006, also includes an outpatient prescription drug benefit. Beneficiaries generally pay varying deductibles and coinsurance amounts that are indexed to increase annually.

PART A helps pay for inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities, and also covers hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility.

- Most beneficiaries do not pay a monthly premium for Part A services, but pay a deductible before Medicare coverage begins. In 2007, the Part A deductible for each "spell of illness" is $992 for an inpatient hospital stay.

- Beneficiaries typically pay a coinsurance for benefits covered under Part A, including extended inpatient stays in a hospital ($248 per day for days 61-90) or skilled nursing facility ($124 per day for days 21-100). There is no copayment for home health visits.

PART B helps pay for outpatient services, such as outpatient hospital care, physician visits and other medical services, including preventive services such as mammography and colorectal screening. Part B also covers ambulance services, clinical laboratory services, durable medical equipment (such as wheelchairs and oxygen), kidney supplies and services, outpatient mental health, and diagnostic tests, such as x-rays and magnetic resonance imaging.

- Beneficiaries enrolled in Part B are generally required to pay a monthly premium ($93.50 in 2007). Some beneficiaries with low incomes and assets are not required to pay the monthly Part B premium (or cost-sharing requirements), because they qualify for additional assistance under the Medicare Savings Programs *(see page 11 for additional information on MSPs).*

- Beginning in 2007, beneficiaries with an annual income over $80,000 ($160,000 for a couple) pay a higher, income-related monthly Part B premium ranging from $105.80 to $161.40.[5] The income thresholds are indexed annually to limit the number of beneficiaries who would be subject to the higher premium in subsequent years.

- Part B benefits are subject to an annual deductible ($131 in 2007).

- Most Part B services are subject to a coinsurance of 20 percent.

Part C (Medicare Advantage) plans generally pay for all benefits covered under Medicare Part A, Part B, and Part D. Private fee-for-service plans are not required to cover prescription drugs. *(See pages 9-10 for additional information about Medicare Advantage.)*

[5] Social Security Administration, *Medicare Part B Premiums: New Rules For Beneficiaries With Higher Incomes*, October 2006.

PART D helps pay for outpatient prescription drug coverage through private health plans. Plans are required to provide a "standard" benefit or one that is actuarially equivalent, and may offer more generous benefits. In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. *(See pages 7-8 for additional information about Part D.)*

Despite the important protections provided by Medicare, there are significant gaps in Medicare's benefit package.

In addition to the fairly high cost-sharing requirements for covered benefits, Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities.

Most notably, Medicare does not pay for custodial long-term care services either at home or in an institution, such as a nursing home or assisted living facility. In addition, Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids. Although many beneficiaries have supplemental insurance to help cover these expenses, they may still face significant out-of-pocket costs to meet their medical and long-term care needs.

WHAT IS THE PART D DRUG BENEFIT AND HOW MANY BENEFICIARIES HAVE PART D COVERAGE?

Medicare beneficiaries have access to outpatient prescription drug coverage offered by private health plans, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs.

In 2007, 1,875 stand-alone prescription drug plans (PDPs) are available nationwide, up from 1,429 in 2006. Beneficiaries in most states have a choice of at least 50 stand-alone PDPs and multiple MA-PD plans.

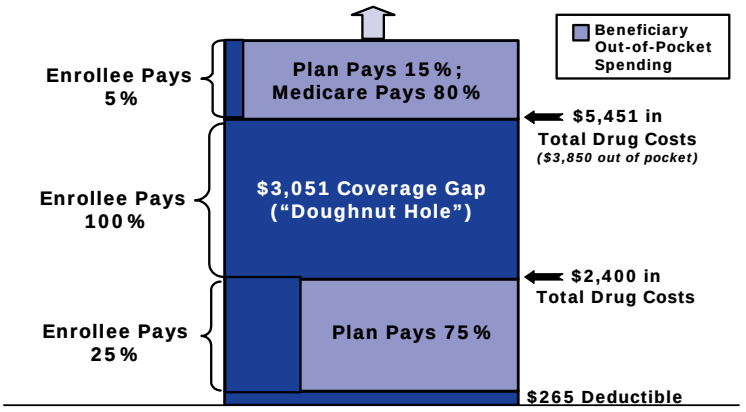
Part D plans are required to offer either the standard benefit that is defined in law, or an alternative that is equal in value ("actuarially equivalent"). Plans can also offer a plan with enhanced benefits.

The standard benefit in 2007 has a $265 deductible and 25 percent coinsurance up to an initial coverage limit of $2,400 in total drug costs, followed by a coverage gap (the so-called "doughnut hole").

Enrollees with at least $2,400 in total costs pay 100 percent of their drug costs until they have spent $3,850 out of pocket (excluding premiums). At that point, the individual pays 5 percent of the drug cost or a copayment ($2.15/generic or $5.35/brand for each prescription) for the rest of the year.

The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

Standard Medicare Prescription Drug Benefit, 2007



NOTE: Annual premium amount based on $27.35 national average monthly beneficiary premium (CMS, August 2006). Amounts for premium, coverage gap, and catastrophic coverage threshold rounded to nearest dollar.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit, updated with Part D benefit parameters for 2007 (from CMS, OACT, May 22, 2006).

In 2007, only a small share of PDPs offer the standard benefit, most charge copayments instead of 25 percent coinsurance, and most do *not* have a deductible. Plans vary widely in terms of formularies, the placement of drugs on certain tiers, cost-sharing requirements, and cost management tools (such as prior authorization requirements).

Most Part D plans have a coverage gap.

In 2007, less than 2 percent of PDPs nationwide cover both brand-name and generic drugs in the gap. In 11 states, there are no PDPs available that offer gap coverage for brand-name drugs. An estimated 4 million Medicare beneficiaries had spending in the doughnut hole in 2006.[6]

[6] Actuarial Research Corporation analysis for the Kaiser Family Foundation, 2006.

