



# Medicare

Medicare is the nation's primary health insurance program for senior citizens over the age of 65, certain people with disabilities, and people of any age with permanent kidney failure. The government-run program provides health coverage to nearly 41 million people, and is a source of coverage for one in seven Americans.

While Medicare provides coverage to all who qualify due to age or disability, many of its beneficiaries are low-income Americans. A survey done in March 2003 concluded that among the 38.4 million enrollees at the time, 52 percent lived at or below 200 percent of the 2002 federal poverty level<sup>1</sup>.

Low-income individuals are often also eligible for coverage under Medicaid, the nation's health insurance program for low-income Americans. Sixteen percent of Medicare beneficiaries are dual enrollees, with 77 percent of dual enrollees having annual incomes below \$10,000.<sup>2</sup> The support provided for dual enrollees includes one of the following or some combination: payment of the monthly Medicare Part B premium (see description below), payment of cost sharing (also known as co-insurance, co-payment, or deductible), and benefits not part of Medicare on its own, such as long-term care and dental and vision care.<sup>3</sup>

In 2003 Congress passed and the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Representing the most significant change to Medicare since its founding, the bill offered reforms ranging from changes to the private managed care option to the addition of a prescription drug benefit. Long-term effects of the bill remain unknown, however the legislation failed to address concerns surrounding the financial stability of Part A (Hospital Insurance Trust Fund). The most recent report from the Medicare trustees, issued in March 2004, indicates that by 2019 the trust fund will no longer have sufficient resources available to pay out benefits.<sup>4</sup>

## MEDICARE BASICS

Medicare was established in 1965 to provide health insurance to the elderly. Prior to the enactment of Medicare, just 56 percent of seniors had hospital insurance.<sup>5</sup> In 1972, the program was expanded to provide coverage to individuals of any age eligible for Social Security disability benefits and to those with end stage kidney disease.

Medicare is managed by the Centers on Medicare and Medicaid Services (CMS), a division of the U.S Department of Health and Human Services. Medicare is divided into several parts, each offering different services. Part A consists of the Hospital Insurance (HI) program, which helps pay for inpatient hospital, skilled nursing, hospice and home health care. This aspect of the program is financed by a 1.45 percent payroll tax paid by employers and employees. The self-employed are taxed at a rate of 2.9 percent. Almost all persons over the age of 65 are automatically eligible

for coverage under Part A of Medicare. In 2003 there were 40.6 million people receiving benefits from Part A.<sup>6</sup>

Enrollment in Part B, the Supplementary Medical Insurance program (SMI), is available for a monthly premium, \$66.60 in 2004.<sup>7</sup> Of the total 41 million seniors and disabled individuals receiving benefits from Medicare, 38.5 million are enrolled in Part B. SMI provides support for costs associated with physician and outpatient hospital care, lab tests, medical supplies, and home health. There is an initial deductible of \$100 for accessing services, after which SMI covers 80 percent of costs associated with care, while the beneficiary must pay 20 percent. SMI is 25 percent financed by premiums and 75 percent financed by general revenues.

Part C, Medicare Advantage, refers to the managed care options that provide Part A and B services to their enrollees. Health maintenance organizations (HMO) manage the care provided to individuals who choose Part C. HMOs were created as an option in the 1970s, with the goal of improving coordination of care and eliminating inefficiencies, thus decreasing costs.<sup>8</sup> Medicare Advantage allows members to join one of 145 different plans, some of which charge premiums in addition to the Part B premium. The average monthly premium in 2003 was \$37, among enrollees in plans that charge premiums. In 2004 11% of beneficiaries, 4.6 million people, were enrolled in Medicare Advantage. This is down from 6.3 million (16%) in 2000. The number of available plans has decreased steadily, from a high of 346 in 1998. In recent years HMOs have been reluctant to offer new managed care options as a result of several circumstances. Pressure within Medicare to control spending has led to a slowdown in the rate of increase of managed care payments, leading to some uncertainty about the future of the Medicare Advantage program.

In addition to the different parts of Medicare, there are additional plans that a patient may purchase in order to fill certain gaps in their coverage. There are ten different standardized options, known as Medigap plans A through J, that offer different types of benefits. Different types of plans are sold in Massachusetts, Minnesota, and Wisconsin. An individual is only eligible to purchase Medigap coverage if she is enrolled in Part A and Part B of Medicare and not enrolled in Medicare Advantage. Each plan is required to offer basic benefits such as Part A coinsurance and hospital benefits, Part B coinsurance, and blood coverage.<sup>9</sup> Beginning January 1, 2006, plans H-J will no longer offer prescription drug coverage.

