MEDICARE

A PRIMER

2010

THE HENRY J. KAISER FAMILY FOUNDATION

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INTRODUCTION

Established in 1965, Medicare is a social insurance program that provides health and financial security for individuals ages 65 and older and for younger people with permanent disabilities. Prior to 1965, roughly half of all seniors lacked medical insurance; today, virtually all seniors have health insurance under Medicare.

Medicare provides health insurance coverage to 47 million people in 2010: 39 million people ages 65 and older and 8 million people with permanent disabilities who are under age 65. The program helps to pay for many important health care services, including hospitalizations, physician services, and prescription drugs. Individuals contribute payroll taxes to Medicare throughout their working lives and generally become eligible for Medicare when they reach age 65, regardless of income or health status.

The health care reform law enacted in March 2010 (P.L. 111-148)[1] expands prescription drug and prevention benefits covered under Medicare and introduces new programs designed to improve the quality and delivery of care to people covered by Medicare. In addition, the law reduces the growth in Medicare payments to health care providers and Medicare Advantage plans, and includes other provisions designed to slow the growth in Medicare spending and strengthen the solvency of the Medicare Hospital Insurance Trust Fund, including the creation of a new Independent Payment Advisory Board.

Comprising an estimated 12 percent of the federal budget and more than one-fifth of total national health expenditures in 2010, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and health care spending in the U.S.[2] With the dual challenges of providing increasingly expensive medical care to an aging population and keeping the program financially secure for the future, discussions about Medicare are likely to remain prominent on the nation's agenda in the years ahead.

[1] Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

[2] The Medicare share of the federal budget is from Office of Management and Budget (OMB), Budget of the U.S. Government, Fiscal Year 2011, February 2010. The Medicare share of national health expenditures is from Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT), National Health Expenditure Projections 2009-2019, February 2010.

MEDICARE: A PRIMER

WHAT IS MEDICARE?

Medicare is the nation's health insurance program for Americans age 65 and older, and for younger adults with permanent disabilities.

Established in 1965 under Title XVIII of the Social Security Act, Medicare was initially established to provide health insurance to individuals age 65 and older, regardless of income or medical history. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities receiving Social Security Disability Insurance payments and people suffering from end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). As of 2010, 47 million people rely on Medicare for their health insurance coverage: 39 million people age 65 and over and 8 million people under age 65 with disabilities.

Medicare consists of four parts, each covering different benefits.

PART A, also known as the Hospital Insurance (HI) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is funded by a tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). The health care reform law[3] increases the Medicare HI payroll tax for higher-income taxpayers (more than $200,000/individual and $250,000/couple) by 0.9 percentage points, beginning in 2013. In 2009, Part A accounted for approximately 36 percent of total Medicare benefit spending.[4] An estimated 45.6 million people were enrolled in Part A in 2009.

PART B, the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, home health, and preventive services. Part B is funded by general revenues and beneficiary premiums ($110.50 per month in 2010; $96.40 per month for beneficiaries held harmless from the premium increase – *see page 5 for additional information*). Beneficiaries who have higher annual incomes (over $85,000/individual, $170,000/couple) pay a higher, income-related monthly Part B premium; beginning in 2011, the health care reform law freezes the income thresholds at 2010 levels through 2019. In 2009, Part B accounted for 27 percent of total benefit spending.[5] An estimated 42.4 million people were enrolled in Part B in 2009.

PART C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization, preferred provider organization, or private fee-for-service plan, as an alternative to the traditional fee-for-service program. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed, and accounted for 24 percent of benefit spending in 2009. As of April 2010, 11.5 million beneficiaries are enrolled in Medicare Advantage plans.[6]

PART D, the outpatient prescription drug benefit, was established by the Medicare Modernization Act of 2003 (MMA) and launched in 2006. The benefit is delivered through private plans that contract with Medicare: either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. Individuals who sign up for a Part D plan generally pay a monthly premium; those with modest income and assets are eligible for assistance with premiums and cost-sharing amounts. The health care reform law establishes a new income-related Part D premium similar to the Part B premium, beginning in 2011, and gradually phases in coverage in the Part D coverage gap. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 10 percent of benefit spending in 2009. As of April 2010, 27.6 million beneficiaries are enrolled in a Part D plan.[7]

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[3] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).
[4] Congressional Budget Office (CBO), Medicare Baseline, March 2009.
[5] CBO, Medicare Baseline, March 2009.
[6] Centers for Medicare & Medicaid Services (CMS), Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations Monthly Summary Report, April 2010.
[7] CMS, Monthly Summary Report, April 2010.

WHO IS ELIGIBLE FOR MEDICARE?

Most people age 65 and older are automatically entitled to Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years (40 quarters).

Individuals age 65 and over qualify for Medicare if they are U.S. citizens or permanent legal residents. Individuals qualify without regard to their medical history or preexisting conditions, and do not need to meet an income or asset test. Adults under age 65 with permanent disabilities are eligible for Medicare after receiving Social Security Disability Income (SSDI) payments for 24 months, even if they have not made payroll tax contributions for 40 quarters. People with end-stage renal disease (ESRD) or Lou Gehrig's disease are eligible for Medicare benefits as soon as they begin receiving SSDI payments, without having to wait 24 months. Individuals who are entitled to Part A do not pay premiums for covered services. Individuals age 65 and over who are not entitled to Part A, such as those who did not pay enough Medicare taxes during their working years, can pay a monthly premium to receive Part A benefits.

Individuals entitled to Part A and others age 65 and older may elect to enroll in Part B.

Part B is voluntary, but about 95 percent of beneficiaries with Part A are also enrolled in Part B. For most individuals who become entitled to Part A, enrollment in Part B is automatic unless the individual declines enrollment. Individuals age 65 and older who are not entitled to Part A may enroll in Part B. With the exception of the working aged (or their spouses) who may delay enrollment if they receive employment-based coverage, those who do not sign up for Part B when they are first eligible typically pay a penalty for late enrollment, in addition to the regular monthly premium, for the duration of their enrollment in Part B.

Individuals are eligible for Part C, or Medicare Advantage, if they are entitled to Part A and enrolled in Part B.

Beneficiaries may generally elect to enroll in a Medicare Advantage (MA) plan on an annual basis between November 15 and December 31 of each year during the annual election period. Beneficiaries enrolled in a Medicare Advantage plan as of January 1 can switch Medicare Advantage plans or return to traditional Medicare for 90 days after the beginning of the calendar year. Beginning in 2011, the annual election period will run from October 15 to December 7 (a change included in the health care reform law[8]). Also beginning in 2011, beneficiaries enrolled in a Medicare Advantage plan as of January 1 will be allowed only 45 days to disenroll from the plan and return to traditional Medicare; they will not be allowed to switch from one Medicare Advantage plan to another during this period.

Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Part A and/or enrolled in Part B.

To get Part D benefits, beneficiaries must enroll in a stand-alone prescription drug plan (PDP) or Medicare Advantage prescription drug (MA-PD) plan. The annual election period for Part D and Medicare Advantage benefits runs from November 15 to December 31 of each year, until 2011, when the election period will be changed to October 15 to December 7. Individuals who delay enrollment in Part D and are without "creditable" drug coverage (at least comparable to the Part D standard benefit) pay a permanent premium penalty for late enrollment.

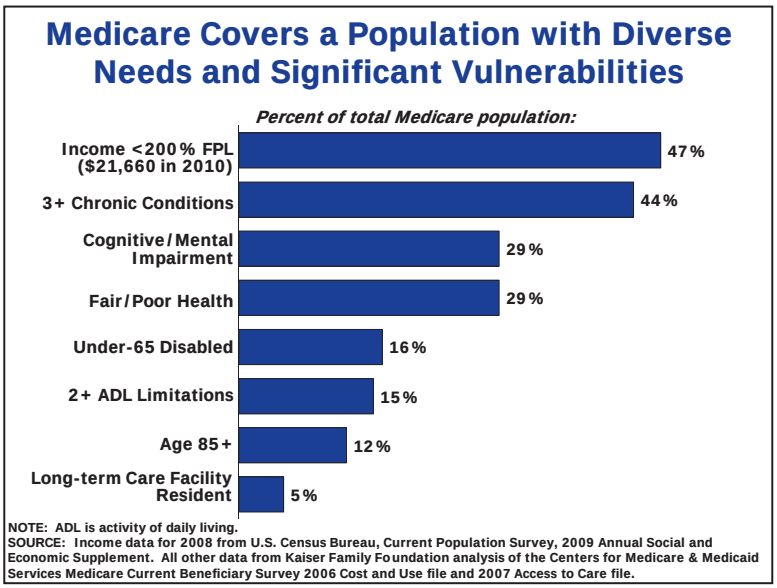
[8] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).

WHAT ARE THE CHARACTERISTICS OF PEOPLE WITH MEDICARE?

Medicare covers a population with diverse needs and circumstances. While many beneficiaries enjoy good health, nearly half live with three or more chronic conditions and more than a quarter have cognitive impairments. Nearly half of all beneficiaries have incomes below twice the poverty level.

More than four in ten Medicare beneficiaries (44 percent) live with three or more chronic conditions. Among the most common conditions are hypertension and arthritis. More than a quarter (29 percent) of all beneficiaries have a cognitive or mental impairment that limits their ability to function independently.

Approximately one in seven (15 percent) beneficiaries has multiple functional limitations, as defined as two or more limitations in activities of daily living (ADLs), such as eating or bathing.



Although the majority of the Medicare population is age 65 or over, 16 percent are under age 65 and permanently disabled.

Nonelderly beneficiaries with disabilities tend to have lower incomes than other beneficiaries. About 40 percent are dually eligible for both Medicare and Medicaid. Because of their disabilities, they tend to have relatively high rates of health problems, including functional limitations and cognitive impairments.

Most beneficiaries live at home, but five percent live in a long-term care setting.

Five percent of Medicare beneficiaries (2.2 million) live in a long-term care setting, such as a nursing home or assisted living facility, but a larger share of beneficiaries who are age 85 or older do so (19 percent).[9] Two-thirds of beneficiaries living in long-term care settings are women, and nearly 60 percent are dually eligible for Medicare and Medicaid.

Poverty rates are especially high among those in racial/ethnic minority groups, women, people under age 65 with disabilities, and those ages 85 and older.

Almost half of all Medicare beneficiaries (47 percent) have an income below 200 percent of poverty ($21,660/individual and $29,140/couple in 2010), and 16 percent have an income below 100 percent of the poverty level.

