

## MEDICARE AT A GLANCE

February 2001

### What Is Medicare and How Is It Financed?

Medicare is the federal health insurance program that covers 34 million Americans aged 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.

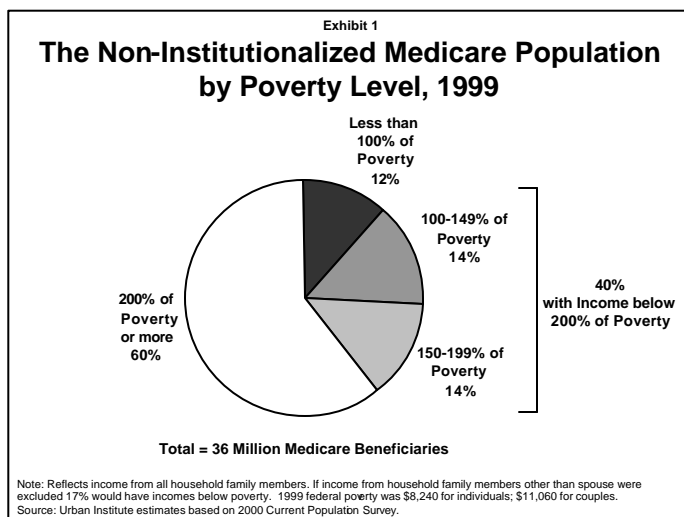
Medicare consists of two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part A is financed mainly by a 1.45% payroll tax paid by both employees and employers. Revenue from the payroll tax is held in the Hospital Insurance Trust Fund and used to pay Part A benefits. Part B 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 become eligible for Medicare usually only 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:

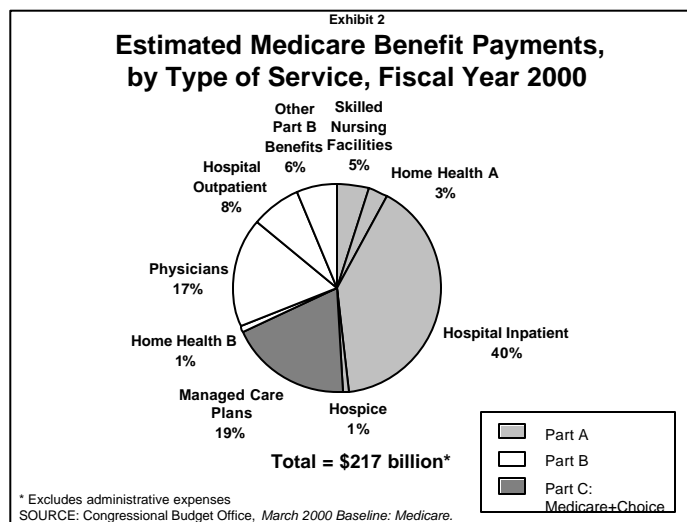
- Most beneficiaries (76%) are ages 65 to 84, but the under-65 disabled (13%) and those 85+ (11%) are growing rapidly.
- Four in ten beneficiaries (40%) have incomes at or below twice the poverty level (\$16,700 individuals; \$22,120 couples) (Exhibit 1).



- 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 generally cover prescription drugs or long-term care. Medicare Part A, which finances 49% 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



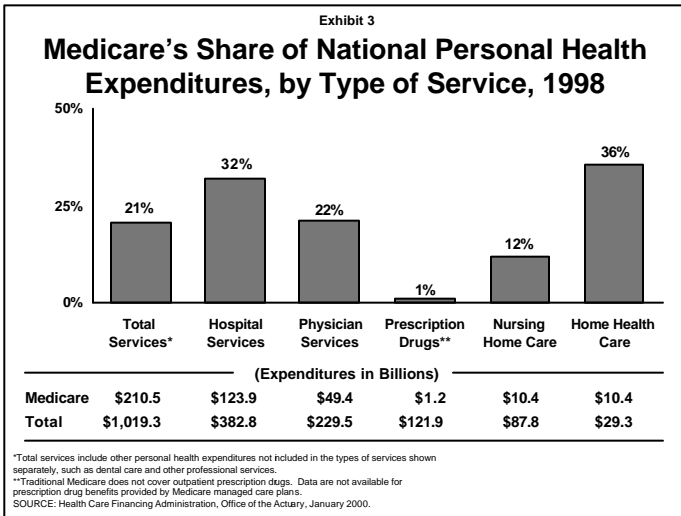
home health services.

Part B, which accounts for 32% of Medicare benefit spending, covers physician and outpatient hospital services, home health visits not covered under Part A, 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 almost all services. Over time, an increasing share of home health visits will be covered under Part B.

Under Medicare Part C, managed care plans contract with Medicare to provide both Part A and B services to enrolled beneficiaries. About 19% of Medicare benefit payments are made to managed care plans.