The new prescription drug benefit provided by the 2003 MMA bill will be known as Part D of Medicare. In order to provide immediate relief from prescription drug prices, individuals were able to purchase a drug discount card starting in May 2004, with benefits made available in June 2004. There are around 70 federally approved drug cards that provide savings to their holders at pharmacies in their coverage area. Cards come with a cost of up to \$30 a year and are free if your income in 2004 is less than \$12,569 for individuals or \$16,862 for couples. Low-income seniors can also receive \$600 a year credit on their card to aid with co-payment costs, projected to be around 5 to 10 percent on each drug purchase. The drug card program will be discontinued in 2005, with the new prescription drug benefit going into effect on January 1, 2006.

The permanent Part D coverage will offer two options to those seeking prescription drug coverage. Those enrolled in traditional fee-for-service Medicare plans can sign up for stand-alone drug coverage offered by a private company or private managed care plans will offer a drug benefit along with along Medicare covered services. There will be a monthly premium of around \$35 a month and a \$250 deductible. The patient pays 25 percent of the costs between \$251 and \$2,250. After reaching \$2,250 in drug costs the individual pays the entirety of costs between \$2,251 and \$5,100

(also known as the “doughnut hole.”) Once the level of \$5,100 in drug costs has been reached catastrophic coverage is triggered and the individual must only pay a flat co-payment of \$2 for every generic drug and \$5 for every name brand drug, or 5 percent of the drug’s cost, whichever is greater.<sup>10</sup>

## **MEDICARE PRESCRIPTION DRUG BILL**

In December 2003 President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Representing decades of effort to add a prescription drug benefit to Medicare, the bill offers prescription drug coverage to the nearly 41 million Americans that rely on Medicare for health benefits. The bill also makes changes to the Part B deductible, increasing it to \$110 in 2005 and indexing it to rise by the annual percentage increase in Part B expenditures, raising the Part B premium in 2007 for those who earn more than \$80,000 as a single, and \$160,000 as a couple, and adding an initial routine physical examination for all new enrollees in 2005.

The transitional discount card program began in June 2004 and will end in January 2006. Designed to provide immediate relief from soaring prescription drug costs, Medicare beneficiaries have the option of selecting one drug discount card. Once the new program begins in January 2006, one can choose to remain in the fee-for-service Medicare plan or choose a Medicare Advantage managed plan that includes all Medicare benefits plus outpatient drug coverage.

Despite the months of negotiation that took place and the implemented changes, the new plan has been the source of criticism and confusion. At the time of the bill’s signing it was estimated to cost \$400 billion over the next ten years; however estimates began to surface in June 2004 that suggested the costs would be much higher. The agency that administers Medicare, CMS, estimated costs between \$500 and \$600 billion, the White House estimated costs of \$534 billion while the Congressional Budget Office estimated a \$395 billion increase between 2004 and 2013. In June 2004 congressional leaders Nancy Pelosi (D-CA) and Tom Daschle (D-SD) called on the Bush administration to release information and documents it had about cost estimates of the bill.

Many advocates and members of Congress have also criticized the new benefit as a win for private pharmaceutical companies, who as a result of the bill are allowed to charge whatever price they wish for their product. Alternatives such as the model used by the United States Veterans Administration (VA) have been proposed in hopes of decreasing the prices of drugs. Currently the VA makes large purchases of drugs and uses their market clout to demand large price reductions from drug companies, making the medication cheaper for their consumers. Research done by Families USA showed that the lowest discount card prices for the top 20 brand-name drugs to be at least 50 percent more expensive than prices negotiated for veterans.<sup>11</sup>

Regardless of flaws in the new legislation, it is unlikely that Congress or the Administration will revisit Medicare as an issue anytime soon.

## **DUAL ELIGIBILITY: THE ROLE OF MEDICARE AND MEDICAID**

While Medicare exists primarily to assist individuals over the age of 65, Medicaid provides health benefits to low-income Americans. For more than 7 million low-income seniors Medicaid plays a role in filling the gaps of Medicare coverage. In 2002 around 6.1 million aged and disabled beneficiaries received assistance from both programs. Another 1 million receive assistance through the coverage of their premium and cost sharing, while not receiving long-term care benefits.