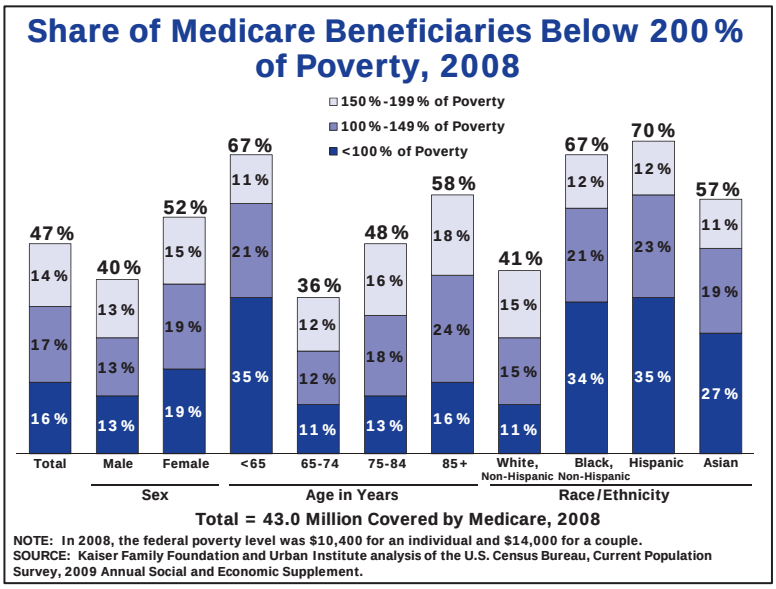
Race/ethnicity: Two-thirds of all African American beneficiaries and seven in ten Hispanic beneficiaries live on incomes below twice the poverty level, compared to 41 percent of White beneficiaries.

[7] Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use file, 2006.

Approximately one-third of African-American and Hispanic beneficiaries have incomes below the poverty level, more than three times the share of White beneficiaries (11 percent).

Age: Two-thirds of all Medicare beneficiaries with disabilities under age 65 live on incomes below twice the poverty level, and more than one-third live in poverty. Among people on Medicare age 65 and older, poverty rates increase with age. Nearly six in ten beneficiaries age 85 and older have annual incomes below twice the poverty level.

Sex: Poverty rates are substantially higher among women on Medicare than men. More than half of all female Medicare beneficiaries live on an annual income below twice the poverty level, substantially higher than the rate for men.



WHAT DOES MEDICARE COVER AND HOW MUCH DO BENEFICIARIES PAY FOR BENEFITS?

Medicare provides coverage of basic medical services including care in hospitals and other settings, physician services, diagnostic tests, preventive services, and an outpatient prescription drug benefit. Beneficiaries generally pay varying deductibles and coinsurance amounts that are indexed to rise annually to keep pace with increases in program costs. ***(See page 21 for more detail about Medicare benefits and cost-sharing requirements for 2010.)***

PART A helps pay for inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities, and also covers hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility.

- Most beneficiaries do not pay a monthly premium for Part A services, but are subject to a deductible before Medicare coverage begins. In 2010, the Part A deductible for each "spell of illness" is $1,100 for an inpatient hospital stay.

- Beneficiaries are generally subject to a coinsurance for benefits covered under Part A, including extended inpatient stays in a hospital ($275 per day for days 61-90 in 2010) or skilled nursing facility ($137.50 per day for days 21-100 in 2010). There is no copayment for home health visits.

PART B helps pay for outpatient services, such as outpatient hospital care, physician visits, and other medical services, including preventive services such as mammography and colorectal screening. Part B also covers ambulance services, clinical laboratory services, durable medical equipment (such as wheelchairs and oxygen), kidney supplies and services, outpatient mental health care, and diagnostic tests, such as x-rays and magnetic resonance imaging. The health care reform law[10] added a free annual comprehensive wellness visit and personalized prevention plan to the list of Medicare-covered benefits, beginning in 2011. The law also gives the Secretary of HHS the authority to modify coverage of Medicare-covered preventive services to conform to the recommendations of the U.S. Preventive Services Task Force (USPSTF).

- Beneficiaries enrolled in Part B are generally required to pay a monthly premium ($110.50 in 2010). However, in 2010 a majority of beneficiaries (73 percent) are not required to pay the higher Part B monthly premium because there was no cost-of-living increase in Social Security benefits; the 2010 Part B monthly premium for these beneficiaries is $96.40, the same as in 2009.[11] New enrollees, higher-income beneficiaries, and low-income beneficiaries (who are not required to pay the monthly Part B premium themselves) are not held harmless from the Part B premium increase. *(See page 12 for additional information on additional assistance for low-income beneficiaries through the Medicare Savings Programs [MSPs]).*

- Beneficiaries with annual incomes greater than $85,000 for an individual or $170,000 for a couple in 2010 pay a higher, income-related monthly Part B premium, ranging from $154.70 to $353.60. The health care reform law freezes these thresholds at 2010 levels through 2019, beginning in 2011. Previously the income thresholds were indexed annually to rise with the rate of inflation, which limited the number of beneficiaries who would otherwise have been subject to the higher premium over time. Approximately 5 percent of all Medicare beneficiaries pay the income-related Part B premium in 2010.

[10] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).
[11] Henry J. Kaiser Family Foundation, "The Social Security COLA and Medicare Part B Premium: Questions, Answers, and Issues", October 2009, http://www.kff.org/medicare/7912.cfm.

- Part B benefits are subject to an annual deductible ($155 in 2010), and most Part B services are subject to a coinsurance of 20 percent. Beginning in 2011, no coinsurance and deductibles will be charged for preventive services that are rated A or B by the USPSTF.

PART C (Medicare Advantage) private health plans pay for all benefits covered under Medicare Part A, Part B, and Part D. Medicare Advantage enrollees generally pay the monthly Part B premium and often pay an additional premium directly to their plan. *(See pages 9-10 for additional information about Medicare Advantage.)*

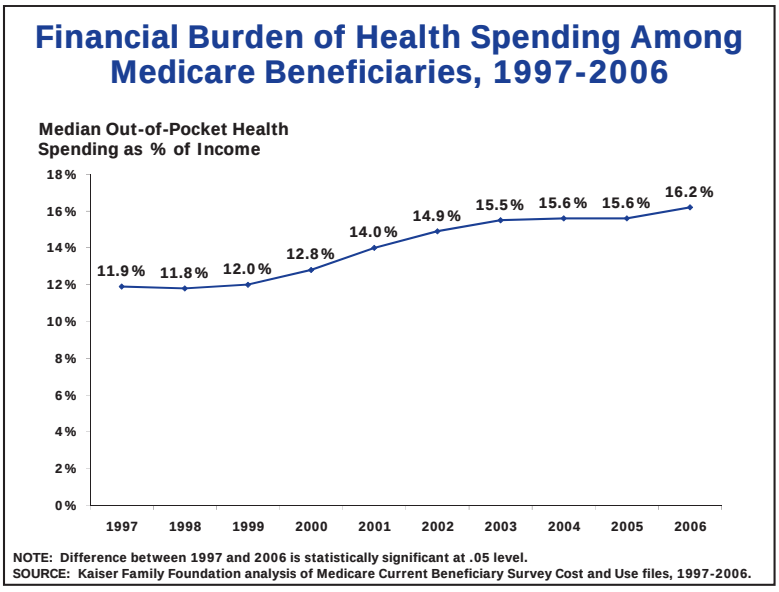
PART D helps pay for outpatient prescription drug coverage through private health plans. Plans are required to provide a "standard" benefit or one that is actuarially equivalent, and may offer more generous benefits. In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. The health care reform law gradually phases in coverage in the Part D coverage gap, and establishes a new income-related Part D premium with income thresholds similar to the Part B premium ($85,000/individual, $170,000/couple), beginning in 2011. As with the Part B income-related premiums, these income thresholds will not be indexed but instead fixed at these levels through 2019. *(See pages 7-8 for additional information about Part D.)*

Despite the important protections provided by Medicare, there are significant gaps in Medicare's benefit package.

Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities. Most notably, Medicare does not pay for custodial long-term care services either at home or in an institution, such as a nursing home or assisted living facility. Medicare also does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids.

Medicare has fairly high deductibles and cost-sharing requirements for covered benefits. Unlike typical large employer plans, Medicare does not have a stop-loss benefit that limits annual out-of-pocket spending. While many beneficiaries have supplemental insurance to help cover their Medicare-related expenses, they often pay premiums for supplemental coverage (including Medigap, Medicare Advantage plans, and employer-sponsored retiree health benefits). As a result, many beneficiaries face significant out-of-pocket costs for both premiums and non-premium expenses to meet their medical and long-term care needs. *(See pages 11-12 for additional information about supplemental insurance.)*

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 percent in 1997 to 16.2 percent in 2006.[12]



[12] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 1997-2006.

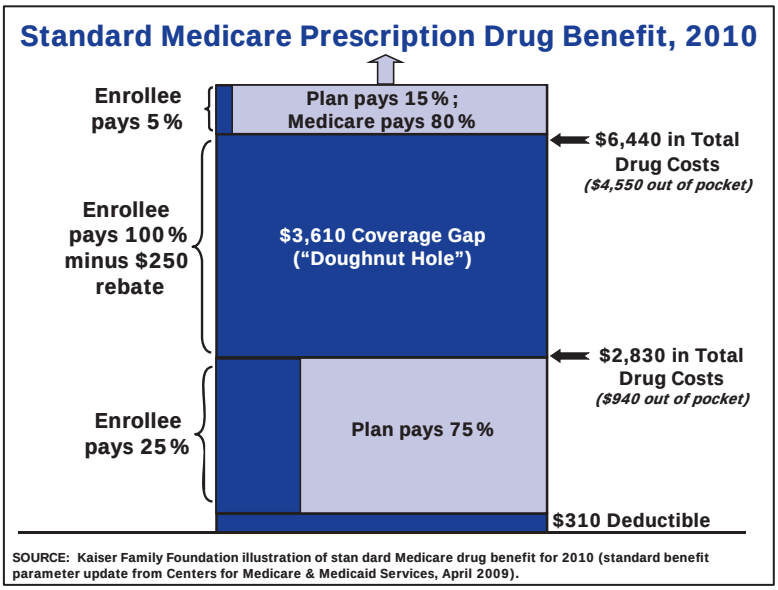
WHAT IS THE MEDICARE PRESCRIPTION DRUG BENEFIT?

Medicare beneficiaries have access to an outpatient prescription drug benefit (Part D) offered through private health plans: either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs.

In 2010, 1,576 stand-alone prescription drug plans (PDPs) are available nationwide, up from 1,429 in 2006 (excluding the territories). Beneficiaries in most states could choose from at least 45 stand-alone PDPs and multiple MA-PD plans.

Medicare Part D drug plans are required to offer either the standard benefit that is defined in law, or an alternative equal in value ("actuarially equivalent"); plans can also offer enhanced benefits. Most Part D plans have a coverage gap (the so-called "doughnut hole").

The standard benefit in 2010 has a $310 deductible and 25 percent coinsurance up to an initial coverage limit of $2,830 in total drug costs, followed by a coverage gap, in which enrollees with at least $2,830 in total costs pay 100 percent of their drug costs until they have spent $4,550 out of pocket (excluding premiums). At that point, the individual pays 5 percent of the drug cost or a copayment ($2.50/generic or $6.30/brand for each prescription) for the rest of the year. The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.