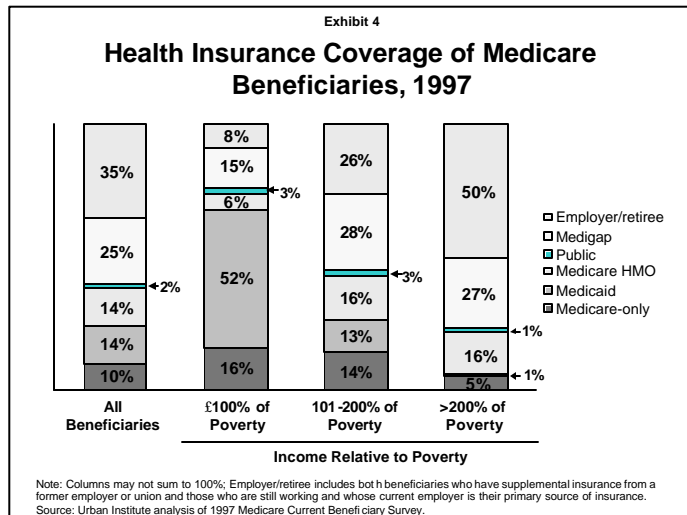
Medicare benefit payments were approximately \$217 billion in 2000, accounting for 12% of the federal budget and 21% of national spending for health services. Medicare finances 32%

of the nation's hospital services, 22% of physician services but only 1% of outpatient prescription drugs (Exhibit 3).



### Gaps in Medicare: Implications for Beneficiaries

Because Medicare does not generally cover outpatient prescription drugs and has high cost-sharing requirements, 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. Supplemental coverage varies by income level. Those with low incomes are more likely than higher income beneficiaries to be without supplemental coverage and substantially less likely to have retiree benefits.



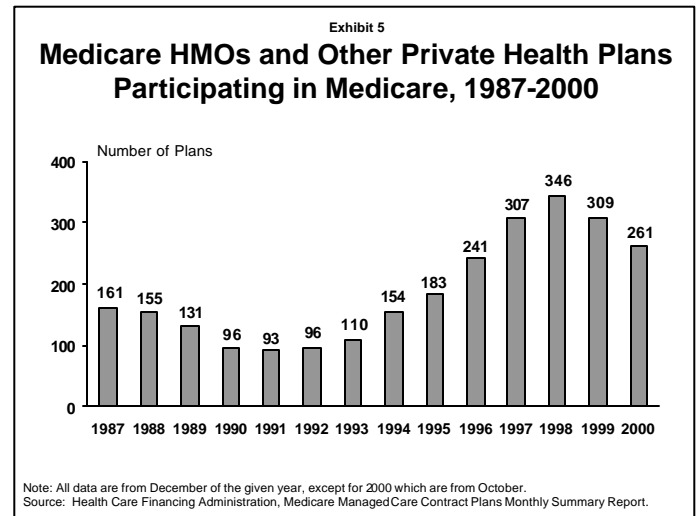
Despite the prevalence of supplemental insurance, one-third of all beneficiaries have no drug coverage. With average drug spending at \$1,263 in 2000, lack of drug coverage can result in high out-of-pocket spending and under-utilization of needed medications. Drug coverage is expected to decline further due to the erosion of retiree benefits, the rise in Medigap premiums, and recent Medicare HMO withdrawals.

The elderly spend an estimated 22% of their income, on average, for health care services and premiums. The most vulnerable spend an even higher percentage. For example, elderly individuals in poor health without supplemental insurance spend about 44% of their income on health care.

Out-of-pocket spending is projected to rise significantly over the next 25 years.

### Medicare Managed Care

Medicare HMOs have been around since the mid-1980s. Beginning in the early 1990s, the number of Medicare HMOs grew rapidly, as did the number of enrollees. Today, 6 million Medicare beneficiaries (16%) are enrolled in Medicare HMOs, more than four times the 1990 enrollment level. However, the number of enrollees appears to be leveling off due to a drop in plan participation (Exhibit 5). More than 100 plans are expected to withdraw from the Medicare market or reduce their service area by the end of 2000, disrupting coverage for nearly 1 million beneficiaries. Declining plan participation has been attributed to changes in Medicare payments to plans, administrative requirements, and other challenges that affect profitability.



### Medicare Expenditures and 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 growth in payments to providers and plans and to promote provider compliance with payment rules. Combined with a strong economy, this downturn has extended the expected life of Medicare's Hospital Insurance Trust Fund to 2025.

While the recent slowdown will produce long-term savings, Medicare spending is expected to grow at a faster pace in coming decades. Even with continued improvements in program efficiency, Medicare will face significant financing challenges. A doubling of program enrollment coupled with the expected rise in national health care costs will likely necessitate greater resources to maintain and improve Medicare benefits such as drug coverage and to secure the financial outlook of the program. Additional challenges ahead include strengthening protections for Medicare's most vulnerable, including those with low incomes, and stabilizing the Medicare managed care market so that it works well for beneficiaries. These key issues will remain critical to the focus of the Medicare policy agenda as the program moves forward.

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