

THE MEDICARE PROGRAM: A BRIEF OVERVIEW

What is Medicare?

Established in 1965, Medicare is a federal health insurance program that provides health care coverage for individuals age 65 and older. The program also covers certain persons under age 65 with disabilities.

Authorized under Title XVIII of the Social Security Act, Medicare consists of Hospital Insurance (*Part A*) and Supplementary Medical Insurance (*Part B*). *Part C* refers to the Medicare Advantage program (formerly known as Medicare+Choice), under which private plans provide Medicare benefits to enrollees. A voluntary outpatient prescription drug benefit (*Part D*) authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)¹ will be implemented in 2006.²

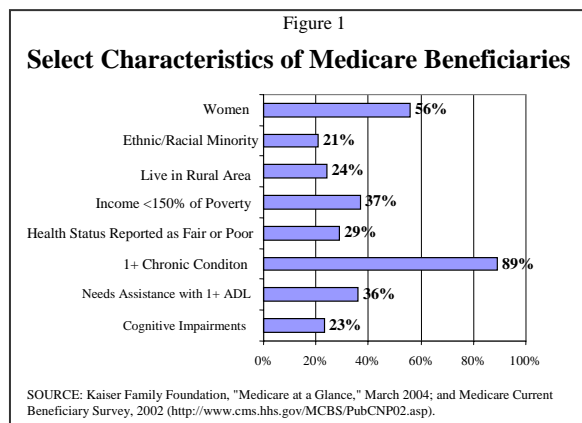
Whom Does Medicare Cover?

Medicare eligibility is available to individuals who fall into three specified categories defined by either age, disability, or end-stage renal disease. The majority of individuals are eligible for Medicare by virtue of attaining age 65.

In 2003,³ Medicare provided coverage to:

- **35 million persons age 65 and older**-- At age 65, individuals qualify for Medicare if they or their spouses paid Social Security taxes for at least 40 calendar quarters (10 years) or if they qualify for Railroad Retirement benefits.⁴
- **6 million persons under age 65 with disabilities**-- Those under age 65 who have received Social Security Disability Insurance (SSDI) cash benefits for at least 24 months are eligible for Medicare.⁵

- **Almost 100,000 persons under age 65 with end-stage renal disease (ESRD)**-- Those with ESRD under age 65 are eligible for Medicare if they or their spouses paid Social Security taxes for at least 40 quarters.



What Services Does Medicare Cover in 2005?

Part A covers:

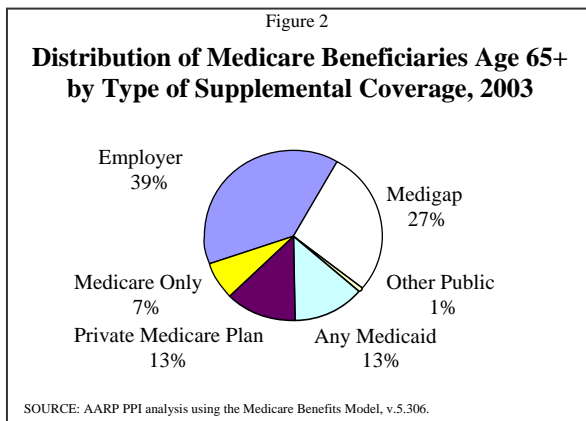
- Inpatient hospital services up to 90 days per "spell of illness"⁶
- Skilled nursing facility services for up to 100 days per spell of illness following a 3+ day hospital stay
- Home health care up to 100 visits per spell of illness following a 3+ day hospital stay
- Hospice care
- Inpatient psychiatric care, for up to 190 days during a beneficiary's lifetime
- Blood (after the beneficiary pays for the first 3 pints per year)

Part B covers:

- Physicians' services, including office visits and a one-time physical examination for new beneficiaries⁷
- Durable medical equipment (e.g., wheelchairs, oxygen) and supplies
- Outpatient hospital services