SOURCE: Kaiser Family Foundation illustration of stan dard Medicare drug benefit for 2010 (standard benefit parameter update from Centers for Medicare & Medicaid Services, April 2009).

The health care reform law[13] provides a $250 rebate to Part D enrollees with any spending in the coverage gap in 2010, and gradually phases in coverage in the gap between 2011 and 2020.

In 2010, only 11 percent of PDPs offer the standard benefit, most charge copayments instead of 25 percent coinsurance, and 60 percent charge a deductible, with 36 percent charging the full $310 deductible amount.[14] The majority (80 percent) of PDPs offer no gap coverage, while for the 20 percent of PDPs offering gap coverage; this coverage is limited primarily to generic drugs only. Plans vary widely in terms of formularies (the list of covered drugs), the placement of drugs on formulary tiers, cost-sharing requirements, and utilization management tools (such as prior authorization requirements).

Monthly Part D premiums and cost-sharing amounts are not uniform nationwide, but vary across plans and regions, and have increased significantly on average since 2006.

In 2010, the national average monthly Part D premium for all plans (including PDPs and MA-PD plans) is $31.94 (*unweighted* by enrollment). Actual PDP premiums vary across plans and regions, ranging from a low of $8.80 in Oregon and Washington to a high of $120.20 in Delaware, Maryland, and Washington, D.C.

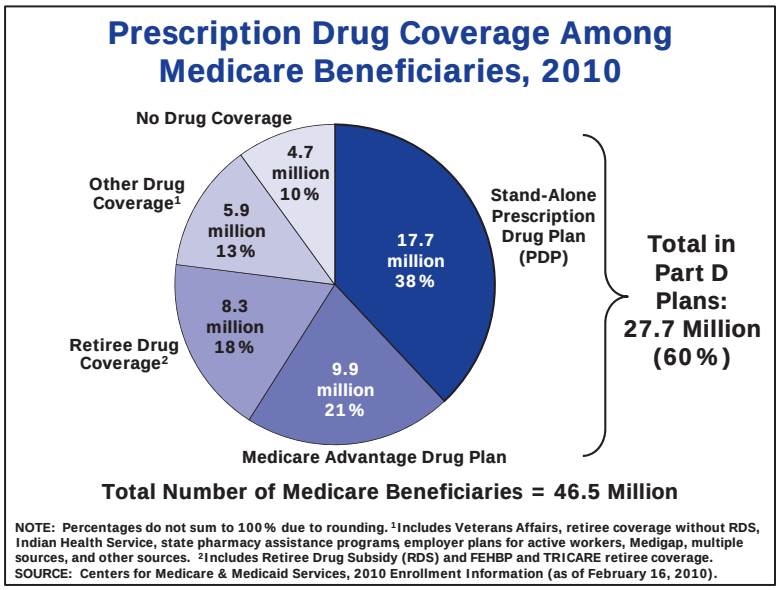
[13] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).
[14] Hoadley J, Cubanski J, Hargrave E, Summer L, and Neuman T, "Medicare Part D Spotlight: Part D Plan Availability in 2010 and Key Changes Since 2006," Kaiser Family Foundation, November 2009, http://www.kff.org/medicare/7986.cfm.

Individuals with modest incomes and assets are eligible for additional assistance with Part D premiums and cost-sharing requirements.

Beneficiaries with income below 150 percent of poverty ($16,245 for an individual; $21,855 for a couple in 2010) and limited assets ($12,510/individual; $25,010/couple in 2010) are eligible for the low-income subsidy (LIS), or "extra help", which helps pay for all or some of the Part D monthly premium, the annual Part D deductible, and prescription drug co-payments. The Centers for Medicare & Medicaid Services (CMS) estimates that of the 12.5 million beneficiaries potentially eligible for low-income subsidies as of February 2009, 2.3 million beneficiaries (18 percent) were not yet receiving them.[15]

Approximately 90 percent of all Medicare beneficiaries have "creditable" prescription drug coverage, while approximately 4.7 million beneficiaries (10 percent) lack a known source of creditable drug coverage.

More than 27 million Medicare beneficiaries are enrolled in a Part D plan, as of April 2010. Of this total, nearly two-thirds (64 percent) are enrolled in stand-alone prescription drug plans. This includes nearly 8 million low-income subsidy recipients, many of whom were automatically enrolled in stand-alone drug plans. Nearly 20 percent of all Medicare beneficiaries (8.3 million) receive prescription drug coverage from an employer or union plan. This includes 6.4 million beneficiaries whose employers receive subsidies equal to 28 percent of drug expenses between $310 and $6,300 per retiree in 2010 through the Medicare Retiree Drug Subsidy (RDS) program.[16]



The health reform law reduces the amount that Medicare Part D enrollees are required to pay for their prescriptions when they reach the coverage gap, gradually phasing in different levels of subsidies for brand-name and generic drugs in the gap beginning in 2011.

In 2010, Part D enrollees with any out-of-pocket spending in the coverage gap will receive a $250 rebate. Beginning in 2011, Part D enrollees will receive a 50 percent discount on the total cost of brand-name drugs in the coverage gap, as agreed to by pharmaceutical manufacturers. Over time, Medicare will gradually phase in additional subsidies in the coverage gap for brand-name drugs (beginning in 2013) and generic drugs (beginning in 2011), reducing the beneficiary coinsurance rate from 100 percent in 2010 to 25 percent by 2020. In addition, between 2014 and 2019, the law reduces the out-of-pocket amount that qualifies an enrollee for catastrophic coverage, further reducing out-of-pocket costs for those with relatively high prescription drug expenses. In 2020, the catastrophic coverage level will revert to that which it would have been absent these reductions.[17]

[15] U.S. Department of Health and Human Services (DHHS), February 1, 2009.
[16] Beginning in 2013, the health care reform law eliminates the tax deductibility of the 28 percent federal subsidy payment that employers who accept the retiree drug subsidy have been able to claim.
[17] For more on the changes to the coverage gap, see Kaiser Family Foundation, "Explaining Health Care Reform: Key Changes to the Medicare Part D Drug Benefit Coverage Gap," http://www.kff.org/healthreform/8059.cfm.

WHAT IS MEDICARE ADVANTAGE?

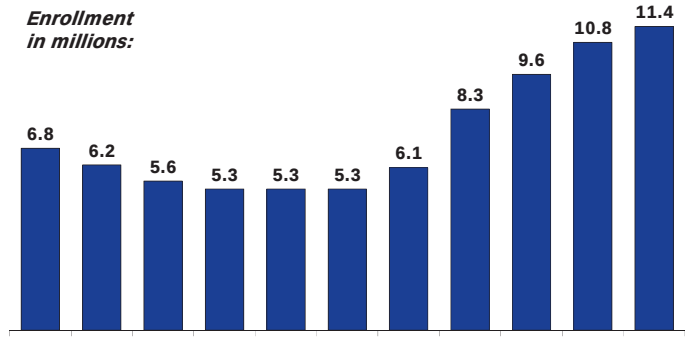
Medicare Advantage (MA), also known as Medicare Part C, is a program that allows beneficiaries to enroll in private health plans to receive Medicare-covered benefits.

Private plans such as health maintenance organizations (HMOs) have been an option under Medicare since the 1970s. Medicare now contracts with other types of private plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, or those with certain chronic conditions. In 2010, Medicare beneficiaries were able to choose from 33 Medicare Advantage plans offered in their area, on average. As of April 2010, 75 percent of Medicare Advantage enrollees are in local HMOs or PPOs, 14 percent in PFFS plans, 7 percent in Regional PPOs, and the remainder in other plan types.[18]

Since 2004, the number of Medicare Advantage plans and enrollees has steadily increased.

Private plans are playing a larger role in Medicare through a revitalization of the Medicare Advantage program, largely due to increased payments. After a decline in the number of plans and enrollees between 1999 and 2003, the program has seen a rapid increase in more recent years. The number of Medicare enrollees in private plans has more than doubled from 5.3 million in 2003 to 11.4 million in early 2010.

Total Medicare Private Health Plan Enrollment, 2000-2010



NOTE: Includes local HMOs, PSOs, PPOs; regional PPOs; PFFS plans; 1876 cost plans; demos; HCPP; and PACE plans.
SOURCE: Mathematica Policy Research, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," February 2000-2010.

Medicare Advantage plans provide all benefits covered under traditional Medicare, and many plans offer additional benefits. The majority of plans also provide Part D prescription drug coverage.

Medicare Advantage plans receive payments from the federal government to provide all Medicare-covered benefits to enrollees. Plan sponsors are generally required to offer at least one plan with basic drug coverage. Nearly 8 in 10 of Medicare Advantage plans (79 percent) offer drug coverage in 2010, and about half of these plans offer some coverage in the coverage gap, mainly for generic drugs only. Plans are required to use any extra payments (rebates) to provide additional benefits to enrollees in the form of lower premiums, lower cost sharing, or extra benefits and services. Examples of extra benefits include vision, hearing, preventive dental care, podiatry, chiropractic services, and gym memberships.

Medicare Advantage plan premiums and cost-sharing requirements vary widely, and have increased in recent years.

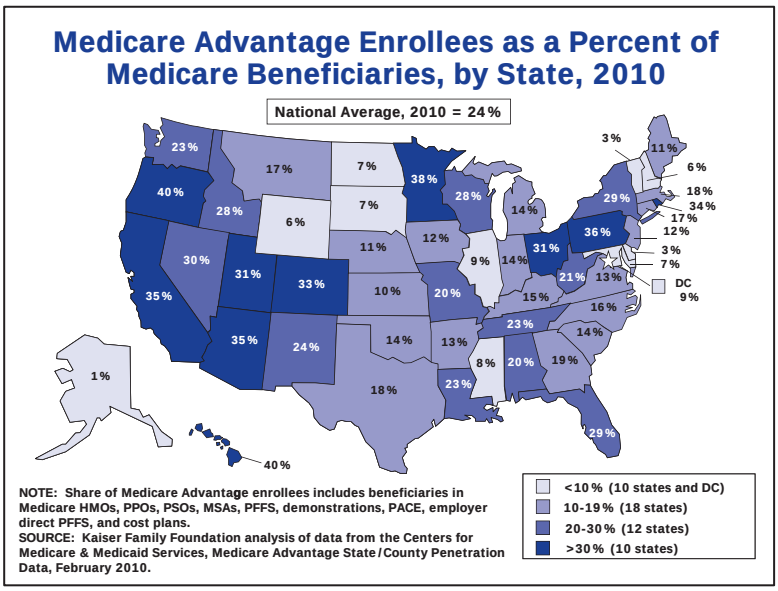
Medicare Advantage enrollees generally pay the monthly Part B premium and often pay an additional premium directly to their plan. In 2010, the *unweighted* average premium for MA-PD plans is $56 per month, but varies by plan type and is lower for HMOs ($40) than for private fee-for-service plans ($74).[19] The *weighted* average monthly premium for MA-PD plans in 2010 is $48, a 32 percent increase

[18] Kaiser Family Foundation analysis of enrollment data from CMS, Monthly Summary Report, April 2010.

from 2009.[20] Most Medicare Advantage plans limit beneficiaries' total out-of-pocket expenses, but cost-sharing requirements vary widely across plans in 2010. Moreover, average cost sharing for some Medicare-covered services increased significantly between 2008 and 2010 among Medicare Advantage plans.[21]

Enrollment in Medicare Advantage plans varies widely across states.