Monthly Part D premiums are not uniform nationwide, but vary across plans and regions.

In 2007, the national average monthly Part D premium is $27.35 (unweighted by enrollment), but actual premiums vary across plans and regions, ranging from a low of $9.50 for a standard benefit PDP to a high of $135.70 for a PDP with enhanced benefits.

Individuals with modest incomes and assets may qualify for additional assistance with Part D premiums and cost-sharing requirements.

Beneficiaries with income below 150 percent of poverty ($15,315/individual; $20,535/couple in 2007) and limited assets ($11,710/individual; $23,410/couple) are eligible for the low-income subsidy (LIS), or "extra help", which canincrease beneficiaries' cost savings by paying for all or some of the Part D monthly premium, annual deductible, and drug co-payments.

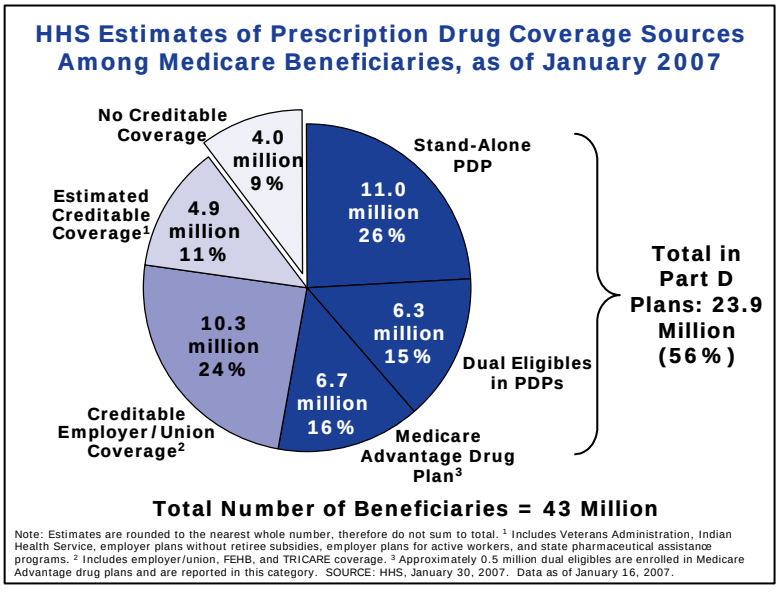
As of January 2007, the Centers for Medicare and Medicaid Services (CMS) estimates that of the 13 million beneficiaries potentially eligible for low-income subsidies, 3 million beneficiaries were not yet receiving them.[7]

Approximately 90 percent of all Medicare beneficiaries have "creditable" prescription drug coverage, as of January 2007.

Nearly 24 million Medicare beneficiaries are enrolled in a Part D plan. Of this total, the majority (72 percent) are enrolled in stand-alone prescription drug plans. This includes 6.3 million dual eligibles, many of whom who were automatically enrolled, and 11 million other beneficiaries.

Almost a quarter of all Medicare beneficiaries (10.3 million) continue to receive prescription drug coverage from a creditable employer or union plan.

Approximately 1 in 10 beneficiaries lack a known source of creditable drug coverage as of January 2007.



[7] Centers for Medicare and Medicaid Services (CMS), "Medicare Drug Plans Strong and Growing," Press Release, January 30, 2007.

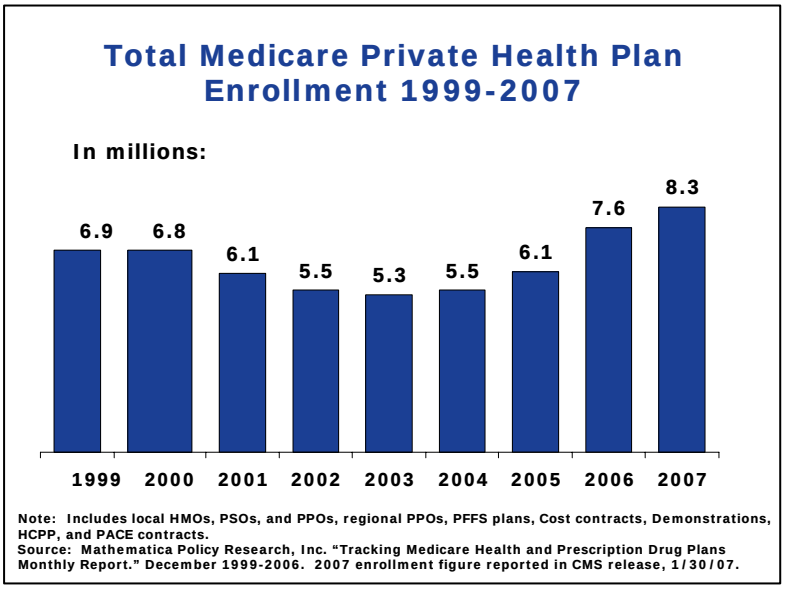
WHAT IS MEDICARE ADVANTAGE?

Medicare Advantage (MA), also known as Medicare Part C, is a program that allows beneficiaries to enroll in private health plans to receive Medicare-covered benefits.

Private plans such as health maintenance organizations (HMOs) have been an option under Medicare since the 1970s. In addition to HMOs, Medicare now contracts with a variety of other types of private health plans including: preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, and those with certain severe and disabling conditions.

In recent years, the number of Medicare Advantage plans and beneficiaries enrolled in these plans has increased rapidly.

Private plans are playing a larger role in Medicare through a revitalization of the Medicare Advantage program attributed to increased payments to plans and new marketing and outreach opportunities associated with the Medicare drug benefit. After a steep decline between 1999 and 2002, the program has recently seen a rapid increase in both the number of plans and enrollees. The number of Medicare enrollees in private health plans increased from 5.3 million in 2003 to 8.3 million as of January 2007. Between 2005 and 2007, the number of enrollees in PFFS plans increased fivefold, from about 209,000 to more than 1 million enrollees.