- Outpatient mental health services
- Clinical laboratory (e.g., blood tests, some screening tests, etc.) and diagnostic tests
- Outpatient occupational, physical, and speech therapy
- Home health care not preceded by a hospital stay and visits over the 100-day Part A limit
- Some preventive services (e.g., mammograms, diabetes screening)⁸
- Blood (after the beneficiary pays for the first 3 pints per year)

Although Medicare provides important coverage for hospital, physician, and other services, its cost-sharing requirements are sometimes substantial. In addition, its benefit package is lacking in key areas. As a result, Medicare paid just under half (48%) of total personal health care expenditures for *all* beneficiaries in 2003.⁹ Many Medicare beneficiaries obtain some type of supplemental insurance (e.g., employer-sponsored coverage, Medigap, Medicaid) that pays for some of the health care costs not covered by Medicare. The cost of private supplemental coverage accounted for, on average, 28 percent of out-of-pocket health care spending in 2003 by non-institutionalized Medicare beneficiaries age 65 or older.¹⁰



How Are Medicare-Covered Services Delivered?

Medicare beneficiaries can obtain Medicare-covered services in one of two ways:

Original Medicare: The majority (over 85%) of beneficiaries receive Part A and B services through “fee-for-service” Medicare. The program pays a share of the Medicare-approved costs, and the beneficiary is responsible for any cost-sharing requirements, such as deductibles and coinsurance.¹¹

The following cost-sharing requirements¹² apply to beneficiaries under original Medicare in 2005:¹³

- **Part A:** For each “spell of illness,” beneficiaries have a \$912 deductible for an inpatient hospital stay of 1-60 days and daily coinsurance starting the 61st day.¹⁴ If they use a skilled nursing facility for more than 20 days in a spell of illness, they must pay \$114 per day for days 21-100.¹⁵
- **Part B:** Beneficiaries have an annual deductible of \$110. In addition, most Part B services require coinsurance of 20 percent of the Medicare-approved amount.¹⁶

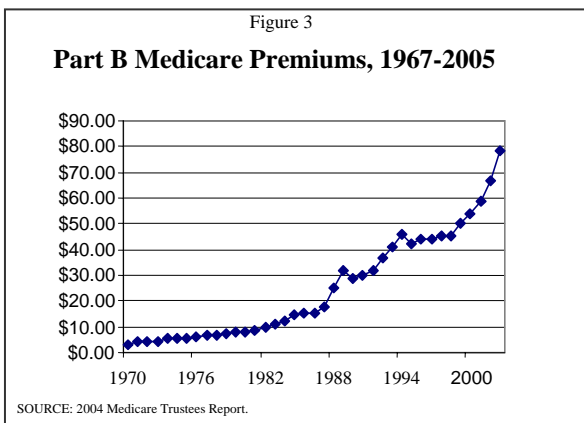
Medicare Advantage (MA): In 2004, about 5.5 million beneficiaries (13%) were enrolled in private health plans (such as health maintenance organizations or HMOs) that contract with Medicare to provide covered services.¹⁷ Medicare pays the MA plan a fixed amount each month for each beneficiary. MA plans must cover, at a minimum, all Part A and Part B services, but may reduce cost-sharing requirements compared to original Medicare and may offer additional benefits that Medicare does not cover (e.g., dental care or vision care).¹⁸ Plans

may charge a premium in addition to the monthly Part B premium.

How Is Medicare Financed?

