Fact Sheet

The Medicare Beneficiary Population

Currently, 44 million beneficiaries—some 15 percent of the U.S. population—are enrolled in the Medicare program. Enrollment is expected to rise to 79 million by 2030.

Only one in 10 beneficiaries relies solely on the Medicare program for health care coverage. The rest have some form of supplemental coverage to help with medical expenses.

Medicare Program Enrollment

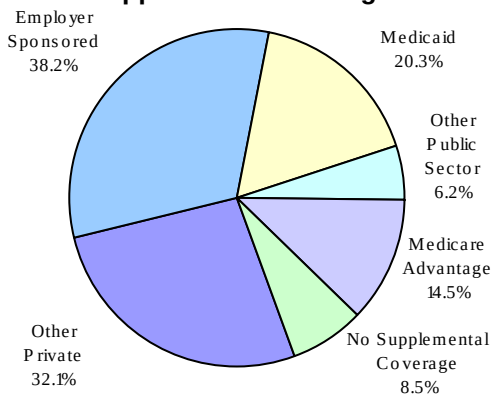
The Medicare population has grown steadily since the program's inception in 1966. In 2007, approximately 44 million people—about 15 percent of the population of the nation—were enrolled in either Part A or Part B. While most receive coverage because of age eligibility, about one-sixth of the Medicare population—about 7.3 million people—receive benefits because of disability status. In addition, about 209,000 people receive Medicare coverage as a result of end-stage renal disease (ESRD), an eligibility category added to Medicare in 1973[1] (another 175,000 or so qualify based on age and have a diagnosis of ESRD).

Most aged Medicare enrollees have both Part A and Part B coverage. Part A, also called Hospital Insurance, covers the expenses of hospitalization, skilled nursing facility care, and some hospice stays. Part B, or Supplementary Medical Insurance, pays for services like clinician visits, outpatient care, and some preventive services. Part B insurance requires a monthly premium, while Part A insurance is free for individuals who have worked for at least 40 quarters in the United States and paid taxes. People who do not meet the employment criteria can pay a monthly premium for Part A coverage; about 1 percent of Part A enrollees pay their own premiums. Most people (93 percent) enroll in both programs, while 6 percent enroll in Part A only and 1 percent enroll in Part B only.[2]

For some of these enrollees, a personal choice about the need for services and the expense of Part B premiums may account for enrollment in Part A only; most of those enrolled in Part B only are ineligible for free Part A insurance and choose to pay for only one type of coverage. Medicare Part C, also called Medicare Advantage, pays for the care of approximately 9.4 million people (one-fifth of beneficiaries) through private plans.[3] Medicare Part D, which provides prescription drug coverage, covers an estimated 25.4 million beneficiaries through a combination of stand-alone prescription drug plans and Medicare Advantage plans that include drug coverage.[4]

Traditional fee-for-service Medicare involves significant cost-sharing from beneficiaries; therefore, most people maintain some form of supplemental insurance, with only about 8.5 percent relying on Medicare alone (figure 1).[5] Employer and private insurance together account for more than 70 percent of supplemental insurance held by the Medicare population.[6]

Figure 1
More than 90 Percent of Medicare Beneficiaries Have Supplemental Coverage



Source: MCBS Cost and Use File, 2005.

Beneficiary Demographics

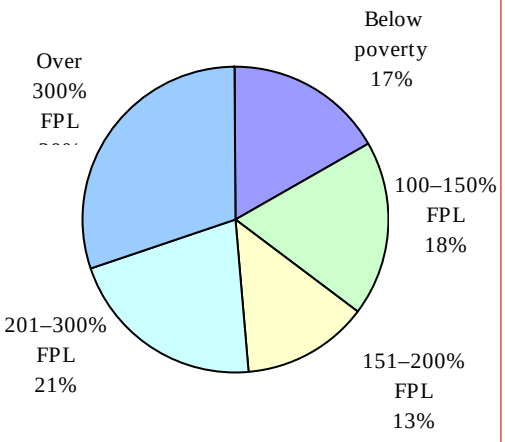
A little more than half of current aged Medicare enrollees are between the ages of 65 and 74, though the older segments of the population are growing.[7] Today, individuals over the age of 85 account for a little more than 10 percent of the total Medicare population,[8] but their use of Medicare services and their overall impact on the program are substantial. Among disabled beneficiaries, almost one-quarter are under age 45, and about one-third are between ages 45 and 54.

Life expectancy is higher for females than for males in the United States, and they outnumber males in the Medicare population by about 5 million. The vast majority of the Medicare population is white, with black and Hispanic individuals comprising the second and third most prevalent racial groups.[9] In 2005, 71 percent of Medicare recipients were high school graduates and 41 percent had received at least some college education.[10]

The living arrangements of Medicare beneficiaries vary widely. About half live with a spouse; 48 percent are widowed, divorced, or never married.[11] Five percent reside in an institution.[12] For many elderly Americans, the care and company received from a spouse or family members are important to maintaining independence and social contact. Most Medicare beneficiaries live in urban locations, and the eastern half of the country tends to have a higher density of Medicare recipients than the nation at large.[13]

The income profile of the Medicare population is diverse (figure 2). Most beneficiaries live above poverty, though 17 percent live below the poverty line and almost half have incomes below 200 percent of the federal poverty level (FPL).[14]

Figure 2
Almost Half of Beneficiaries Have Incomes below 200 percent of Federal Poverty Level



Source: MCBS Cost and Use file, 2005.

Utilization and Spending

About 75 percent of beneficiaries use Medicare services in a given year.[15] In 2006, for instance, 33.1 million beneficiaries out of a total Medicare population of 43.3 million used one or more services.[16] Of these, 32.2 million saw a clinician under Medicare's Part B program and 7.5 million had at least one hospital admission.[17] A smaller number, fewer than 2 million, used skilled nursing

facilities and home health agency services. Less is known about use of prescription drugs, particularly since the implementation of the Part D program.