Note: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, Cost contracts, Demonstrations, HCPP, and PACE contracts.
Source: Mathematica Policy Research, Inc. "Tracking Medicare Health and Prescription Drug Plans Monthly Report." December 1999-2006. 2007 enrollment figure reported in CMS release, 1/30/07.

Enrollment rates in Medicare Advantage plans vary widely across states.

In 2006, less than 1 percent of beneficiaries in 4 states (Alaska, Maine, New Hampshire, and Vermont) were enrolled in Medicare Advantage plans while at least 25 percent of beneficiaries in 8 states (Arizona, California, Colorado, Hawaii, Nevada, Oregon, Pennsylvania, and Rhode Island) were in such plans. Nationwide, half of all Medicare Advantage enrollees lived in 5 states (Arizona, California, Florida, New York, and Pennsylvania) in 2006.

Medicare Advantage plans generally provide all benefits covered under traditional Medicare, but many plans offer additional benefits.

Medicare Advantage plans receive payments from the federal government to provide benefits to enrollees, and plans are required to use any savings between the payments they receive

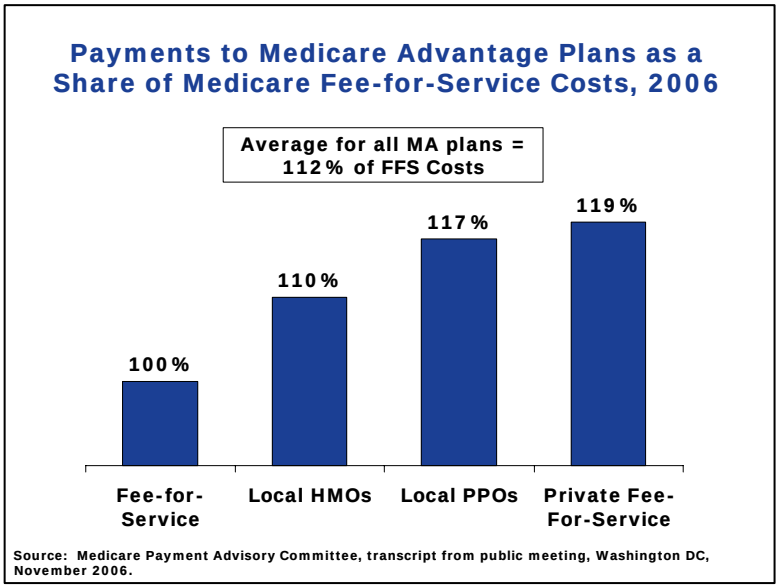
and their costs to reduce enrollee premiums or improve benefits offered. Plans may also offer supplemental benefits for which they are permitted to charge enrollees a supplemental premium. Examples of these benefits include vision, hearing, preventive dental care, podiatry, and chiropractic services.

The majority of Medicare Advantage plans provide prescription drug coverage.

Medicare Advantage plan sponsors are generally required to offer at least one plan with basic drug coverage. Private fee-for-service plans are not required to provide drug coverage; in 2006, about half of PFFS elected to offer it. The Medicare Medical Savings Account plans are not permitted to offer prescription drug coverage. In 2006, most MA plans offered prescription drug coverage. Among these MA-PD plans, a majority of HMOs (68 percent) and PPOs (85 percent) and all PFFS plans that offered drug benefits had a so-called "doughnut hole".

Recent studies show that Medicare pays private plans more per enrollee than average costs would be in the traditional Medicare fee-for-service program.

An analysis by the Medicare Payment Advisory Commission (MedPAC) based on July 2006 Medicare enrollment data finds that Medicare payments to private health plans on behalf of enrollees average 112 percent of Medicare fee-for-service costs for the counties where MA enrollees reside. PFFS plans are paid 119 percent of traditional Medicare fee-for service costs, before adjusting for enrollee risk.



WHAT TYPES OF SUPPLEMENTAL INSURANCE DO BENEFICIARIES HAVE?

Many Medicare beneficiaries have some type of supplemental insurance coverage to help fill the gaps in Medicare's benefit package and help with Medicare's cost-sharing requirements.

Today, employer and union-sponsored plans remain a leading source of supplemental coverage, providing retiree health benefits to about one in four Medicare beneficiaries.

For retirees on Medicare, employer plans remain an important source of prescription drug coverage, and often provide additional benefits, including limits on retirees' out-of-pocket health expenses. An estimated 10.3 million Medicare beneficiaries receive prescription drug benefits under an employer or union-sponsored retiree health plan, including FEHB for federal retirees and TRICARE for military retirees.[8] However, retiree health benefits are on the decline. The share of large firms offering retiree health benefits has dropped by half over the past two decades, from 66 percent in 1988 to 35 percent in 2006.[9] There was some initial concern that the new Medicare drug benefit would hasten the erosion of employer-sponsored retiree health coverage, but thus far, this has not occurred.

Employer plans are the primary source of health insurance coverage for an estimated 2.6 million Medicare beneficiaries who are working.[10] For these individuals, Medicare is the secondary payer.

Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is a source of supplemental coverage for more than 7 million Medicare beneficiaries. These beneficiaries are known as *dual eligibles* because they are dually eligible for Medicare and Medicaid.

Medicaid helps to make Medicare affordable for low-income beneficiaries, given gaps in the benefit package, premiums, deductibles and other cost-sharing requirements. Most dual eligibles qualify for full Medicaid benefits, including long-term care and dental services, and prior to 2006, received prescription drug coverage under Medicaid. Dual eligibles also get help with Medicare's premiums and cost-sharing requirements.

