THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE AT A GLANCE

November 2008

OVERVIEW OF MEDICARE

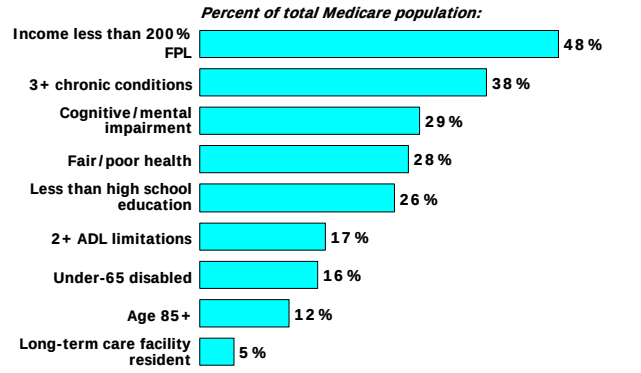
Medicare is the federal health insurance program created in 1965 for all people age 65 and older regardless of their income or medical history, and now covers 45 million Americans. Medicare plays a vital role in helping to provide financial security to beneficiaries.

Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. Medicare was expanded in 1972 to include people under age 65 with permanent disabilities. People under age 65 who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those with End Stage Renal Disease (ESRD) and Lou Gehrig's disease become eligible for Medicare when they begin receiving SSDI payments.

Medicare benefit outlays are expected to total $477 billion in 2009, accounting for 13% of the federal budget, and 22% of personal health care expenditures (CBO).

Exhibit 1

Characteristics of the Medicare Population, 2006



NOTES: ADL is activity of daily living. The federal poverty (FPL) threshold for people age 65 and over was $9,669/individual and $12,201/couple in 2006.
SOURCE: Income data from US Census Bureau, Current Population Survey published on statehealthfacts.org; all other data from Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2006 Access to Care file.

CHARACTERISTICS OF PEOPLE ON MEDICARE

Medicare covers a diverse population: nearly half of all people on Medicare (48%) have incomes below 200% of poverty ($20,800/single and $28,000/couple in 2008) (Exhibit 1). More than a third (38%) of all beneficiaries has three or more chronic conditions, and more than a quarter (29%) has a cognitive/mental impairment. Sixteen percent – just over 7 million beneficiaries in 2006 – are under age 65 and permanently disabled, and twelve percent of beneficiaries are age 85 or older.

MEDICARE'S STRUCTURE

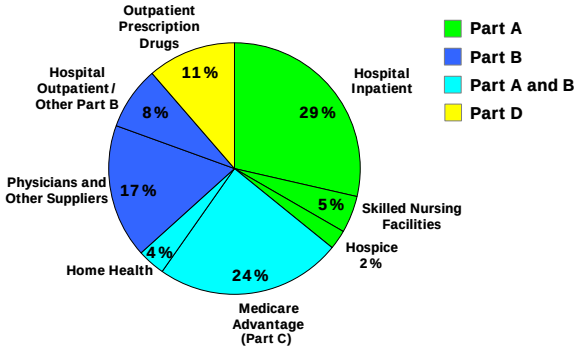
Medicare is organized into four parts.

Part A pays for inpatient hospital, skilled nursing facility, home health (also under Part B) and hospice care, and accounts for 36% of benefit spending in 2009 (Exhibit 2).

Part B pays for physician, outpatient, preventive services, and home health visits, and accounts for 29% of benefit spending in 2009.

Exhibit 2

Medicare Benefit Payments By Type of Service, 2009



Total Benefit Payments = $477 billion

NOTE: Does not include administrative expenses such as spending to administer the Medicare drug benefit and the Medicare Advantage program.
SOURCE: CBO Medicare Baseline, March 2008.

Part C refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO), and receive all Medicare-covered benefits, including prescription drugs. In recent years, Congress has increased payments to Medicare private plans to encourage plan participation throughout the country, including rural areas. As a result, the average Medicare payment to Medicare Advantage plans is 113% of the cost of similar benefits in the original fee-for-service program (MedPAC, 2008). Part C now accounts for 24% of benefit spending.

Part D is the voluntary, subsidized outpatient prescription drug benefit, with additional subsidies for beneficiaries with low incomes and modest assets. Unlike Parts A and B benefits, the Part D drug benefit is not covered under the original fee-for-service Medicare program. Instead, it is offered under private plans that contract with Medicare, both stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs). More than 25 million beneficiaries are enrolled in a Medicare Part D plan. Part D accounts for 11% of Medicare benefit spending in 2009.

