FACT SHEET

MEDICARE

MEDICARE AT A GLANCE

April 2003

WHAT IS MEDICARE?

Medicare is the federal health insurance program that covers 41 million Americans. Medicare 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.

Most individuals ages 65 and over are automatically entitled to Medicare Part A (the Hospital Insurance Program) if they or their spouse are eligible for Social Security payments. People under 65 who receive Social Security cash payments due to a disability 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 (the Supplementary Medical Insurance Program) is voluntary, but covers 95% of all Part A beneficiaries.

HOW IS MEDICARE FINANCED?

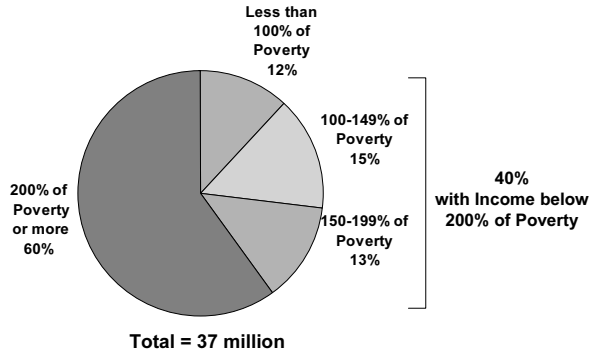
Part A is financed mainly by a 1.45% payroll tax paid by both employees and employers. Revenue from the payroll tax is held in the Hospital Insurance Trust Fund and is used to pay Part A benefits. Part B is financed by both beneficiary premiums ($58.70/month, 2003) and general revenues. Premiums cover about a quarter of total Part B spending.

Looking at the Medicare program as a whole, over half of revenues in 2003 were from payroll taxes (55%). General revenues accounted for 28% of the total and premiums represented 9%, with the remainder coming from interest and taxes paid on Social Security benefits.

Medicare has relatively low administrative costs, accounting for less than 2% of total benefit spending.

Figure 1

The Non-Institutionalized Medicare Population by Poverty Level, 2000



Note: Reflects family income as defined by the Census. Under an alternative definition linked to eligibility levels, 49% of beneficiaries would have incomes <200% of poverty. 2000 federal poverty thresholds for individuals age 65+ were $8,259 /singles and $10,419 /couples; for individuals under age 65, they were $8,959 /singles and $11,590 /couples.
SOURCE: Urban Institute estimates based on 2001 Current Population Survey.

WHO IS COVERED UNDER MEDICARE?

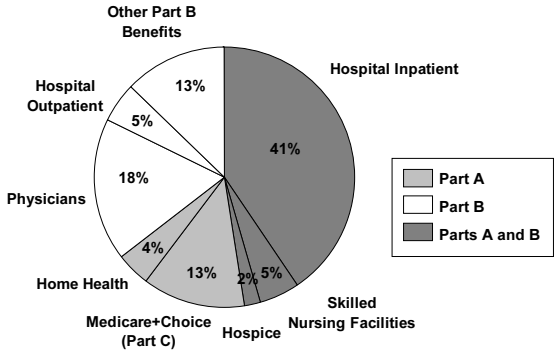
- Medicare covers more than 35 million Americans ages 65+ and 6 million younger adults with permanent disabilities.
- Four in ten (40%) have incomes at or below 200% of the federal poverty level ($16,988 per senior and $21,430 per senior couple in 2001) (Figure 1).
- Forty percent of all beneficiaries have less than $12,000 in countable assets (2002).
- Three in ten (30%) say their health status is fair or poor.

WHAT BENEFITS DOES MEDICARE COVER?

Medicare provides broad coverage of basic benefits, but does not cover outpatient prescription drugs or long-term care. Part A, which financed 48% of benefits in 2003, covers inpatient hospital services, skilled nursing facility (SNF) benefits, home health visits following a hospital or SNF stay, and hospice care (Figure 2). Inpatient hospital services are subject to a deductible ($840/benefit period, 2003) 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 ($105/day, 2003) for days 21-100. No copayments apply to home health.

Figure 2

Estimated Medicare Benefit Payments, by Type of Service, Fiscal Year 2003



•Includes administrative expenses. Pie may not sum to 100% due to rounding.
SOURCE: Congressional Budget Office, *March 2003 Baseline: Medicare.*

Part B, which accounted for one-third of Medicare benefit spending last year, 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 has been met, a 20% coinsurance is required for most services.

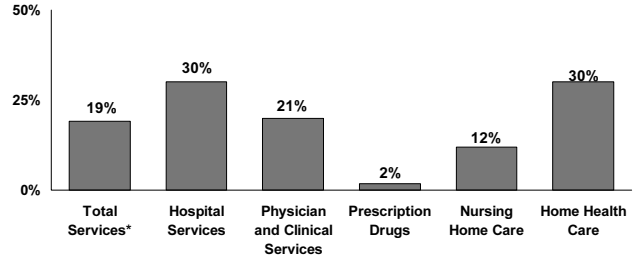
Medicare+Choice (M+C) plans contract with Medicare to provide both Part A and B services to enrolled beneficiaries. M+C plans accounted for an estimated 13% of Medicare benefit payments in 2002. Home health, also funded under Parts A and B, accounted for 4% of Medicare spending.

The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 (650) 854-9400 Facsimile: (650) 854-4800
Washington, D.C. Office: 1330 G Street, N.W., Washington, DC 20005 (202) 347-5270 Facsimile: (202) 347-5274 **Publications:** (800) 656-4533 **Website:** www.kff.org

Medicare benefit payments account for 19% of total national spending for personal health services. In 2001, Medicare financed 30% of the nation's hospital services and 21% of physician and clinical services, but only 2% of outpatient prescription drugs (Figure 3).