Some dual eligibles do not qualify for full Medicaid benefits, but get

Medicare Savings Programs Eligibility Pathways and Benefits, 2007

Pathway	Income Eligibility	Asset Limit (single/couple)	Covered Costs and Services
SSI	< 74% of poverty (SSI income eligibility)	$2,000 / $3,000	Medicaid benefits, Medicare premiums and cost-sharing
Qualified Medicare Beneficiary (QMB)	< 100% of poverty ($10,210 / $13,690)	$4,000 / $6,000	Medicare premiums and cost-sharing
Specified Low-Income Medicare Beneficiary (SLMB)	100%-120% of poverty ($12,252 / $16,428)	$4,000 / $6,000	Medicare premiums
Qualified Individual (QI)	120% - 135% of poverty ($13,783 / $18,482)	$4,000 / $6,000	Medicare premiums

[8] CMS, January 2007.
[9] Kaiser Family Foundation and Hewitt, Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.
[10] CMS, January 2007.

help with Medicare premiums and some cost-sharing requirements under the Medicare Savings Programs (MSP), administered under Medicaid. Eligibility for this assistance is based on a beneficiary's income and resources.

Medigap policies – also called Medicare supplements - are sold by private insurance companies and help cover Medicare's cost-sharing requirements and fill gaps in the benefit package.

Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. Prior to implementation of the Medicare drug benefit in 2006, Medigap insurers also sold policies that helped pay for outpatient prescription drugs. Beneficiaries may renew Medigap policies offering prescription drug coverage if they were purchased prior to 2006 (although that coverage is not comparable to the standard Part D drug benefit), but insurers are now prohibited from issuing new Medigap policies with prescription drug coverage.

In 2003, a quarter of all Medicare beneficiaries had an individually purchased Medicare supplemental insurance policy. It is not known whether this number has changed as a result of the new drug benefit, since beneficiaries could have decided to drop their Medigap policies with drug coverage and enroll instead in a Medicare drug plan.

Medicare Advantage plans are a source of supplemental coverage for people on Medicare.

As of January 2007, more than 8 million Medicare beneficiaries are enrolled in Medicare Advantage plans.[11] Most MA plan enrollees receive prescription drug coverage through their plan. Many receive additional benefits and face lower cost-sharing requirements than they would under traditional Medicare.

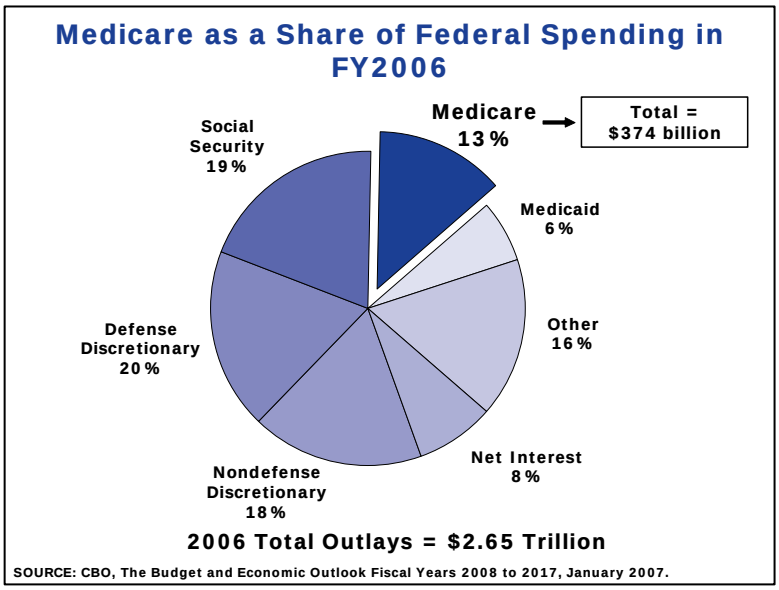
Another 2 million beneficiaries receive supplemental assistance (including prescription drug benefits) through the Veterans Administration and other government programs.[12]

[11] CMS, January 2007.
[12] Id.

HOW MUCH DOES MEDICARE COST AND HOW IS THE MONEY SPENT?

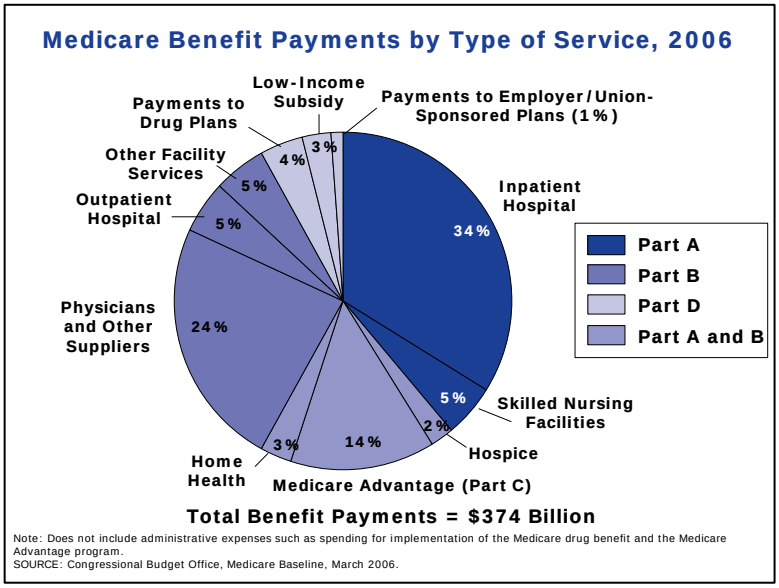
In 2006, Medicare benefit payments totaled $374 billion, accounting for 13 percent of federal spending.

Inpatient hospital services comprised the largest share of Medicare benefit payments (34 percent), followed by physician and other outpatient services (24 percent). Spending on the new prescription drug benefit accounted for 8 percent of total benefit payments in 2006. With the addition of prescription drug coverage, the composition of Medicare expenditures is changing. CBO projects that by 2010, prescription drugs will account for 20 percent of Medicare benefit payments.



Net federal spending on Medicare is projected to increase from $374 billion in 2006 to $564 billion in 2012, according to CBO.