Part A income and expenditures are administered through the Medicare Hospital Insurance (HI) Trust Fund. HI Trust Fund income is generated primarily by payroll taxes from current workers; employees and employers each pay 1.45 percent of wage earnings (self-employed individuals pay 2.9%). Other sources of income include interest on trust fund assets and taxes on Social Security benefits.¹⁹ According to the 2004 Medicare Trustees Report, under current policy, Part A will be able to pay the full cost of benefits through 2018.²⁰

Part B income and expenditures are administered through the Supplementary Medical Insurance (SMI) Trust Fund. Part B income comes from: 1) *beneficiary premiums* and 2) *federal general revenues*. Beneficiary premiums (\$78.20 per month in 2005) cover about 25 percent of total annual costs for Part B services, while federal general revenues cover the remaining 75 percent.²¹



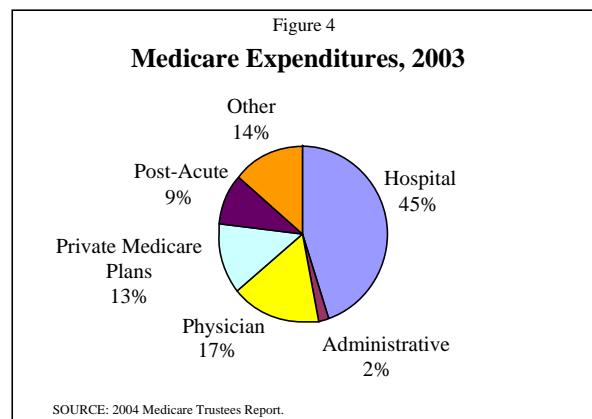
Benefits for enrollees in private health plans under **Part C** (Medicare Advantage) are paid out of the HI and SMI Trust Funds.

Part D (new outpatient prescription drug benefit) will be administered through a separate account within the SMI Trust Fund. As is the case with Part B, Part D will be financed with beneficiary premiums (25.5%) and general revenues (74.5%).

How Much Does Medicare Spend?

In 2003, Medicare spent just over \$280 billion on benefits and administration. About 45 percent of Medicare expenses in 2003 were for payments for inpatient or outpatient hospital services. Another 17 percent were for physician fee schedule services. Payments to private Medicare plans accounted for 13 percent, and post-acute care (home health and skilled nursing facility care) accounted for 9 percent of Medicare expenses. Other benefits and administrative expenses made up 14 percent and 2 percent, respectively.²²

Medicare spending increased 5.7 percent in 2003, compared with growth of 8.1 percent in 2001 and 7.6 percent in 2002.²³ When looking at similar benefits, Medicare's spending growth has compared favorably with that of private health insurance. Between 1969 and 2002, for benefits in common to both sectors, Medicare spending grew at a rate that was one percent less than private health insurance premiums (9.1% vs. 10.1%).²⁴



¹ The MMA, signed into law in December 2003, established a new prescription drug benefit and enacted a number of other programmatic changes that affect Medicare beneficiaries and providers, including a Medicare-approved drug discount card program that operated in 2004 and 2005. For more information on the MMA, see www.cms.hhs.gov/medicarereform.

² Medicare beneficiaries with incomes and assets below certain levels can receive additional subsidies under Part D.

³ Enrollment figures are from 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, March 23, 2004.

⁴ Most individuals in Part A do not pay a premium because they or their spouse had 40 or more quarters of Medicare-covered employment. It is projected that 434,000 enrollees will pay a premium for Part A coverage in 2005 (See 69 Fed Reg 4673, 4674 (Sept. 9, 2004)). Persons with 30-39 quarters can enroll in Part A for a monthly premium of \$206 in 2005; those with fewer than 30 quarters who are not otherwise eligible for premium-free Part A will pay a monthly premium of \$375. See www.medicare.gov.

⁵ Individuals disabled with Amyotrophic Lateral Sclerosis (ALS) are not subject to the Medicare waiting period. To receive SSDI benefits, an applicant's medical condition must be evaluated and determined to meet Social Security's strict definition of disability.

⁶ A "spell of illness" period begins on the first day a beneficiary receives inpatient hospital services and ends 60 consecutive days after discharge if the person is not readmitted to the hospital.

⁷ Medicare covers a one-time "Welcome to Medicare" physical examination within the first six months of enrollment in Part B for a beneficiary whose Part B coverage begins on or after January 1, 2005. Normal Part B cost-sharing requirements apply.