In 2010, less than 5 percent of beneficiaries in 3 states (Alaska, Delaware, and Vermont) are enrolled in Medicare Advantage plans while more than 30 percent of beneficiaries in 10 states (Arizona, California, Colorado, Hawaii, Minnesota, Ohio, Oregon, Pennsylvania, Rhode Island, and Utah) are in such plans. Nationwide, nearly half of all Medicare Advantage enrollees live in 6 states (California, Florida, New York, Ohio, Pennsylvania, and Texas).[22]



Medicare pays private plans more per enrollee, on average, than it pays for beneficiaries in the traditional Medicare fee-for-service program.

Since 2006, Medicare has paid private plans under a bidding process: plans submit bids that estimate their costs per enrollee for services covered under Medicare Parts A and B. If plans bid higher than the county-level benchmark, enrollees pay the difference in the form of monthly premiums. If plans bid lower than the benchmark, plans receives 75 percent of the difference; Medicare keeps the other 25 percent.

According to the Medicare Payment Advisory Commission (MedPAC), Medicare payments to private plans in 2010 are higher, on average, than Medicare fee-for-service costs. Medicare payments to plans in 2010 would have averaged 113 percent of Medicare fee-for-services costs if Congress had not acted to prevent the scheduled 21 percent reduction in physician fees under Medicare, as of January 2010. If Congress enacts legislation to prevent the physician fee reduction for all of 2010, MedPAC estimates payments to plans would average 109 percent of Medicare fee-for-service costs in 2010.[23]

The 2010 health care reform law[24] reduces Medicare payments to private plans and rewards high-quality plans.

Over time, Medicare payments to Medicare Advantage plans will be reduced to levels closer to county-level Medicare fee-for-service (FFS) costs. Plans in counties with relatively high Medicare FFS costs will be paid 95 percent of FFS costs per enrollee, while plans in counties with relatively low Medicare FFS costs will be paid 115 percent of FFS costs per enrollee. Medicare payments will also be reduced to adjust for the health status of plan enrollees, and high-quality plans will receive bonus payments, with high-quality plans in certain counties receiving double bonuses.

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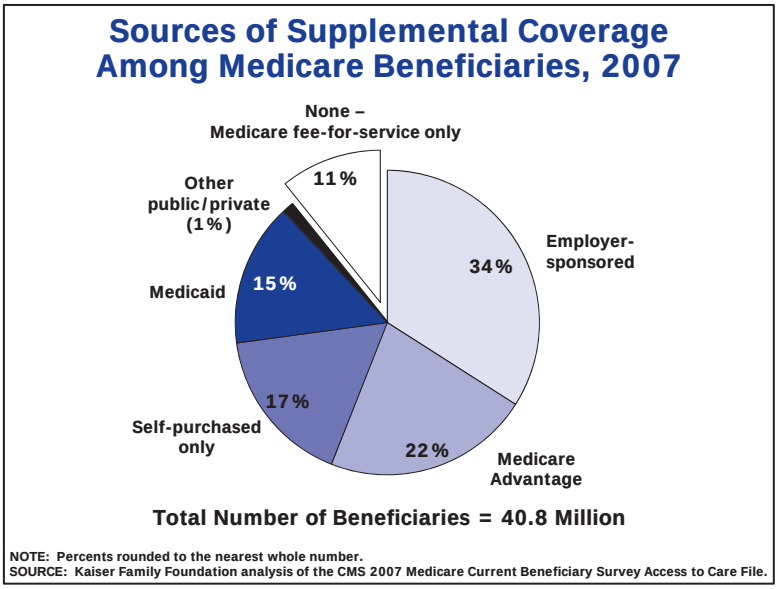
[19] Gold M, Phelps D, Neuman T, Jacobson G, Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums, Kaiser Family Foundation, November 2009, http://www.kff.org/medicare/8007.cfm.
[20] Weighted by 2009 enrollment; Gold M, et al, Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums, November 2009.
[21] Gold M, Hudson M, Jacobson G, Neuman T, Medicare Advantage 2010 Data Spotlight: Benefits and Cost Sharing, Kaiser Family Foundation, February 2010, http://www.kff.org/medicare/8047.cfm.
[22] Kaiser Family Foundation analysis of CMS Medicare Advantage State/County Penetration file, February 2010.
[23] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare Payment Policy," March 2010.
[24] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).

WHAT TYPES OF SUPPLEMENTAL INSURANCE DO BENEFICIARIES HAVE?

Many Medicare beneficiaries have some type of supplemental insurance coverage to help fill the gaps in Medicare's benefit package and help with Medicare's cost-sharing requirements.

Employer and union-sponsored plans are a leading source of supplemental coverage, providing health benefits to about one in three Medicare beneficiaries.

In 2007, 34 percent of Medicare beneficiaries had coverage from an employer-sponsored health plan.[25] The vast majority of these beneficiaries received supplemental coverage as part of a retiree health benefits plan. Employer plans also often provide additional benefits, including prescription drug coverage and limits on retirees' out-of-pocket health expenses. For an estimated 1.3 million Medicare beneficiaries who are working (or have working spouses), employer plans are their primary source of health insurance coverage.[26] For these individuals, Medicare is the secondary payer.



Access to retiree health benefits is on the decline, however. The share of large firms offering retiree health benefits has dropped by more than half over the past two decades, from 66 percent in 1988 to 29 percent in 2009.[27]

Medicare Advantage plans are a source of supplemental coverage for people on Medicare.

Enrollment in private Medicare Advantage health plans has increased in recent years. Medicare beneficiaries who enroll in private Medicare Advantage health plans often receive supplemental benefits that are not covered under traditional Medicare, such as vision and dental benefits. The Congressional Budget Office (CBO) estimates that the average value of these extra benefits was $87 per month in 2009, but projects that the average value of extra benefits will decline as a result of payment reductions enacted as part of the health care reform law.[28] *(See pages 9-10 for additional information about Medicare Advantage.)*

[25] Kaiser Family Foundation analysis of the CMS 2007 Medicare Current Beneficiary Survey Access to Care File. The hierarchy for assigning sources of supplemental coverage is: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Self-purchased only, 5) Other public/private coverage, and 6) No supplemental coverage (Medicare fee-for-service only). Beneficiaries with multiple sources of coverage were assigned to the source of coverage that is higher up in the hierarchy.
[26] DHHS, February 2009.
[27] Kaiser Family Foundation/HRET Employer Health Benefits 2009 Annual Survey, http://ehbs.kff.org/.
[28] Congressional Budget Office, Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare Under Current Law and Under Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate, March 19, 2010.

Medigap policies – also called Medicare Supplement Insurance – are sold by private insurance companies and help cover Medicare's cost-sharing requirements and fill gaps in the benefit package.

Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. In 2007, about one in five Medicare beneficiaries had an individually-purchased Medicare supplement insurance policy.[29] Currently there are 12 different standard Medigap plans (labeled Plan A-L), each offering coverage of a different set of benefits. As of June 2010, two new plans (Plans M and N) will be offered, while Plans E, H, I, and J will no longer be available for sale.[30] Premiums vary by plan type and may vary by insurer, age of the enrollee, and state of residence.

Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is a source of supplemental coverage for 8 million Medicare beneficiaries with low incomes and modest assets in 2010. These beneficiaries are known as *dual eligibles* because they are dually eligible for Medicare and Medicaid.

Medicaid helps to make Medicare affordable for low-income beneficiaries, given gaps in the benefit package, premiums, deductibles, and other cost-sharing requirements. Most dual eligibles—6.3 million in 2009—qualify for full Medicaid benefits, including long-term care and dental services.[31] Dual eligibles also get help with Medicare's premiums and cost-sharing requirements, and receive subsidies that help pay for drug coverage under Medicare Part D plans.

Medicaid and Medicare Savings Programs Eligibility Pathways and Benefits for Medicare Beneficiaries

Pathway	Income Eligibility Levels[1] (individual/couple)	Asset Limit[2] (individual/couple)	Covered Costs and Services
Full Medicaid	<74% of poverty (SSI income eligibility; varies by state)	$2,000/$3,000 (varies by state)	Medicaid benefits, Medicare Part A and Part B premiums and cost-sharing
Qualified Medicare Beneficiary (QMB)	<100% of poverty ($10,830/$14,570)	$8,100/$12,910	Medicare Part B premiums and cost-sharing
Specified Low-Income Medicare Beneficiary (SLMB)	100%-120% of poverty ($12,996/$17,484)	$8,100/$12,910	Medicare Part B premiums
Qualified Individual (QI)	120%-135% of poverty ($14,621/$19,670)	$8,100/$12,910	Medicare Part B premiums
Qualified Disabled and Working Individual (QDWI)	<200% of poverty ($21,660/$29,140)	$5,500/$9,000	Medicare Part A premiums

NOTE: [1]Applicants are allowed a $20 disregard from any income before their income is measured against the poverty levels. [2]Asset limits for QMB, SLMB, QI, and QDWI include $1,500 per person for burial expenses. SSI is Supplemental Security Income.

Some dual eligibles—1.8 million in 2009—do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements through the Medicare Savings Programs (MSP), administered under Medicaid.[32] Eligibility for this assistance is based on a beneficiary's income and resources (generally less than $8,100 for an individual and $12,910 for a couple).

Another 1.6 million beneficiaries receive supplemental assistance (including prescription drug benefits) through the Veterans Administration and other government programs.[33]

[29] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2007.
[30] Centers for Medicare & Medicaid Services, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, March 2010.
[31] DHHS, February 2009.
[32] DHHS, February 2009.
[33] DHHS, February 2009.

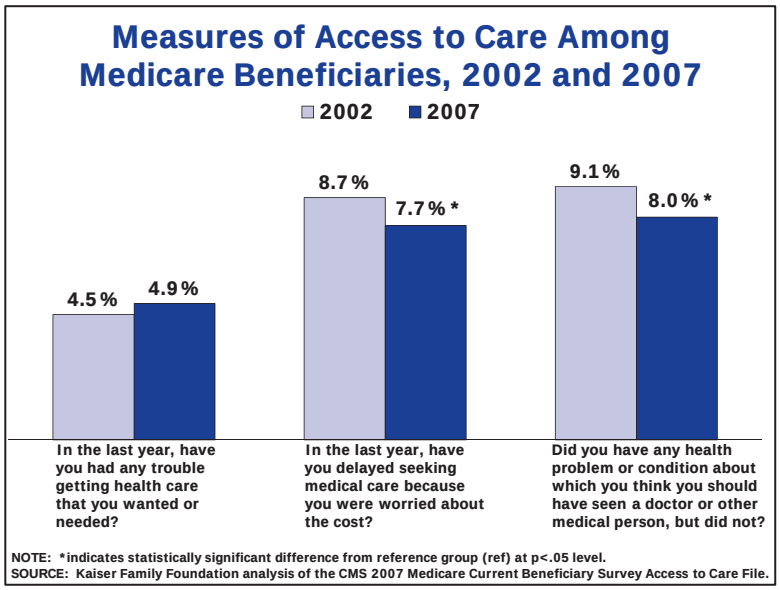
HOW DO MEDICARE BENEFICIARIES FARE WITH RESPECT TO ACCESS TO CARE?