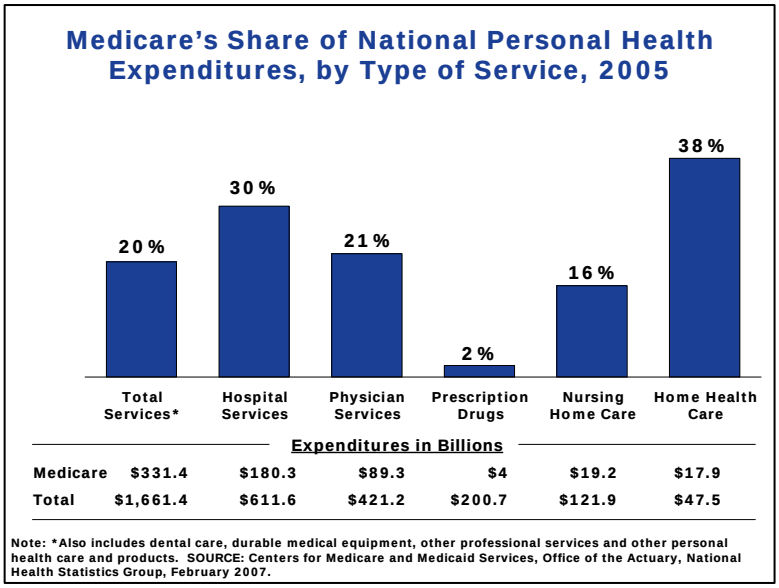
The annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services and higher prices for health care services. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2004 was slightly lower for Medicare (8.9 percent) than for private health insurance (9.9 percent) for common benefits (excluding prescription drugs).[13]



[13] CMS, Office of the Actuary, 2006.

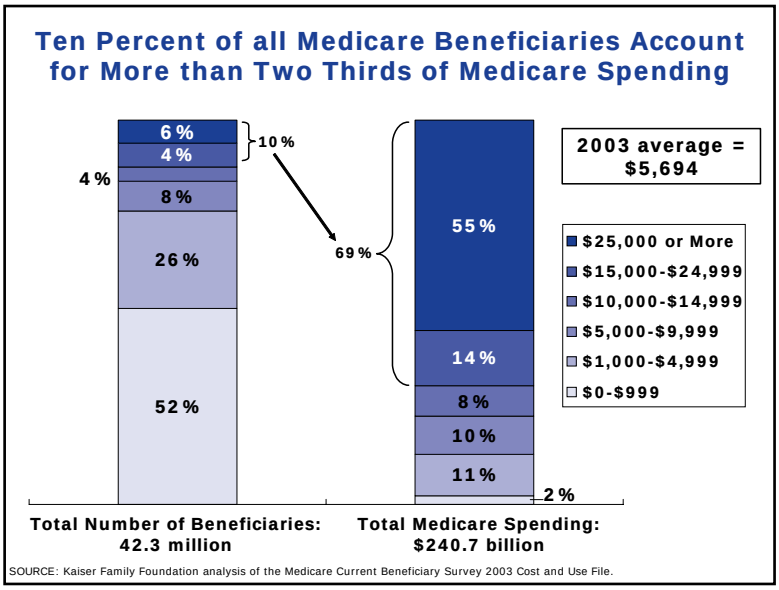
Medicare spending accounted for almost one-fifth of the $1.7 trillion in personal health care expenditures in the U.S in 2005.

Medicare's share of national personal health care expenditures varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2005, Medicare paid for 30 percent of all hospital spending and 38 percent of home health care spending but less than 2 percent of prescription drug costs. In 2006 and future years, Medicare is expected to pay a larger share of national expenditures for prescription drugs through the Part D drug benefit.



Medicare spending is highly concentrated among a small share of beneficiaries.

A small share of the Medicare population accounts for a majority of Medicare spending. Ten percent of beneficiaries accounted for more than two-thirds of Medicare spending in 2003.[14] At the other end of the spectrum, just over half of all Medicare beneficiaries (52 percent) accounted for only 2 percent of total expenditures, while 22 percent of beneficiaries incurred no expenditures at all.



Medicare spending varies by eligibility category.

In 2003, Medicare spending for each beneficiary averaged $5,694. Per capita payments were nearly $1,000 higher for the elderly ($6,191) than they were for under-65 beneficiaries with disabilities ($5,325). Per capita spending was highest for those beneficiaries with ESRD - $48,947 on average in 2003 – who comprise less than one percent of the total Medicare population.[15]

[14] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2003 Cost and Use file.
[15] Id.

HOW IS MEDICARE FINANCED AND WHAT ARE MEDICARE'S FUTURE FINANCING CHALLENGES?

Funding for Medicare comes primarily from payroll tax revenues, general revenues, and premiums paid by beneficiaries.

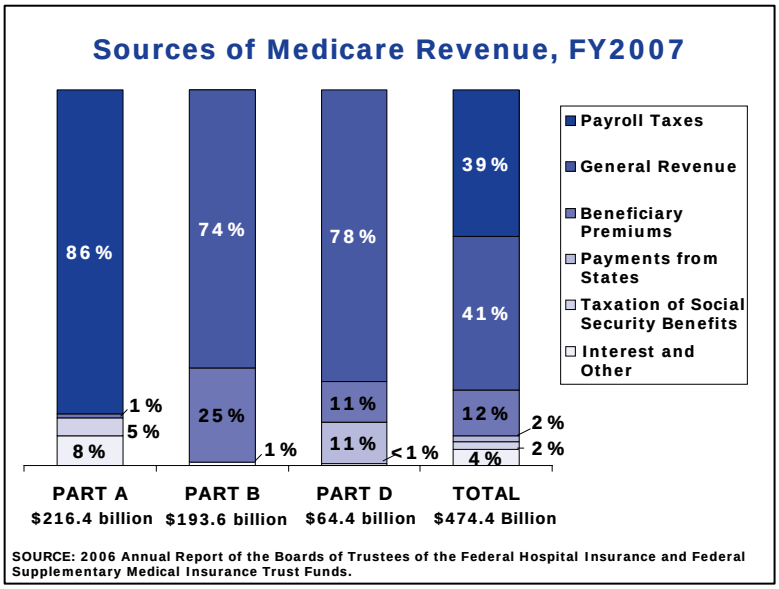
Medicare is funded as follows:

- **Part A,** the Hospital Insurance (HI) Trust Fund, is financed largely through a dedicated tax of 2.9 percent of earnings paid by employers and their employees (1.45 percent each). In 2007, these taxes are estimated to account for 86 percent of the $216 billion in revenue to the Part A Trust Fund.