⁸ Other preventive services covered under Medicare Part B include pap smears, colorectal cancer screening, glaucoma testing, prostate cancer screening, cardiovascular screening blood tests, and vaccinations. Some may require cost-sharing, and certain restrictions may apply. For more details on covered preventive services, see CMS, *Medicare and You 2005*, available online at www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

⁹ AARP Public Policy Institute analysis using Medicare Benefits Model, v. 5.306. Personal health care expenditures include the costs of *health care goods and services* purchased directly by beneficiaries or paid by a third party on behalf of beneficiaries. These include spending on inpatient and outpatient hospital, physician, vision, hearing, dental, nursing home, and home health services (medical home health care only), as well as on outpatient prescription drugs and medical supplies and equipment.

¹⁰ Craig Caplan and Normandy Brangan, "Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older in 2003," AARP Public Policy Institute, September 2004.

¹¹ Beneficiaries may also have to pay "balance billing" charges (i.e., physicians who are not participating providers in Medicare may charge Medicare beneficiaries up to 15 percent above the Medicare-approved amount for the service).

¹² Cost-sharing requirements under Part A, Part B, and Part D are subject to change annually.

¹³ Under Part D, the standard drug benefit in 2006 has a \$250 deductible, a 25 percent coinsurance for drug costs between \$250 and \$2,250 in total, no coverage for drug costs between \$2,250 in total and \$3,600 out-of-pocket, and the greater of a 5

percent coinsurance or a \$2/\$5 (generic/brand) copayment once out-of-pocket drug spending reaches \$3,600.

¹⁴ In 2005, the copayment is \$228 per day for days 61-90 of a hospital stay; and \$456 per day for additional hospital days, up to a lifetime limit of 60 days.

¹⁵ There is no cost-sharing for Medicare home health services under either Part A or Part B.

¹⁶ Medicare pays 50 percent of the Medicare-approved amount for outpatient mental health therapy after the annual Part B deductible had been paid. For some outpatient hospital services, beneficiaries pay a coinsurance amount that is greater than 20 percent of the Medicare-approved amount. Also, some preventive services are not subject to Part B cost-sharing. See www.medicare.gov for more information.

¹⁷ AARP Public Policy Institute calculation using Medicare Advantage enrollment data from the Monthly Tracking Report for November 2004

(www.kff.org/medicare/loader.cfm?url=/commons/spot/security/getfile.cfm&PageID=49677) and data from the 2004 Medicare Trustees Report.

¹⁸ Starting in 2006, Medicare Advantage plans that offer drug coverage must at least offer one option with the standard Part D benefit.

¹⁹ Up to 85 percent of Social Security income is taxed if total income exceeds certain thresholds; a portion of these taxes goes to the HI Trust Fund.

²⁰ Craig Caplan and Ryan Cool, "The Status of the Medicare Part A and Part B Trust Funds: The Trustees' 2004 Annual Report," AARP Public Policy Institute, March 2004.

²¹ Although enrollment in Part B is voluntary, almost 95 percent of Part A enrollees were also enrolled in Part B in July 2003. (Figure based on AARP Public Policy Institute analysis using Medicare enrollment data from CMS's website. See www.cms.hhs.gov/statistics/enrollment/st03all.asp.

Beneficiaries aged 65 and older who do not enroll in Part B when they first become eligible for Medicare can do so later with a financial penalty. For each 12-month period that a beneficiary could have enrolled in Part B after turning age 65 but did not, an additional 10 percent penalty (i.e., additional monthly premium) is assessed. This penalty does not apply to a beneficiary with group health insurance through an employer (or spouse's employer) so long as the beneficiary follows Medicare's application rules once such employment-sponsored coverage ends.

²² Percentages based on AARP Public Policy Institute calculations using 2004 Medicare Trustees Report data.

²³ Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, Vol. 24, No. 1, January/February 2005, pp. 185-194.

²⁴ Katharine Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, et al., "Health Spending Rebound Continues in 2002," *Health Affairs*, Vol. 23, No. 1, January/February 2004, pp. 147-159.

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