The enactment of Medicare dramatically improved access to care for millions of elderly Americans.

Prior to the enactment of Medicare in 1965, less than half of all elderly people had insurance to help pay for hospital and other medical services.[34] Many were unable to get health insurance either because they could not afford the premiums or because they were denied coverage based on their age or pre-existing health conditions. Medicare significantly improved access to care for elderly Americans and is now a vital source of health and financial security for nearly all elderly Americans, as well as millions of people with permanent disabilities.

Beneficiaries generally enjoy broad access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures. Yet there is some evidence of access problems among certain demographic subgroups.

Access to care: A relatively small share of Medicare beneficiaries report experiencing problems accessing needed medical care, with modest decreases reported in some measures of access difficulties over the past several years. For example, only 5 percent of all beneficiaries reported trouble getting health care in 2007 (the most recent year for which data are available), while 8 percent said they delayed seeking medical care due to cost, and 8 percent said they had a serious medical problem for about which they should have seen a doctor but did not.[35]



Rates of access problems are higher among certain subgroups of the Medicare population, including Black and Hispanic beneficiaries, the nonelderly disabled, those with low incomes, and those living in rural areas.[36] A larger share of beneficiaries without supplemental coverage than those with supplemental coverage report access problems, which suggests that Medicare's cost-sharing requirements pose financial barriers to care for some individuals.

Finding a physician: Medicare beneficiaries are about as likely as privately insured individuals to report problems finding a primary care doctor or specialist who would see them. Among the small share of Medicare beneficiaries (6 percent) who reported looking for a new primary care physician in 2008, 28 percent reported a problem finding one.[37] A 2006 survey found 97 percent of physicians reported accepting new Medicare patients, but a smaller share (80 percent) reported accepting all or most new Medicare patients.[38]

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[34] M. Gornick, et al, "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," Health Care Financing Review, 1985 Annual Supplement.
[35] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2007.
[36] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2007.
[37] MedPAC, "Report to the Congress: Medicare Payment Policy," March 2009.
[38] MedPAC, "Report to the Congress: Medicare Payment Policy," March 2009.

HOW IS MEDICARE FINANCED?

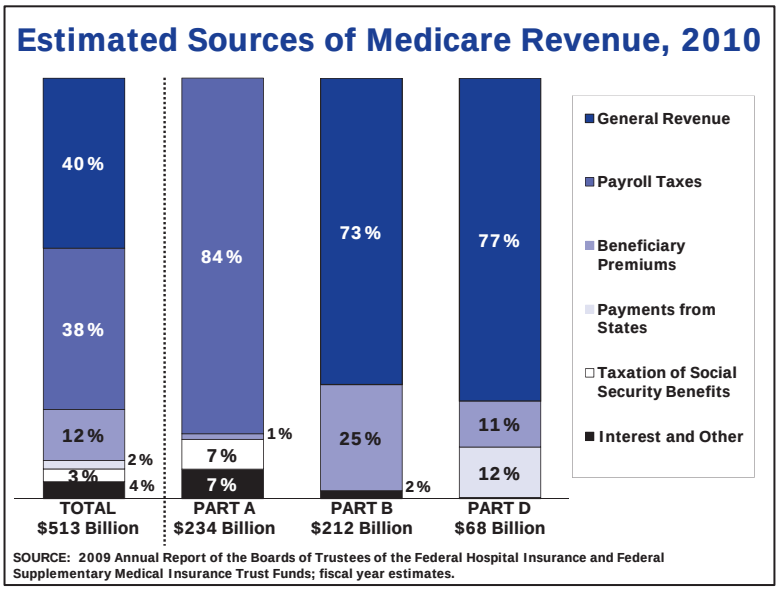
Funding for Medicare comes primarily from general revenues, payroll tax revenues, and premiums paid by beneficiaries. Other sources include taxation of Social Security benefits, payments from states, and interest.

Medicare is funded as follows:

- **Part A,** the Hospital Insurance (HI) Trust Fund, is financed largely through a dedicated tax of 2.9 percent of earnings paid by employers and their employees (1.45 percent each). In 2010, these taxes are estimated to account for 84 percent of the $234 billion in revenue to the Part A Trust Fund. The health care reform law[39] increases the Medicare Hospital Insurance payroll tax for higher-income taxpayers (more than $200,000/individual and $250,000/couple) by 0.9 percentage points (from 1.45 percent to 2.35 percent), beginning in 2013, with additional revenues deposited into the HI Trust Fund.

- **Part B,** the Supplementary Medical Insurance (SMI) Trust Fund, is financed through a combination of general revenues and premiums paid by beneficiaries. Premiums are automatically set to cover 25 percent of spending in the aggregate, while general revenues subsidize the remaining 75 percent. Higher-income beneficiaries pay a larger share of spending, ranging from 35 percent to 80 percent. In 2010, Part B revenue is estimated to be $212 billion.

- **Part C,** the Medicare Advantage program, provides benefits under Parts A, B, and D, and thus is not separately financed.



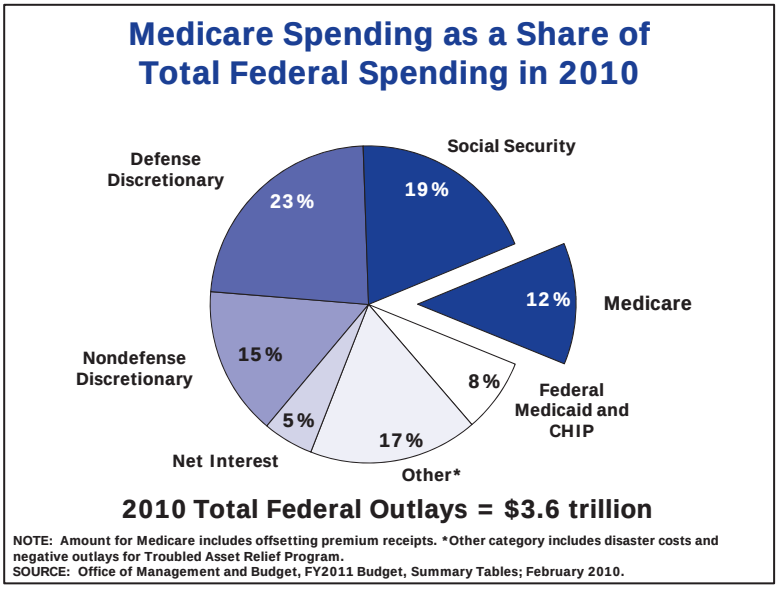
- **Part D** is financed through general revenues, beneficiary premiums, and state payments for dual eligibles (who received drug coverage under state Medicaid programs prior to 2006). The monthly premium paid by enrollees is set to cover 25.5 percent of the cost of standard drug coverage, and Medicare subsidizes the remaining 74.5 percent. Similar to Part B, higher-income beneficiaries will pay a larger share of the cost of standard drug coverage and receive a smaller premium subsidy, beginning in 2011. In 2010, Part D revenue is projected to be $68 billion, 77 percent of which will be from general revenues, 11 percent from premiums, and 12 percent from state payments.

[39] PPACA (P.L. 111-148), as amended by HCERA (P.L. 111-152).

HOW MUCH DOES MEDICARE COST AND HOW IS THE MONEY SPENT?

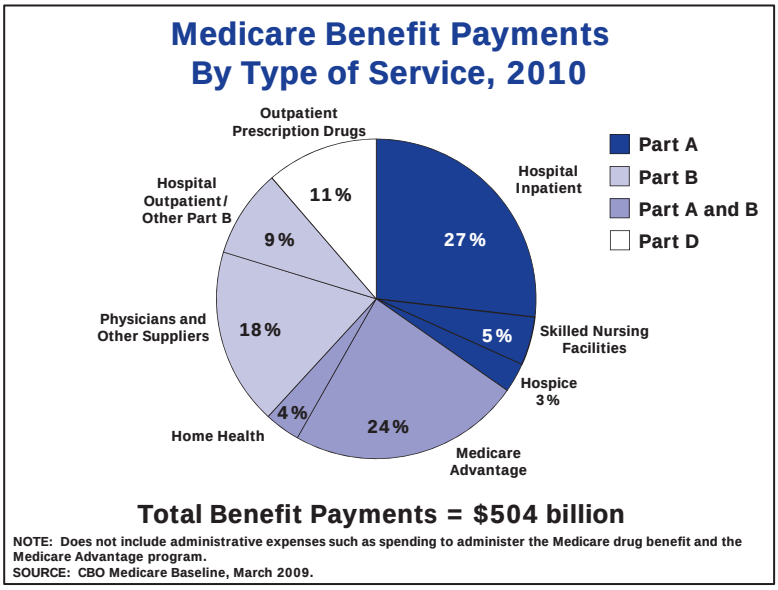
Spending on Medicare is estimated to account for 12 percent of total federal spending in 2010.

Federal spending for fiscal year 2010 is expected to total $3.6 trillion, with spending on Medicare comprising 12 percent of that amount.[40] Of the three main entitlement programs—Social Security, Medicare, and Medicaid—Medicare is second largest in terms of the share of federal spending on each program. Social Security is largest, at 19 percent of federal spending in 2010. Spending on Medicaid and CHIP (the Children's Health Insurance Program) represents 8 percent of federal spending.



Medicare benefit payments are estimated to total $504 billion in 2010.

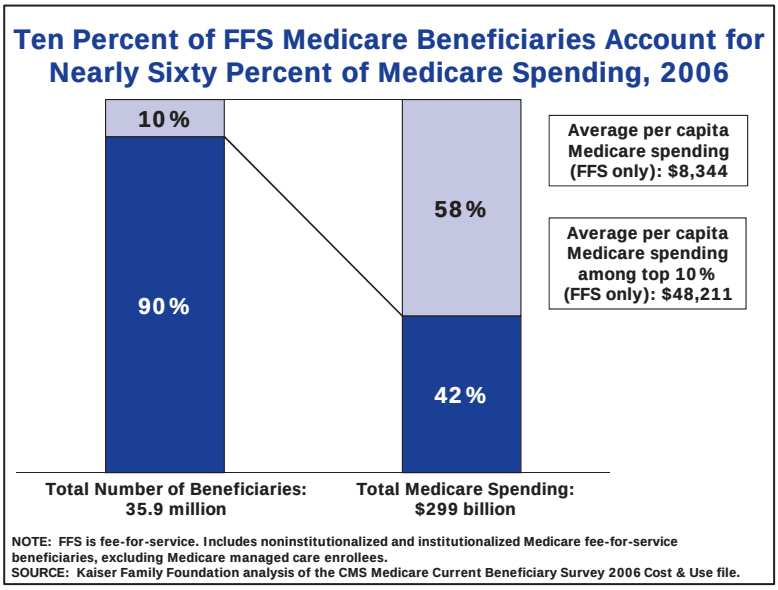
Inpatient hospital services comprise the largest share of Medicare benefit payments (27 percent), followed by payments to Medicare Advantage plans (24 percent), and physician and other suppliers (18 percent). Spending on the Part D prescription drug benefit accounts for 11 percent of total benefit payments in 2010. Prior to enactment of the 2010 health reform law, CBO projected that Medicare Advantage payments would account for 22 percent of Medicare benefit payments and prescription drugs another 15 percent of Medicare benefit payments in 2019.[41]



[40] OMB, Budget of the U.S. Government, Fiscal Year 2011, February 2010.
[41] CBO, Medicare Baseline, March 2009.