- **Part B,** the Supplementary Medical Insurance (SMI) Trust Fund, is financed through a combination of general revenues and premiums paid by beneficiaries. Premiums are automatically set to cover 25 percent of revenues in the aggregate. In 2007, Part B revenue is estimated to be $194 billion.

- **Part C** is not separately financed.

- **Part D** is financed through general revenues, beneficiary premiums, and state payments for dual eligibles (who received drug coverage under state Medicaid programs prior to 2006). In 2007, Part D revenue is projected to be $64 billion, 78 percent of which will be from general revenues.



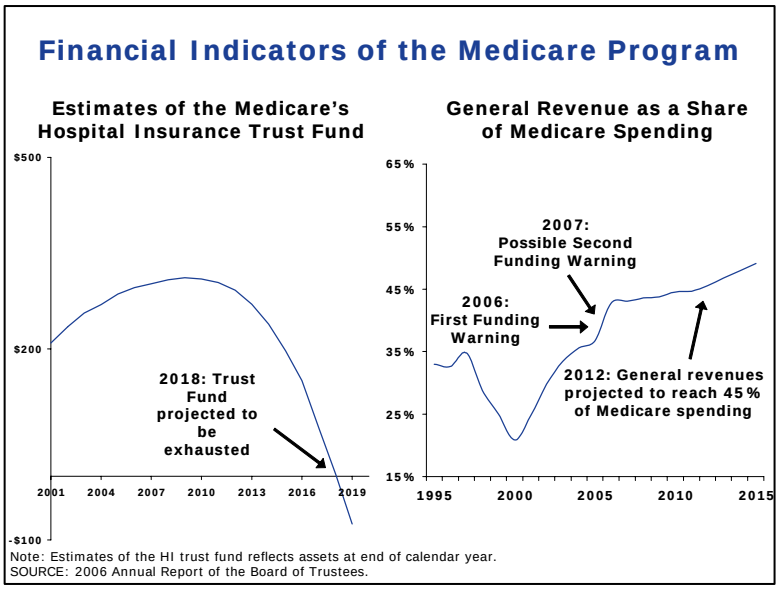
Looking to the future, Medicare is expected to face significant financing challenges due to the aging of the U.S. population, the declining ratio of workers to beneficiaries, increasing health care costs, and various economic factors.

A number of measures are used to assess the long-term financial status of Medicare.

- **Medicare spending as a share of gross domestic product (GDP)** is one of several measures reported by the Medicare Trustees in their annual report to the Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. If current trends continue, Medicare expenditures as a share of GDP are projected to rise from 3.1 percent of GDP in 2007 to 7.3 percent of GDP in 2035.

- **Solvency of the Part A (Hospital Insurance, or HI) Trust Fund** is another measure that has been used to present a picture of Medicare's financial health. This indicator looks exclusively at Part A, and does not take into account spending or financing for other parts of the Medicare program. According to the Medicare Trustees, Part A spending is expected to exceed income in 2010, and the HI Trust Fund reserves are projected to be exhausted in 2018.[16]

  The projected insolvency of the Medicare HI Trust Fund has fluctuated from year to year mainly because the projections are highly sensitive to changes in both Medicare policy and the overall economy. For example, in 1997, the Trustees projected that the HI Trust Fund would be insolvent by 2001, yet by 2001, the Trustees projected that the trust fund would be solvent through 2029, due in part to economic growth, slower than expected expenditure growth, and decreased payments to Medicare managed care plans over the five-year period.



- **The amount of general revenues as a share of total Medicare spending** is a new measure of Medicare's fiscal health established under the MMA. The purpose of this measure is to establish a specific limit on the share of total Medicare spending that would come from general revenues.

  Each year, the Medicare Trustees are required to examine general revenues as a share of total Medicare spending, and make a determination as to whether general revenues are projected to exceed 45 percent of total outlays for any of the succeeding six years. If the Trustees make this determination two years in row, a "Medicare funding warning" would be issued. In response, the President is required to submit proposed legislation to Congress, which must consider this legislation on an expedited basis.

  In 2006, the Medicare Trustees reported that general revenues are projected to exceed 45 percent of Medicare spending in 2012. If the Trustees make the same determination in 2007, looking out to 2013, a "Medicare funding warning" will be issued.

[16] CMS, 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2006.

MEDICARE BENEFITS AND COST-SHARING REQUIREMENTS, 2007

PART A	
Deductible	$992 per benefit period
Inpatient hospital	
Days 1-60	No coinsurance
Days 61-90	$248 per day
Days 91-150	$496 per day
After 150 Days	$496 per day for 60 lifetime reserve days
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$124 per day
After 100 Days	Not covered
Home Health	No coinsurance;no limit on number of visits;
Hospice	Copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	Up to 190 days in a lifetime
PART B	
Deductible	$131
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance; benefit limit of $1,780
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance; no limit on number of visits
Outpatient mental health services	50% coinsurance
One-time "Welcome to Medicare" physical	20% coinsurance
Preventive services	
Flu shots, Pneumococcal vaccines	No coinsurance; one flu shot per flu season limit
Hepitis B vaccine; colorectal and prostate cancer screenings; pap smears; mammograms; abdominal aortic aneurysm (AAA) screenings	Deductible and coinsurance waived for certain preventive services such as colorectal cancer screenings and AAA screenings
Bone mass measurement, diabetes monitoring; glaucoma screening	20% coinsurance
PART D	
Information below applies to the standard Part D benefit design in 2007. Benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.	
Deductible	$265
Initial coverage (up to $2,400 in drug costs)	25% coinsurance
Coverage gap or "doughnut hole"	100% coinsurance (no coverage)
Catastrophic coverage (above $3,850 in out-of-pocket spending)	5% coinsurance