Overall, the Medicare population is healthy. Half of all beneficiaries consider themselves to be in "good" or "fair" health, and an additional 40 percent rate their health as "very good" or "excellent."[18] That said, a large fraction of Medicare beneficiaries live with one or more chronic conditions, such as high blood pressure or high cholesterol, and it is not uncommon for individuals to have several chronic conditions simultaneously. The proportion of individuals with multiple chronic conditions increases with age.

Overall, Medicare spending is split among various services (figure 3). The largest portion of spending remains hospital inpatient care, though this fraction has declined over time. Managed care occupies the next largest share of expenditures, followed by a number of other benefits and care delivery systems.

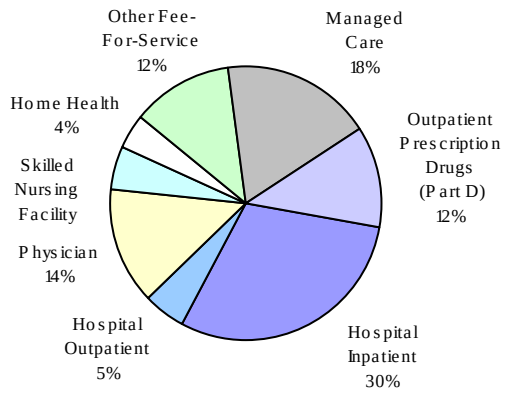
Future Changes

The Medicare population is expected to change significantly in several respects over the next several decades. These changes will be the result of national demographic trends as the population ages.

One of the most impressive changes will be the increase in the size of Medicare enrollment. As the baby boom generation ages, the Medicare population is projected to grow to 79 million by 2030, more than double the year 2000 enrollment.[19] The increase in patient volume poses administrative and fiscal challenges to the system.

The program will see an increasing number of beneficiaries with multiple chronic conditions. High blood pressure (hypertension) and diabetes currently top the list of chronic conditions reported among Medicare beneficiaries, but in 2002 more than half of the Medicare population was treated for five or more chronic conditions.[20] The treatment of multiple chronic conditions drives Medicare spending, by some estimates accounting for nearly all spending growth between 1987 and 2002.[21] The increase in chronic conditions among the future Medicare population can be expected to drive more spending increases.

Figure 3
Medicare Spending Is Widely Distributed across Services



Source: *MedPAC Data Book, 2008.*

These increases seem to be due to two main causes. First, advances in medical technology and understanding allow us to diagnose many conditions that formerly would have been undetectable. Furthermore, modern treatment means that complicated illnesses can now be managed successfully or cured, allowing us live longer at the price of higher medical costs. Second, people are entering the Medicare system with more numerous and complicated chronic conditions than ever before.
Medicare will also see a large increase in minority populations. The prevalence of particular diseases and conditions varies between racial groups, and as the minority population grows, the need for resources and expertise will change.

Language barriers may also complicate delivery of care, result in errors, and make it difficult for beneficiaries to navigate the Medicare system.

A more encouraging demographic change will come in the form of a more educated population. A greater fraction of the coming Medicare population has a high school diploma or college degree than the current Medicare cohort.[22] Higher levels of education are associated with delayed onset of many chronic conditions, and future beneficiaries may have different attitudes about treatment, prevention, and healthy lifestyle choices. Future beneficiaries are also likely to be better informed about medical treatment options and Medicare services, perhaps leading to more informed decision-making and more effective use of health care resources.

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[1] *CMS Data Compendium 2007*, Ch. 4, p. 31b. http://www.cms.hhs.gov/DataCompendium/01_Overview.asp#TopOfPage. Accessed October 1, 2008.

[2] Health Care Financing Review/2007 Statistical Supplement. http://www.cms.hhs.gov/MedicareMedicaidStatSupp/downloads/2007Table2.1b.pdf. Accessed October 1, 2008.

[3] *MedPAC Data Book, June 2008*. Washington, DC: Medicare Payment Advisory Commission. June, 2008.

[4] Kaiser State Health Facts, data as of January 2008. www.statehealthfacts.org/comparetable.jsp?cat=6&ind=307

[5] University of Maryland analysis of the 2005 MCBS Cost and Use file.

[6] Ibid.

[7] *CMS Data Compendium 2007*, Ch. 4, p. 32a. The referenced data reflect the population in 2006.

[8] Ibid.

[9] University of Maryland analysis of the 2005 MCBS Cost and Use file.

[10] *MedPAC June Data Book 2008*, Chart 2-5.

[11] University of Maryland analysis of the 2005 MCBS Cost and Use file.

[12] *MedPAC June Data Book 2008*, Chart 2-5.

[13] University of Maryland analysis of the 2005 MCBS Cost and Use file, and "Kaiser State Health Facts: Medicare Enrollment as a Percent of Total Population," 2008. www.statehealthfacts.org/comparemaptable.jsp?ind=291&cat=6

[14] University of Maryland analysis of the 2005 MCBS Cost and Use file.

[15] *CMS Health Care Financing Review/2007 Statistical Supplement*, Table 3.3.

[16] Ibid.

[17] *CMS Health Care Financing Review/2007 Statistical Supplement*, Table 3.3.

[18] *MedPAC June Data Book 2008*, Chart 2-5.

[19] *MedPAC Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007. Washington, DC: Medicare Payment Advisory Commission. June, 2007.

[20] Ibid.

[21] K. E. Thorpe and D. H. Howard, "The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity," *Health Affairs* 25:5 (2006), w378–388.

[22] MedPAC Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007. In this instance, MedPAC takes its data from Census Bureau sources.

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