Medicare spending is concentrated among a small share of beneficiaries and varies geographically.

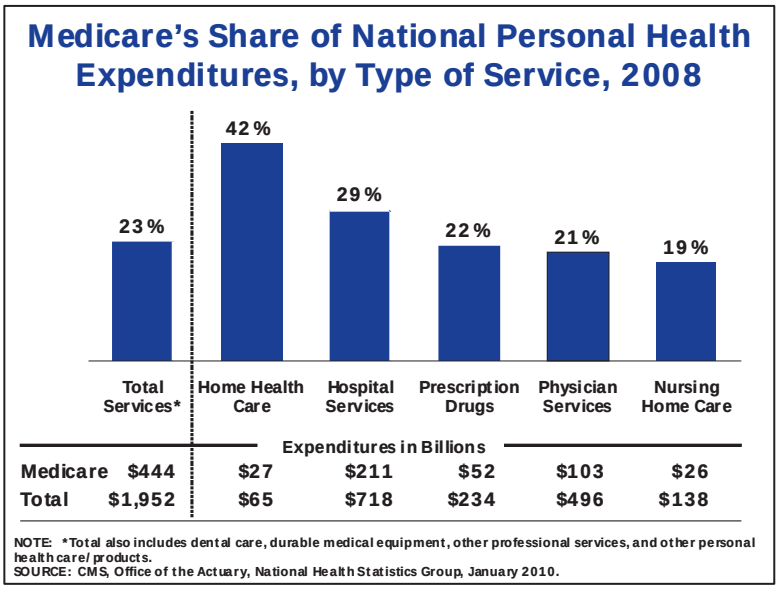
A small share of Medicare beneficiaries accounts for a majority of Medicare spending. Ten percent of beneficiaries in the fee-for-service program accounted for nearly 60 percent of Medicare spending in 2006 (the most recent year for which data are available).[42] At the other end of the spectrum, 22 percent of all fee-for-service beneficiaries had total spending of less than $1,000, accounting for just 1 percent of total expenditures. Twelve percent of beneficiaries incurred no expenditures at all.



Average per capita Medicare FFS payments for elderly beneficiaries (including Part A and B reimbursement, direct and indirect medical education, and disproportionate share hospital payments) vary by geographic area. Most counties have average per capita Medicare FFS payments between $4,000 and $6,000. However, 6 counties have average per capita payments of less than $2,000, while 8 counties have FFS payments of $8,000 or more per capita.[43]

Medicare spending accounted for more than one-fifth of the $1.9 trillion in personal health care expenditures in the U.S in 2008.

Medicare's share of national personal health care expenditures varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2008, Medicare accounted for 42 percent of home health care spending and 29 percent of all hospital spending. Medicare accounted for 22 percent of total national prescription drug spending in 2008 – a significant increase from 2 percent in 2005, the year before the Part D drug benefit went into effect.

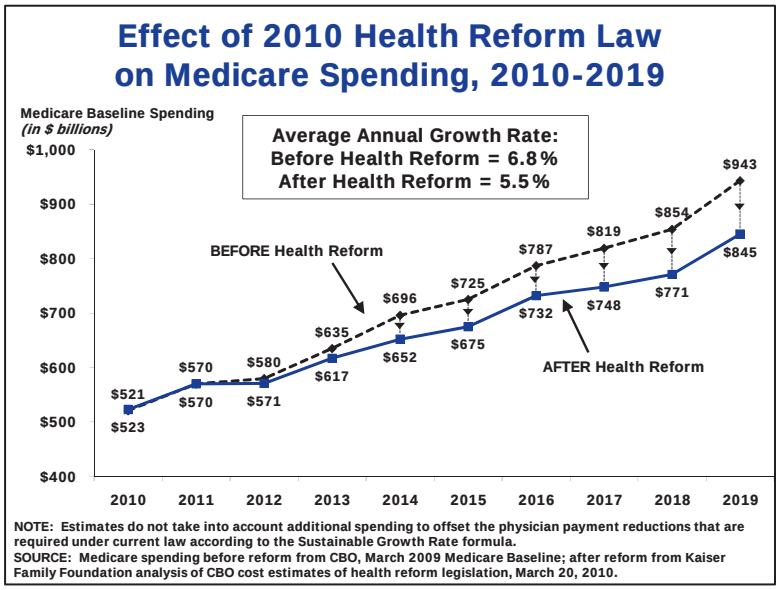


[42] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.
[43] Kaiser Family Foundation analysis of CMS Medicare Fee-for-Service Data, 2008.

HOW IS THE HEALTH CARE REFORM LAW EXPECTED TO AFFECT FUTURE MEDICARE SPENDING?

The 2010 health care reform law[44] includes a number of changes that are expected to reduce the growth in Medicare spending over the next decade and beyond.

The Medicare provisions of the health care reform law are estimated to result in a net reduction of $428 billion in Medicare spending between 2010 and 2019, taking into account $533 billion in Medicare savings and $105 billion in new Medicare spending over the 10-year period, according to analysis of CBO estimates.[45] The law is expected to reduce the average annual growth rate in Medicare spending between 2010 and 2019 from 6.8 percent to 5.5 percent.



Medicare spending reductions are achieved through a number of provisions, including:

- **Payments to Medicare Advantage Plans.** The law reduces federal payments to plans so that, on average, Medicare does not continue to pay substantially more for beneficiaries who enroll in Medicare Advantage plans than it pays for beneficiaries in the traditional fee-for-service program.
- **Payments to providers.** The law reduces annual updates in Medicare payments to hospitals, skilled nursing facilities, home health agencies, and various other providers (other than physicians), and adjusts payments to account for productivity improvements.
- **Delivery system reforms.** The law includes several new policies and programs designed to reduce costs and improve quality of patient care, including reducing payments associated with unnecessary hospital readmissions and hospital-acquired infections, pilot programs related to the delivery of post-acute care, value-based purchasing for providers, and the establishment of accountable care organizations. In addition, the law creates a new Center for Medicare and Medicaid Innovation within CMS, with the authority to test payment and service delivery models and implement effective models nationwide.

In addition, the law establishes a new Independent Payment Advisory Board to recommend policies to reduce Medicare spending, if projected spending exceeds target growth rates.

The Board's initial proposal is due in 2014, and the savings recommendations will take effect automatically unless Congress adopts alternative proposals that achieve equivalent Medicare savings. The establishment of the Board represents the first time that the Medicare program will be subject to annual spending limits with requirements for automatic enactment of the Board's recommendations. CBO projects the Board will achieve savings in each year after it begins making recommendations (2015-2019) and will continue to reduce Medicare spending beyond the ten-year budget window.[46]

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[44] PPACA (P.L. 111-148) as amended by HCERA (P.L. 111-152).
[45] CB0, Cost Estimate for the Amendment in the Nature of a Substitute for H.R. 4872, Incorporating a Proposed Manager's Amendment Made Public on March 20, 2010; March 20, 2010. These estimates do not take into account additional spending to offset the physician payment reductions that are required under current law according to the Sustainable Growth Rate formula.
[46] CBO, Cost Estimate for the Amendment in the Nature of a Substitute for H.R. 4872; March 20, 2010.

MEDICARE SAVINGS AND SPENDING IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152)

MEDICARE SAVINGS PROVISIONS	COST ESTIMATE *(in $ billions)*
Annual provider payment updates	$157
Medicare Advantage payment reforms	$136
Home health payments	$40
Part B premiums for higher-income enrollees	$25
Disproportionate Share Hospital (DSH) payments	$22
Medicare Improvement Fund	$21
Independent Payment Advisory Board	$16
Part D premiums for higher-income enrollees	$11
Fraud, waste, and abuse	$7
Reducing hospital readmissions	$7
Part D enrollment and other consumer protections	$6
Delivery system pilot programs	$5
Other provisions	$7
Interactions*	$75
TOTAL 10-YEAR MEDICARE SAVINGS	**$533**
MEDICARE SPENDING PROVISIONS	
Part D coverage gap discount program and new federal subsidies	$43
Premium interactions	$38
Physician payment reforms	$7
Preventive services	$5
Other provider payments	$1
Medicare Savings Programs and Part D low-income subsidies	$1
Disproportionate Share Hospital (DSH) payments	$1
Part D enrollment and other consumer protections	$1
Medicare Advantage reforms	$1
Other provisions	$4
Interactions*	$3
TOTAL 10-YEAR MEDICARE SPENDING	**$105**
NET 10-YEAR MEDICARE SAVINGS	**$428**

OTHER RELATED REVENUE PROVISIONS	
Raise Medicare payroll tax on high earnings (Deposited in HI Trust Fund)	$87
Fee on drug manufacturers (Deposited in SMI trust fund)	$27
Eliminate Part D employer deduction	$5

NOTE: *Savings interactions include interactions with Medicare Advantage and TRICARE; spending interactions include implementation of Medicare changes, Part D interactions with Medicare Advantage provisions, Part B interactions with Part D provisions, and Medicaid interactions with Medicare Part D provisions.
SOURCE: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on March 20, 2010; Revenue estimates based on Joint Committee on Taxation estimates as provided on March 20, 2010.

WHAT ARE MEDICARE'S FUTURE FINANCING CHALLENGES?

Looking to the future, Medicare is expected to face significant financing challenges due to increasing health care costs, the aging of the U.S. population, the declining ratio of workers to beneficiaries, and various economic factors.

In light of the recent economic downturn and pressures to reduce the federal budget deficit, policymakers are likely to continue focusing on ways to reduce federal spending on entitlement programs, including Medicare, Medicaid, and Social Security. In February 2010, President Obama established a bipartisan National Commission on Fiscal Responsibility and Reform to recommend policies to reduce the nation's rising debt and the federal budget deficit – including, but not limited to, curbing the growth in entitlement spending – with a report due by December 2010.