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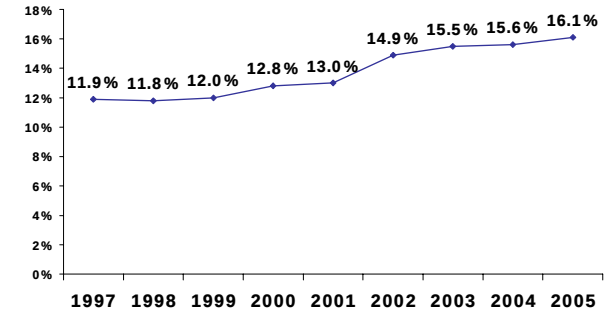
BENEFIT GAPS, OUT-OF-POCKET SPENDING AND SUPPLEMENTAL COVERAGE

Medicare has relatively high cost-sharing requirements, no limit on out-of-pocket spending, and a coverage gap (or "doughnut hole") in the prescription drug benefit. Further, Medicare does not pay for many services of critical importance to elderly and disabled beneficiaries, such as long-term care, dental or vision.

With health costs rising faster than income for Medicare beneficiaries, median out-of-pocket health spending as a share of income increased from 11.9% in 1997 to 16.1% in 2005 (Exhibit 3).

Exhibit 3

Financial Burden of Health Spending Among Medicare Beneficiaries, 1997-2005



Note: Difference between 1997 and 2003 is statistically significant at .05 level.
Source: Kaiser/UCLA analysis of Medicare Current Beneficiary Survey Cost and Use files, 1997-2005.

To help with cost-sharing requirements and fill in the benefit gaps, most Medicare beneficiaries have some form of supplemental insurance.

- **Employer-sponsored retiree health plans** provide supplemental coverage for about a third of all beneficiaries, but the share of employers offering retiree health benefits has dropped from 66% in 1988 to 31% in 2006 (KFF/HRET 2008).
- About one in five beneficiaries (19%) purchase Medicare supplemental policies, known as **Medigap**.
- **Medicaid** helps pay for Medicare's premiums and cost-sharing for more than 7 million beneficiaries with low-incomes and modest assets (known as "dual eligibles"). Most of these beneficiaries qualify for full Medicaid benefits, such as long-term care.
- Eleven percent of Medicare beneficiaries had **no supplemental coverage** in 2006. The under-65 disabled, the near poor (incomes between $10,000 and $20,000), rural residents, and African Americans were disproportionately represented among those without supplemental coverage.

MEDICARE SPENDING NOW AND IN THE FUTURE

Medicare benefit spending is projected to nearly double from $477 billion in 2009 to $871 billion in 2018, according to the Congressional Budget Office (CBO). The annual growth in Medicare spending is influenced by factors that affect health spending generally, including both increasing volume of services and rising prices. CBO estimates that a larger share of future growth in Medicare spending as a share of the Gross Domestic Product will result from growth in health care costs rather than from growth in enrollment. Efforts to control rising health costs across-the-board would help mitigate Medicare's future funding shortfall.

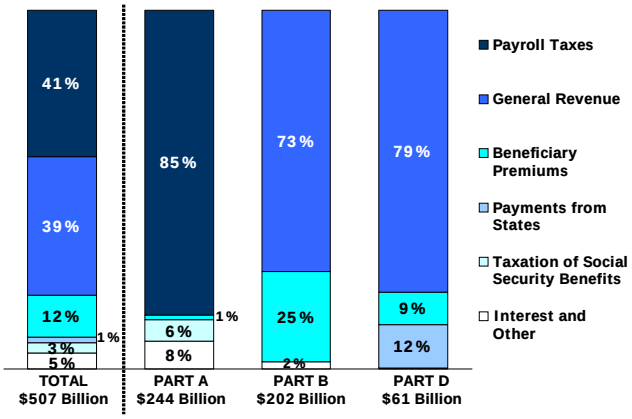
HOW MEDICARE IS FINANCED

Medicare is financed by a combination of payroll taxes (41%), general revenues (39%), beneficiary premiums (12%), interest and other sources (Exhibit 4).

- Part A is funded mainly by a dedicated tax of 2.9% of earnings paid by employers and employees (1.45% each) deposited into the Hospital Insurance Trust Fund.
- Part B is funded by general revenues and beneficiary premiums ($96.40/month in 2009). Beneficiaries with higher incomes ($85,000/individual; $170,000/couple in 2009) pay a higher, income-related monthly Part B premium.
- Part C (Medicare Advantage) plans are not separately financed. They provide benefits under Parts A, B and D.
- Part D is funded by general revenues, beneficiary premiums, and state payments.

Exhibit 4

Sources of Medicare Revenue, FY2009



SOURCE: 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

FUTURE CHALLENGES

Looking to the future, Medicare faces a number of critical issues and challenges, but none greater than financing care for an aging population. According to the Medicare Trustees, the Part A Trust Fund is projected to be depleted in 2019, with insufficient funds to pay benefits. Another critical issue relates to improving the management of care for chronically ill high-cost beneficiaries who account for a disproportionate share of Medicare spending.

In addition to these fiscal challenges, Medicare faces other persistent issues including setting fair payments to providers and plans, and providing health and financial security for an aging U.S. population, particularly those with the greatest needs.

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