DEMOGRAPHICS OF THE MEDICARE POPULATION, 2005

State	Total Beneficiaries[1]	Beneficiaries by Age[2]				Beneficiaries by Income[2]			
		19-64	65-74	75-84	85+	<100% FPL	100-150% FPL	150-200% FPL	200%+ FPL
U.S. Total	*42,394,926*	5,888,331	17,189,454	12,641,950	3,896,037	6,656,722	6,549,436	5,637,565	21,341,263
Alabama	740,214	151,189	284,776	199,958	NSD	174,434	118,702	103,298	291,708
Alaska	51,149	11,884	20,296	13,540	NSD	6,968	9,814	4,621	30,276
Arizona	776,637	108,689	407,250	259,460	63,607	130,737	119,349	90,137	500,928
Arkansas	463,957	67,128	209,207	115,600	NSD	76,035	78,633	71,028	198,598
California	4,157,832	531,160	1,762,576	1,388,496	447,105	613,425	785,098	541,836	2,236,484
Colorado	512,523	47,315	208,760	144,543	38,079	63,508	65,958	50,678	267,482
Connecticut	519,977	73,601	218,986	166,942	51,240	67,464	74,572	66,201	305,798
Delaware	124,992	19,691	58,718	37,459	NSD	16,184	15,423	15,177	79,717
District of Columbia	72,102	9,854	27,469	21,304	7,927	17,713	12,094	6,752	31,082
Florida	3,008,193	374,658	1,378,408	1,023,889	296,969	438,318	453,202	459,601	1,749,173
Georgia	1,015,752	188,015	466,871	215,269	NSD	182,530	174,590	122,709	473,911
Hawaii	179,649	18,180	76,398	69,354	23,838	30,579	27,315	21,113	109,425
Idaho	188,414	23,225	67,261	54,427	NSD	21,213	27,410	29,107	83,349
Illinois	1,674,114	223,635	641,848	585,700	208,406	247,057	254,017	271,908	906,328
Indiana	892,803	145,381	289,389	241,714	81,482	121,547	129,103	134,049	382,759
Iowa	483,575	48,172	198,430	129,460	41,913	49,158	59,872	71,336	241,869
Kansas	396,527	49,964	159,646	130,291	40,380	48,575	48,031	52,133	237,104
Kentucky	667,911	149,388	261,044	165,236	51,428	152,398	112,629	103,254	269,418
Louisiana	630,267	116,530	287,366	158,594	59,834	121,662	125,896	93,353	294,323
Maine	233,217	37,490	80,575	64,255	24,817	38,319	36,704	33,771	101,179
Maryland	686,746	94,060	286,441	239,017	78,633	132,901	97,154	88,870	390,164
Massachusetts	960,688	159,212	331,932	289,978	89,669	121,699	175,230	125,701	452,696
Michigan	1,468,341	217,159	581,541	430,149	139,625	187,697	233,592	166,891	788,162
Minnesota	690,792	65,711	293,964	226,654	60,308	66,480	74,833	94,800	413,188
Mississippi	449,495	98,281	172,073	128,666	42,971	132,607	82,563	63,364	169,582
Missouri	900,828	138,420	337,167	284,090	67,676	131,909	157,466	136,552	412,034
Montana	146,145	24,006	66,151	45,447	14,874	21,409	23,268	28,171	78,110
Nebraska	258,613	22,289	101,312	81,059	27,760	28,686	38,943	32,459	134,532
Nevada	293,711	44,582	152,886	95,942	NSD	45,928	51,988	43,745	175,408
New Hampshire	185,337	20,790	79,008	56,643	19,891	22,404	28,236	23,590	102,506
New Jersey	1,215,354	151,024	447,796	396,180	133,944	173,141	171,584	147,326	645,031
New Mexico	260,947	45,473	126,181	78,122	27,086	54,677	47,705	33,147	144,900
New York	2,757,934	354,247	1,149,702	911,307	277,198	518,852	446,039	399,010	1,368,676
North Carolina	1,254,732	209,093	539,106	292,531	110,166	239,377	259,562	163,699	518,250
North Dakota	102,591	9,563	37,523	33,712	10,465	9,449	15,478	15,575	51,355
Ohio	1,731,215	216,973	640,972	532,913	152,244	206,825	243,375	275,217	842,540
Oklahoma	531,147	76,633	265,727	152,832	49,100	98,840	93,222	85,246	271,801
Oregon	531,608	59,758	228,707	170,471	50,476	56,205	92,801	71,916	289,841
Pennsylvania	2,108,470	242,395	827,412	661,723	205,548	283,906	338,621	294,701	1,058,242
Rhode Island	170,581	24,400	52,293	51,408	17,811	28,133	26,251	21,365	72,620
South Carolina	636,971	113,833	300,460	183,434	NSD	149,686	109,807	88,244	300,438
South Dakota	123,333	12,117	50,137	39,283	11,768	17,925	21,843	13,725	62,928
Tennessee	902,876	177,832	420,416	254,599	73,782	184,941	165,148	164,403	426,823
Texas	2,490,766	376,716	1,195,478	785,575	195,348	548,393	443,369	330,738	1,278,486
Utah	231,263	25,785	103,835	57,381	NSD	20,238	23,348	28,645	134,945
Vermont	95,245	12,036	41,620	27,723	8,384	10,105	18,776	11,672	50,067
Virginia	981,026	141,547	411,138	256,019	85,679	134,395	145,043	110,627	524,428
Washington	807,208	100,432	313,385	270,694	80,919	111,459	106,538	90,178	469,340
West Virginia	351,432	73,796	128,141	108,739	26,255	59,330	67,612	62,273	152,759
Wisconsin	817,762	113,422	319,637	264,546	101,650	119,111	111,424	123,943	452,293
Wyoming	70,095	8,181	32,368	23,022	NSD	9,603	11,098	9,271	40,213

Note: FPL is federal poverty level.