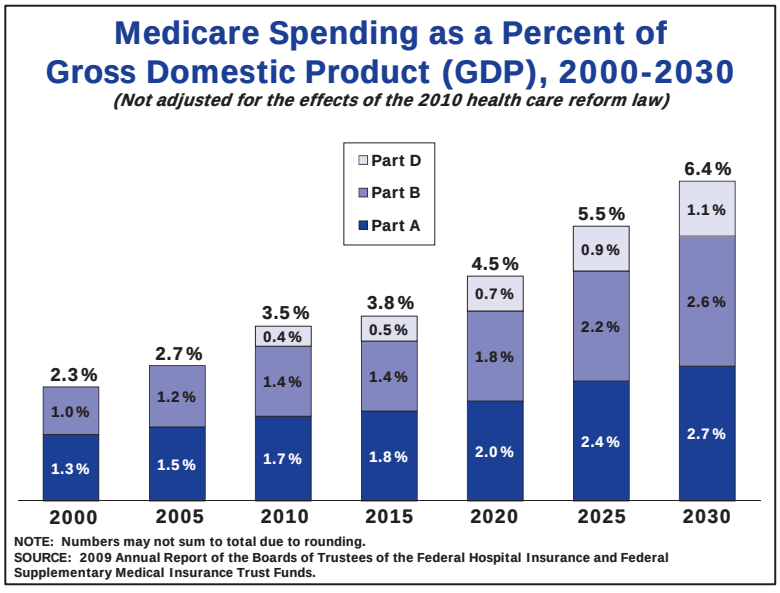
Over the long term, several factors – including rising health care costs, an aging population, a decline in the number of workers per beneficiary, and increasing life expectancy – will present fiscal challenges for Medicare. From 2010 to 2030, the number of people on Medicare is projected to rise from 47 million to 79 million, while the ratio of workers per beneficiary is expected to decline from 3.7 to 2.4.[47]

Total Medicare spending is projected to nearly double from $528 billion in 2010 to $1,038 billion in 2020, according to CBO.[48] These projections do not take into account Medicare spending reductions that are scheduled to occur over the next decade as part of the 2010 health care reform law.

Sustained increases in health care costs are placing upward fiscal pressure on Medicare, as for other payers. The annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services, higher prices for health care services, and new technologies. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2008 was slightly lower for Medicare (8.3 percent) than for private health insurance (9.3 percent) for common benefits (excluding prescription drugs).[49] Moving forward, system-wide efforts to curtail overall health care costs, including several provisions of the 2010 health reform law, are expected to improve Medicare's financial outlook.

A number of measures are used to assess the long-term financial status of Medicare.

- **Medicare spending as a share of gross domestic product (GDP)** is one of several measures reported by the Medicare Trustees in their annual report to the Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. Medicare expenditures as a share of GDP are projected to rise from 3.5 percent of GDP in 2010 to 6.4 percent of GDP in 2030.



[47] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 2009.
[48] These estimates exclude offsetting receipts (primarily premiums paid by beneficiaries). These estimates also do not take into account additional spending to offset the physician payment reductions that are required under current law according to the Sustainable Growth Rate formula.
[49] CMS, OACT, National Health Statistics Group, 2010.

However, these projections do not take into account Medicare spending reductions that are scheduled to occur over the next decade as part of the 2010 health care reform law.

- **Solvency of the Part A (HI) Trust Fund** is another measure that has been used to present a picture of Medicare's financial health. This indicator looks exclusively at Part A, and does not take into account spending or financing for other parts of the Medicare program. According to the Medicare Trustees, Part A spending has exceeded income since 2008. In May 2009, the Medicare Trustees projected that the HI Trust Fund reserves would be depleted in 2017.[50] However, the reductions in Medicare spending that were enacted as part of the 2010 health care reform law, coupled with additional revenue raised by the increase in the payroll tax on taxpayers with relatively high earnings, are projected to extend the solvency of the Medicare Hospital Insurance Trust Fund from 2017 to 2029, according to CMS.[51]

- **The Medicare per capita spending growth rate relative to the growth rate of inflation and the growth rate of GDP plus 1 percentage point** will be used by the new Independent Payment Advisory Board to determine whether the Board is required to recommend Medicare savings proposals to Congress, beginning in 2014, as well as the magnitude of savings to be achieved. Prior to 2018, the Board is required to recommend savings proposals if the projected five-year average percentage increase in per capita Medicare spending exceeds the projected five-year average percentage increase in the consumer price index (CPI) and the CPI for medical care (CPI-M). In 2018 and beyond, the Medicare spending target growth rate is the projected five-year average percentage increase in nominal per capita GDP plus 1 percentage point. If Medicare spending exceeds the target growth rate, the Board is required to recommend savings to achieve the lesser of either (1) the amount by which projected Medicare costs exceeds the spending target or (2) a specified percentage multiplied by total projected Medicare spending for the year.

  The Secretary of HHS is required to implement the Board's recommendations by August 15 of the year the proposal is submitted, unless Congress has already passed legislation that achieves the same level of savings. If the Board fails to act, the Secretary is required to submit a proposal to achieve an equivalent level of savings. If Congress does not enact a legislative package that achieves the required level of Medicare savings, the Board's (or Secretary's) original proposal will take effect immediately.

- **The amount of general revenues as a share of total Medicare spending** is another way to measure Medicare's fiscal health, established under the Medicare Modernization Act of 2003. Each year, the Medicare Trustees are required to examine general revenues as a share of total Medicare spending, and make a determination as to whether general revenues are projected to exceed 45 percent of total outlays within a seven-year timeframe. If the Trustees make this determination two years in row, a "Medicare funding warning" is issued, indicating that general revenues are becoming a substantial share of total financing for Medicare. In response, the President is required to submit proposed legislation to Congress, which must consider this legislation on an expedited basis. In 2009, for the fourth year in a row, the Medicare Trustees projected that general revenues would exceed 45 percent of total Medicare spending within seven years (by 2014). However, in January 2009, the U.S. House of Representatives passed a resolution to suspend congressional consideration of funding warning legislation for the 111th Congress.[52]

Ensuring Medicare's financial stability over the long term is a pressing challenge for policymakers. Medicare provides essential coverage for 47 million beneficiaries, many of whom have multiple chronic conditions and significant health needs. Securing access to affordable health care for seniors and people with disabilities while addressing Medicare's fiscal pressures is a high priority for the future.

[50] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 2009.
[51] CMS, Office of the Actuary, Estimated Effects of the Patient Protection and Affordable Care Act, as Amended, on the Year of Exhaustion for the Part A Trust Fund, Part B Premiums, and Part A and Part B Coinsurance Amounts, April 22, 2010.
[52] H. Res. 5, January 6, 2009.

MEDICARE BENEFITS* AND COST-SHARING REQUIREMENTS, 2010

PART A	
Deductible	$1,100 per benefit period
Inpatient hospital	
Days 1-60	No coinsurance
Days 61-90	$275 per day
Days 91-150	$550 per day (for up to 60 lifetime reserve days)
After 150 Days	Not covered
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$137.50 per day
After 100 Days	Not covered
Home Health	No coinsurance; no limit on number of visits
Hospice	No coinsurance for hospice care; copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	Up to 190 days in a lifetime
PART B	
Deductible	$155
Premium	$110.50/month; higher for those with incomes above $85,000/single or $170,000/couple; $96.40/month for those held harmless from the premium increase
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance; certain limits may apply
Clinical laboratory services	No coinsurance
Home health care	No coinsurance; no limit on number of visits
Outpatient mental health services	45% coinsurance (gradually decreasing to 20% in 2014)
One-time "Welcome to Medicare" physical exam	20% coinsurance; covered within first 12 months of Part B enrollment; Part B deductible does not apply
Preventive services*	
Flu shot, Pneumococcal shot	No coinsurance; limit of one flu shot per flu season
Hepatitis B shot, colorectal and prostate cancer screening, pap smear, mammogram, cardiovascular screening, abdominal aortic aneurysm (AAA) screening, bone mass measurement, diabetes screening and monitoring, glaucoma screening, smoking cessation	20% coinsurance after annual Part B deductible is met; however, Part B deductible and coinsurance are waived for some preventive services
PART D	
Information below applies to the standard Part D benefit; benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.	
Deductible	$310
Premium	$31.94 national average monthly premium *(unweighted PDP and MA-PD plan average)*
Initial coverage *(up to $2,830 in total drug costs)*	25% coinsurance
Coverage gap *(between $2,830 and $6,440 in total drug costs)*	100% coinsurance (not covered) – minus $250 rebate
Catastrophic coverage *(above $4,550 in out-of-pocket spending)*	Minimum of $2.50/generic, $6.30/brand; or 5% coinsurance

NOTE: *This table does not include all Medicare-covered benefits or preventive services; for a complete listing, see http://www.medicare.gov/Coverage/Home.asp and http://www.medicare.gov/Health/Overview.asp.
SOURCE: CMS, www.medicare.gov, Medicare & You 2010, Your Guide to Medicare's Preventive Services.

IMPLEMENTATION TIMELINE FOR KEY MEDICARE PROVISIONS OF THE 2010 HEALTH CARE REFORM LAW, 2010-2015

2010	
Cost containment	• Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust payments for productivity • Ban new physician-owned hospitals in Medicare
Improving quality and health system performance	• Establish a new office within the Centers for Medicare & Medicaid Services (CMS), the Federal Coordinated Health Care Office, to improve care coordination for dual eligibles
Prescription drug benefit	• Provide a $250 rebate for beneficiaries who reach the Part D coverage gap
2011	
Cost containment	• Establish a new Center for Medicare and Medicaid Innovation within CMS • Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels ($85,000/individual and $170,000/couple), and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple • Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012
Medicare Advantage	• Prohibit Medicare Advantage plans from imposing higher cost sharing for some Medicare-covered benefits than is required under the traditional fee-for-service program • Restructure payments to Medicare Advantage (MA) plans by phasing payments to different percentages of Medicare fee-for-service rates; freezes payments for 2011 and 2010 levels
Physician payment	• Provide a 10% Medicare bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas
Prescription drug benefit	• Begin phasing in federal subsidies for generic drugs in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% by 2020) • Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap (reducing coinsurance from 100% in 2010 to 50% in 2011)
Preventive services	• Eliminate Medicare cost sharing for some preventive services • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan
2012	
Cost containment	• Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the savings they achieve for the Medicare program • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions
Improving quality and health system performance	• Create the Medicare Independence at Home demonstration program • Establish a hospital value-based purchasing program and develop plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers
Medicare Advantage	• Reduce rebates for Medicare Advantage plans • High-quality Medicare Advantage plans begin receiving bonus payments
Prescription drug benefit	• Make Part D cost sharing for dual eligible beneficiaries receiving home and community-based care services equal to the cost sharing for those who receive institutional care
2013	
Improving quality and health system performance	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care
Prescription drug benefit	• Begin phasing in federal subsidies for brand-name drugs in the Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand discount)
Tax changes	• Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly • Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments
2014	
Cost containment	• Independent Payment Advisory Board comprised of 15 members begins submitting legislative proposals containing recommendations to reduce Medicare spending if spending exceeds a target growth rate • Reduce Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care
Medicare Advantage	• Require Medicare Advantage plans to have medical loss ratios no lower than 85%
Prescription drug benefit	• Reduce the out-of-pocket amount that qualifies for Part D catastrophic coverage (through 2019)
2015	
Cost containment	• Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%