Though Medicare covers basic health benefits, many rely on Medicaid to pay Medicare premiums and cost sharing and also for benefits that Medicare does not provide such as nursing home and other long-term care services. Based upon one's income there are different levels of support for which one may qualify. The poorest Medicare beneficiaries receive full assistance with Medicare premiums and cost sharing and coverage of all Medicaid benefits. For beneficiaries with more resources there are buy-in programs, through which individuals are eligible to receive assistance with premiums and/or deductibles.

Most dual enrollees have very low-incomes and substantial health needs. While 77 percent of dual enrollees have incomes below \$10,000, only 18 percent of all other Medicare beneficiaries have incomes that low. Almost 25 percent of dual-enrollees are in nursing homes and a third have significant limitations in activities of daily living, compared with 3 percent of regular Medicare beneficiaries living in nursing homes and 12 percent experiencing limitations. Thus many of these individuals experience serious economic strains and rely on the support of both programs to improve beneficiary's access to quality care and decrease costs. While the average Medicare beneficiary spends 20 percent of her income on out-of-pocket healthcare expenses, dual enrollees average 5 percent.<sup>12</sup>

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will change the way many dual eligible individuals receive outpatient prescription drugs. Medicare recipients who have been receiving prescription drug coverage through Medicaid will no longer be eligible for this coverage. Instead they must enroll in Part D of the Medicare program. However, it is unclear how this coverage will compare with prescription drug coverage under Medicaid since the law does not require that the coverage be the same as is currently provided under Medicare. Once the new prescription drug benefit takes effect on January 1, 2006, states will not be able to provide additional drug benefits through Medicaid to individuals in the Medicare program.

Additional assistance will be available for those seniors that are dually eligible for both Medicaid and Medicare. Medicaid will cover many out-of-pocket expenses, including the premium and deductible, although there will be co-payments of \$1 to \$2 for generic drugs and \$3 to \$5 for name-brand drugs.<sup>13</sup> Beneficiaries with incomes under 135 percent of the poverty line (\$12,569 for individuals and \$16,862 for couples in 2004) will be eligible for the Transitional Assistance Program. Through this program individuals with incomes at or below 100 percent of the federal poverty level will pay 5 percent of the discounted cost of the drug and those with incomes between 100 percent and 135 percent of the poverty line will pay 10 percent of the discounted cost of the drug. Those eligible for the program will not have to pay a premium or deductible, and will receive a credit of \$600 a year in order to cover the costs of co-payments. They will also not be subject to the "doughnut hole" gap in coverage. Most of the above amounts will go up in future years based on a formula tied to the previous year's spending on Part D coverage.

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<sup>1</sup> Medicare At A Glance; The Henry J. Kaiser Family Foundation. March 2004.

2002 federal poverty level \$8860/single and \$11,940/couple

<sup>2</sup> Medicaid and the Uninsured: Dual Enrollees: Medicaid's Role for Low-Income Medicare Beneficiaries. The Henry J. Kaiser Family Foundation. February 2003.

<sup>3</sup> Ibid.

<sup>4</sup> 2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. March 23, 2004. p. 8. < <http://www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf>>.

<sup>5</sup> Serafini, Marilyn W. "The Real Medicare Crisis Ahead." The National Journal 5 June 2004: 1792-1793.

<sup>6</sup> Fast Facts about Medicare. National Committee to Preserve Social Security and Medicare.  
<http://www.ncpssm.org/medicare/fastfactm/>.

<sup>7</sup> Medicare At A Glance; The Henry J. Kaiser Family Foundation. March 2004.

<sup>8</sup> Medicare Advantage fact sheet. The Henry J. Kaiser Family Foundation. March 2004.

<sup>9</sup> Center for Medicare and Medicaid Services. "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." April 2004 p.12. <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>.

<sup>10</sup> Fast Facts about Medicare. National Committee to Preserve Social Security and Medicare.  
<http://www.ncpssm.org/medicare/fastfactm/>.

<sup>11</sup> June 2, 2004. Families USA press release.

[http://www.familiesusa.org/site/PageServer?pagename=Media\\_Statement\\_Medicare\\_Discount\\_Card\\_0602](http://www.familiesusa.org/site/PageServer?pagename=Media_Statement_Medicare_Discount_Card_0602).

<sup>12</sup> ibid

<sup>13</sup> ibid