Figure 3

Medicare's Share of National Personal Health Expenditures, by Type of Service, 2001



	(Expenditures in Billions)					
Medicare	$223.5	$135.0	$63.9	$2.4	$11.6	$9.9
Total	$1,236.4	$451.2	$313.6	$140.6	$98.9	$33.2

*Total services also includes dental care, other professional services, durable and non-durable medical equipment, and other personal health care services.
SOURCE: Levit, et al., *Health Affairs*, Jan/Feb 2003.

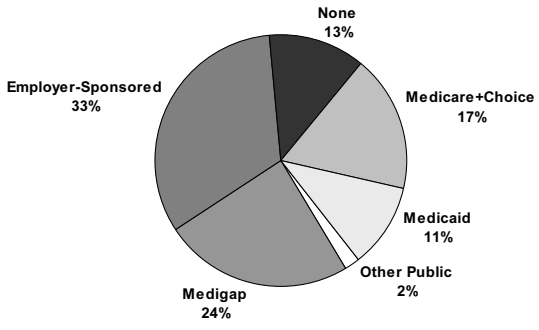
FILLING MEDICARE'S GAPS

Medicare has high cost-sharing requirements and does not generally cover outpatient prescription drugs. As a result, the elderly spent an estimated 22% of their income, on average, for health-care services and premiums in 2002 (Maxwell, et al., 2002). To help with Medicare's gaps, most have some form of supplemental insurance. In the Fall of 1999:

- A third (33%) of all Medicare beneficiaries had employer-sponsored benefits.
- Nearly a quarter (24%) owned a Medigap policy.
- Eleven percent had Medicaid, the major public financing program for low-income Americans.
- Another 17% were enrolled in an M+C plan, the majority of which are Medicare HMOs (Figure 4).

Figure 4

Sources of Health Insurance Coverage, Fall 1999



Total = 34.6 million non-institutionalized Medicare beneficiaries

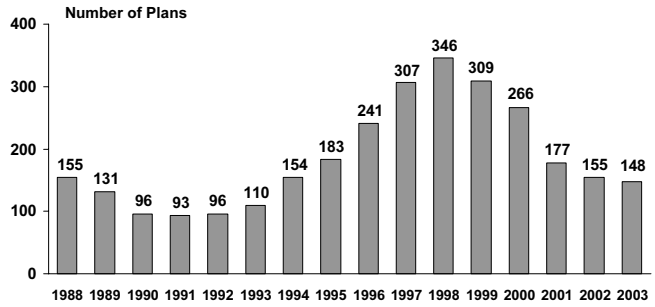
Note: Analysis of non-institutionalized beneficiaries enrolled in Medicare for a full year.
SOURCE: Laschober, et al., *Health Affairs*, February 2002.

MEDICARE+CHOICE

Medicare HMOs have been an option since the mid-1980s. Beginning in the early-1990s, the number of M+C plans grew rapidly, as did the number of enrollees. More recently, M+C enrollment declined, along with a drop in plan participation due to concerns about administrative requirements, Medicare payments to plans, and other factors (Figure 5). Today, 4.6 million Medicare beneficiaries (11%) are enrolled in Medicare HMOs, up from 1.3 million in 1990, but down from a peak of 6.3 million in 2000. By 2010, CBO projects enrollment to shrink to 8% of the total Medicare population–a substantially smaller share than was previously projected.

Exhibit 5

Medicare HMOs and Other Private Health Plans Participating in Medicare, 1988-2003



Note: All data are from December of the given year except for 2003 data which is from March.
SOURCE: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report.

MEDICARE AND PRESCRIPTION DRUGS

While most people on Medicare have supplemental insurance, almost 4 in 10 beneficiaries (38%) lacked drug coverage in the Fall of 1999, with higher rates reported by those in rural areas (Laschober, 2002). Lack of drug coverage is associated with higher out-of-pocket drug spending and higher rates of skipping doses or not filling prescriptions due to costs (Safran, et al., 2002). Average out-of-pocket drug spending among beneficiaries increased from $644 in 2000 to an estimated $996 in 2003 and is expected to continue to rise due to eroding coverage and other factors (ARC, 2003).

MEDICARE'S FINANCIAL OUTLOOK

CBO projects Medicare benefit spending to be $271 billion in 2003, accounting for 13% of the federal budget. Medicare spending increased by 7.8% in 2002, less than the 10.5% rise in private health-care spending (Levit, et al., 2003). While spending in Medicare is growing more slowly than in private plans, it is increasing more rapidly than it did between 1997 and 2000, when spending grew at an annual average rate of 1.2%. CBO projects that Medicare spending will grow by 6% in 2003 and by an average of 6.8% between 2004 and 2013.

The Medicare Part A Trust Fund, another measure of the program's fiscal condition, is projected to remain solvent through 2026.

In the future, the aging of the baby-boom generation, the decline in the number of workers per beneficiary, and the projected rise in national health-care spending will present fiscal challenges for Medicare, requiring greater resources to maintain current benefits and to secure the financial outlook of the program. Additional challenges include improving benefits, particularly prescription drugs; strengthening protections for Medicare's most vulnerable; securing access to providers; and stabilizing the M+C program. Addressing these issues will be critical for meeting the needs of the growing number of people on Medicare.