SOURCES: [1] CMS Statistics: Medicare State Enrollment, 2005 [2] U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement.

MEDICARE BENEFICIARIES, BY MEDICARE ADVANTAGE ENROLLMENT AND SOURCE OF DRUG COVERAGE, JANUARY 2007

STATE	Total Medicare Beneficiaries	Beneficiaries in Medicare Advantage	Beneficiaries Part D Plans	Dual Eligibles Enrolled in Part D Plans	Part D Enrollees with Low-Income Subsidy (Including Dual Eligibles)	Beneficiaries with Creditable Employer Coverage	Unknown/No Source of Drug Coverage
*U.S. Total**	*42,394,926*	*8,281,162*	*23,901,433*	*6,270,154**	*9,181,180*	*10,265,745***	*8,872,572****
Alabama	740,214	106,966	427,281	104,362	221,700	214,698	123,194
Alaska	51,149	275	21,973	11,926	13,870	20,720	10,525
Arizona	776,637	284,419	478,990	69,461	144,840	187,524	130,594
Arkansas	463,957	34,822	282,726	73,611	132,710	97,123	99,985
California	4,157,832	1,444,229	2,885,891	940,312	1,120,060	749,190	690,780
Colorado	512,523	162,662	305,480	47,378	88,680	143,450	80,512
Connecticut	519,977	46,323	275,384	70,106	98,470	134,271	127,731
Delaware	124,992	2,581	63,254	11,397	24,020	44,171	21,265
District of Columbia	72,102	6,998	32,743	16,197	20,210	24,978	19,407
Florida	3,008,193	783,923	1,724,027	385,277	571,600	761,258	609,614
Georgia	1,015,752	107,267	612,834	164,680	288,620	249,273	183,711
Hawaii	179,649	67,011	119,905	25,204	34,670	40,962	25,290
Idaho	188,414	36,395	109,116	20,818	34,480	39,598	44,493
Illinois	1,674,114	148,878	921,828	263,160	324,250	421,261	391,483
Indiana	892,803	79,220	463,994	109,306	165,260	245,219	213,670
Iowa	483,575	52,600	317,654	59,667	82,170	79,762	101,898
Kansas	396,527	28,667	238,983	43,046	67,160	66,754	103,063
Kentucky	667,911	73,121	375,482	98,502	190,560	170,122	145,314
Louisiana	630,267	100,277	361,319	124,943	183,000	137,222	160,708
Maine	233,217	4,113	133,324	48,524	66,930	50,196	55,904
Maryland	686,746	53,486	291,378	64,962	120,560	269,303	148,300
Massachusetts	960,688	168,389	530,261	195,656	238,690	246,466	222,394
Michigan	1,468,341	203,489	688,549	204,412	266,590	518,524	312,150
Minnesota	690,792	202,364	462,786	72,542	123,180	112,000	136,712
Mississippi	449,495	43,508	291,872	131,388	161,530	73,194	100,896
Missouri	900,828	145,185	550,070	152,983	192,750	192,060	187,953
Montana	146,145	15,931	85,262	16,473	24,970	29,522	35,980
Nebraska	258,613	23,519	168,026	33,096	43,950	45,811	52,549
Nevada	293,711	92,133	167,608	23,438	44,900	75,371	59,558
New Hampshire	185,337	2,873	82,512	21,211	30,860	52,902	54,857
New Jersey	1,215,354	113,073	622,198	143,992	223,600	348,406	290,576
New Mexico	260,947	59,108	152,285	38,967	64,550	74,515	43,305
New York	2,757,934	654,329	1,403,763	547,469	688,800	669,395	785,589
North Carolina	1,254,732	163,292	753,010	231,549	339,190	314,575	221,242
North Dakota	102,591	5,899	72,736	11,543	17,590	12,079	20,985
Ohio	1,731,215	301,416	837,870	202,382	314,370	606,883	352,567
Oklahoma	531,147	62,215	316,638	80,194	120,280	118,773	115,089
Oregon	531,608	212,861	341,152	45,691	93,260	90,939	114,663
Pennsylvania	2,108,470	712,282	1,250,523	174,160	380,470	442,471	481,762
Rhode Island	170,581	60,635	112,885	27,456	40,660	25,675	38,400
South Carolina	636,971	52,710	347,637	122,997	169,930	195,043	111,920
South Dakota	123,333	6,277	83,022	13,164	21,960	18,015	26,138
Tennessee	902,876	165,636	578,372	225,655	278,670	193,864	160,795
Texas	2,490,766	364,028	1,442,420	363,889	666,120	690,439	437,223
Utah	231,263	50,836	126,752	22,895	32,830	66,643	44,505
Vermont	95,245	839	53,305	17,097	25,740	24,302	20,729
Virginia	981,026	86,001	499,768	116,170	198,160	306,377	196,005
Washington	807,208	157,567	430,332	105,586	145,820	216,765	184,139
West Virginia	351,432	35,504	179,625	48,984	85,820	107,492	76,083
Wisconsin	817,762	153,441	395,018	114,419	136,400	176,213	272,981
Wyoming	70,095	3,246	39,321	6,264	10,870	14,904	18,264

*Notes: *Approximately 0.5 million dual eligibles are enrolled in MA-PDs and are counted as beneficiaries in Medicare Advantage.**Employer includes private, FEHBP, and TriCARE.***Of this total, an estimated 4.9 million Medicare beneficiaries have alternative sources of creditable prescription drug coverage such as VA; however, state-level distributions are not available. SOURCES: CMS Statistics: Medicare State Enrollment.*

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