SOURCE: Kaiser Family Foundation analysis of the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

AGE AND INCOME OF MEDICARE BENEFICIARIES, BY STATE, 2008

STATE	Total Number of Beneficiaries[1]	Age				Income as Percent of Federal Poverty Level (FPL)[2]			
		19-64	65-74	75-84	85 and older	<100% FPL	100-150% FPL	150-200% FPL	200%+ FPL
U.S. Total	***45,830,913***	***6,809,144***	***18,682,883***	***12,522,255***	***4,185,781***	***6,965,217***	***7,375,012***	***6,294,135***	***21,565,699***
Alabama	832,913	183,103	335,585	229,492	55,106	148,015	143,876	109,956	401,437
Alaska	63,974	12,238	28,384	11,962	4,334	7,024	9,743	8,361	31,790
Arizona	909,557	140,316	369,558	210,086	81,633	115,150	140,237	94,737	451,468
Arkansas	524,907	104,851	193,557	107,969	40,293	82,085	101,589	59,207	203,789
California	4,669,125	504,921	1,941,947	1,221,581	516,476	684,811	867,183	541,787	2,091,144
Colorado	609,849	79,734	257,430	153,152	47,876	72,775	81,741	67,501	316,175
Connecticut	560,340	66,801	220,342	142,409	75,960	62,236	75,245	71,806	296,225
Delaware	145,842	20,788	59,626	39,129	12,334	20,335	23,999	18,607	68,937
District of Columbia	77,028	15,244	28,852	19,444	8,329	17,340	13,135	8,646	32,749
Florida	3,314,477	458,063	1,462,260	1,040,904	328,549	531,236	507,064	504,141	1,747,336
Georgia	1,211,860	253,071	497,303	266,494	65,193	228,625	201,656	186,662	465,117
Hawaii	202,750	22,297	75,362	70,009	26,651	40,908	30,468	24,102	98,839
Idaho	224,133	21,101	106,997	69,634	15,799	22,569	31,296	30,179	129,487
Illinois	1,818,883	292,572	639,312	494,171	169,612	245,328	262,890	233,024	854,425
Indiana	991,222	135,113	377,747	287,356	101,474	116,306	155,511	140,304	489,571
Iowa	513,404	61,982	197,627	122,435	56,577	48,885	73,976	81,857	233,904
Kansas	428,471	50,160	163,887	112,448	40,370	48,630	65,583	51,947	200,705
Kentucky	748,151	177,663	310,827	171,419	53,728	129,635	135,228	115,970	332,805
Louisiana	677,365	135,051	272,810	184,714	58,152	146,859	158,690	115,131	230,045
Maine	260,686	41,806	104,065	72,058	25,646	31,633	45,741	36,180	130,021
Maryland	771,790	90,162	313,190	201,716	95,407	118,269	93,911	91,017	397,278
Massachusetts	1,045,371	147,743	380,056	301,590	115,192	155,377	172,864	155,245	461,094
Michigan	1,625,605	258,493	628,471	497,753	124,209	192,170	225,065	243,964	847,728
Minnesota	774,433	88,373	311,606	209,772	89,172	78,427	82,260	102,192	436,044
Mississippi	489,980	105,032	194,779	118,785	28,283	109,450	84,963	56,765	195,701
Missouri	991,772	195,299	423,223	270,894	71,984	142,855	173,693	155,332	489,521
Montana	166,315	26,140	61,929	53,378	17,134	20,717	27,019	32,047	78,798
Nebraska	276,731	30,826	94,772	77,567	23,062	24,887	31,729	34,148	135,463
Nevada	347,112	44,403	162,155	80,723	26,590	41,005	38,891	49,480	184,494
New Hampshire	213,449	24,194	83,718	54,106	10,936	20,892	22,144	26,496	103,422
New Jersey	1,310,966	176,886	519,333	368,052	139,113	215,515	174,799	185,259	627,811
New Mexico	307,056	40,857	123,244	73,451	29,734	57,599	43,017	38,392	128,278
New York	2,954,341	417,109	1,219,092	871,182	287,758	565,849	484,981	365,187	1,379,124
North Carolina	1,460,593	256,894	610,982	366,278	140,792	234,975	274,864	203,308	661,799
North Dakota	107,765	6,793	41,427	27,500	9,016	10,916	17,032	12,187	44,601
Ohio	1,876,347	246,778	746,755	528,404	120,526	257,952	297,261	256,569	830,681
Oklahoma	596,181	91,251	233,612	175,019	56,835	87,437	93,129	85,501	290,650
Oregon	608,330	61,430	255,269	154,838	60,577	68,721	78,536	85,675	299,180
Pennsylvania	2,259,681	289,075	854,735	719,230	212,648	289,590	371,958	383,094	1,031,046
Rhode Island	180,984	30,829	63,150	45,804	21,417	24,291	26,902	25,871	84,136
South Carolina	755,843	146,961	361,571	187,679	49,021	138,177	138,204	121,999	346,851
South Dakota	135,136	12,775	62,218	37,925	15,176	17,704	19,261	13,706	77,422
Tennessee	1,038,035	175,617	447,739	287,989	80,117	180,502	196,933	172,785	441,243
Texas	2,938,054	498,970	1,351,779	759,316	240,692	624,498	546,920	390,992	1,288,348
Utah	277,162	37,412	107,670	69,528	32,114	22,958	43,329	40,586	139,850
Vermont	109,156	13,633	43,803	28,924	11,444	14,793	18,415	13,890	50,706
Virginia	1,122,504	186,776	461,395	302,621	90,739	174,313	124,682	149,346	593,189
Washington	950,097	118,021	370,932	255,760	76,739	104,754	108,283	106,721	501,693
West Virginia	378,108	80,551	141,800	94,140	31,008	51,938	67,769	61,661	166,130
Wisconsin	898,374	124,286	332,319	254,541	86,086	107,915	157,345	122,657	409,315
Wyoming	78,705	8,699	36,682	20,928	8,168	10,385	14,001	11,957	38,134

NOTE: NSD is not sufficient data.

[1]Excludes beneficiaries living in the territories and beneficiaries who were pending assignment to a particular state of residence.

[2]In 2008, the federal poverty level was $10,400 for an individual and $14,000 for a couple.

SOURCE: Total Number of Beneficiaries from CMS Management Information Integrated Repository (MIIR), as of February 16, 2010. Age and income estimates from the U.S. Census Bureau, Current Population Survey, 2008 and 2009 Annual Social and Economic Supplements (pooled data from 2007 and 2008).

MEDICARE BENEFICIARIES BY TYPE OF COVERAGE, BY STATE

STATE	Total Number of Beneficiaries[1] (2010)	Medicare Advantage Enrollees (2010)	Part D Plan Enrollees (2010)	Part D Low-Income Subsidy Recipients (Including Dual Eligibles) (2010)	Dual Eligibles (2008)
U.S. Total	*45,830,913*	*11,265,447*	*27,134,318*	*9,940,717*	*7,519,667*
Alabama	832,913	177,482	475,744	228,051	184,211
Alaska	63,974	405	24,635	14,587	12,504
Arizona	909,557	334,719	555,707	165,389	130,084
Arkansas	524,907	78,519	318,639	137,900	105,263
California	4,669,125	1,673,692	3,236,180	1,224,748	1,138,715
Colorado	609,849	212,938	357,983	98,339	75,966
Connecticut	560,340	101,257	309,028	108,077	73,681
Delaware	145,842	5,290	73,268	25,698	21,047
District of Columbia	77,028	7,622	36,492	23,007	16,875
Florida	3,314,477	1,059,119	2,001,495	648,925	503,397
Georgia	1,211,860	253,260	736,142	304,514	229,307
Hawaii	202,750	87,118	134,050	37,291	27,354
Idaho	224,133	65,836	131,275	37,487	27,866
Illinois	1,818,883	178,010	1,005,949	360,547	239,472
Indiana	991,222	158,098	558,686	180,547	131,071
Iowa	513,404	67,389	342,323	85,325	70,002
Kansas	428,471	46,701	264,745	71,986	52,479
Kentucky	748,151	120,791	453,378	199,760	145,468
Louisiana	677,365	161,831	420,171	197,977	151,610
Maine	260,686	31,657	162,644	89,833	79,192
Maryland	771,790	61,800	338,396	129,647	93,400
Massachusetts	1,045,371	201,088	603,824	256,575	199,472
Michigan	1,625,605	256,035	766,928	285,176	199,926
Minnesota	774,433	321,979	529,153	134,119	88,956
Mississippi	489,980	46,024	318,349	165,257	139,511
Missouri	991,772	210,046	619,451	203,910	122,564
Montana	166,315	29,882	94,713	26,752	16,518
Nebraska	276,731	33,057	178,704	44,763	28,514
Nevada	347,112	111,709	193,420	50,565	35,561
New Hampshire	213,449	14,739	101,154	34,174	18,144
New Jersey	1,310,966	166,660	689,991	227,777	173,418
New Mexico	307,056	77,572	189,727	71,368	58,314
New York	2,954,341	903,435	1,755,806	763,653	506,234
North Carolina	1,460,593	284,420	865,919	353,663	278,263
North Dakota	107,765	8,474	74,520	17,291	8,448
Ohio	1,876,347	624,359	1,023,939	339,513	252,472
Oklahoma	596,181	90,725	355,166	127,353	87,322
Oregon	608,330	256,076	394,181	102,680	81,102
Pennsylvania	2,259,681	869,414	1,419,049	424,190	283,766
Rhode Island	180,984	63,212	122,450	42,279	28,914
South Carolina	755,843	119,388	409,792	175,736	132,427
South Dakota	135,136	10,705	87,776	22,116	16,058
Tennessee	1,038,035	253,790	666,643	292,015	239,479
Texas	2,938,054	577,085	1,671,980	724,014	519,245
Utah	277,162	93,383	155,423	37,068	26,861
Vermont	109,156	4,504	60,927	27,106	22,243
Virginia	1,122,504	161,733	587,546	209,012	150,918
Washington	950,097	238,781	506,734	164,967	130,413
West Virginia	378,108	85,646	229,524	89,816	63,849
Wisconsin	898,374	262,697	482,063	146,938	93,229
Wyoming	78,705	5,295	42,536	11,236	8,562

NOTE: [1]Excludes beneficiaries living in the territories and beneficiaries who were pending assignment to a particular state of residence.
SOURCE: Number of Total Beneficiaries, Medicare Advantage, Part D, and Low-Income Subsidy Enrollees from Centers for Medicare & Medicaid Services (CMS) Management Information Integrated Repository (MIIR), as of February 16, 2010; Number of Dual Eligibles from CMS 2009 Medicare & Medicaid Statistical Supplement, as of July 1, 2008.

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