

FACTS from EBRI

Employee Benefit Research Institute ■ 2121 K Street, NW, Suite 600 ■ Washington, DC ■ 20037

April 2004

The Basics of Medicare Updated With the 2004 Board of Trustees Report

History

- In 1965, Congress enacted Title 18, “Health Insurance for the Aged,” of the Social Security Act, which created the Medicare program. Medicare consists of two parts: Part A, Hospital Insurance (HI), covers hospital services and some home health care and skilled nursing facility services, and Part B, Supplemental Medical Insurance (SMI), covers physician care, outpatient hospital services, and independent laboratory services.
- In 1972, the Medicare program was expanded to include disabled persons who qualified for benefits under the Disability Insurance (DI) program and certain individuals with end-stage renal (kidney) disease.
- In 1986, all state and local government employees hired after Mar. 31, 1986, and not covered under Social Security, were required to be covered by Medicare.
- In 1997, the Balanced Budget Act of 1997 expanded the delivery of health care under Medicare with the Medicare+Choice program. See below for more details.
- In 1997, under the Balanced Budget Act of 1997, home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI were transferred from the HI program to the SMI program, effective January 1998.
- In 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare+Choice program. See below for more details.
- In 2003, Congress enacted the Medicare Prescription Drug Improvement and Modernization Act, which created Part D, prescription drug coverage, means-tested Part B premiums, and increased the Part B deductible.

Covered Beneficiaries

- Medicare serves elderly and disabled workers who qualify for DI benefits. Enrollment in Part A (HI) is automatic, while enrollment in Part B (SMI) is voluntary. In 2003, 34.6 million elderly and 6.0 million disabled individuals were enrolled in Part A, and 33.1 million elderly and 5.3 million disabled individuals were enrolled in Part B.

Financing

- Expressing Medicare expenditures as a percentage of gross domestic product (GDP) gives a relative measure of the size of the Medicare program compared with the general economy. The projection of this measure affords the public an idea of the relative financial resources that will be necessary to pay for Medicare services. In 2003, expenditures in the Medicare program equaled 2.6 percent of GDP. By 2078, that percentage is estimated to be 13.8 percent.
- In 2024, Medicare costs are projected to exceed those of the Social Security Old-Age and Survivors and Disability Insurance (OASDI) program and to be almost twice as much by 2078.

► *Part A: Hospital Insurance (HI)*

- The Balanced Budget Act of 1997 contained numerous provisions affecting the Medicare program. These provisions were designed in part to postpone the imminent depletion of the HI trust fund, which, according to the 1997 Board of Trustees’ report, had been projected for 2001. Under this legislation, fund exhaustion is postponed until 2030, based on the intermediate assumptions used in the 2002 Board of Trustees’ report. In 2003, the financial status of the trust fund deteriorated significantly; asset exhaustion is projected for 2019 in the 2004 Trustees report, compared with 2026 in the 2003 Trustees report.

- HI payroll taxes for 2003 were based on a combined employer/employee rate of 2.9 percent. The Omnibus Budget Reconciliation Act of 1993 completely removed any wage base limit for the HI payroll tax, effective Jan. 1, 1994. For years 2004 and afterward, the payroll tax is scheduled to be 2.9 percent. In 2003, total income for the HI trust fund was \$175.8 billion: \$149.2 billion came from payroll taxes, \$8.3 billion from taxation of Social Security benefits, \$15.0 billion from interest and other income,¹ and \$1.6 billion from premium payments, and \$1.6 billion from miscellaneous revenue.
- In 2003, the average amount reimbursed per enrollee in Part A was \$3,747.
- Administrative costs for Part A were \$2.5 billion, or 1.6 percent of expenditures.
- By the end of 2078, the unfunded obligation of the HI trust fund is estimated to be \$8.2 trillion.

▶ **Part B: Supplementary Medical Insurance (SMI)**

- The SMI trust fund is financed on a year-by-year basis. The SMI program derives its revenues from premium payments by beneficiaries and general revenues from the federal budget. Under current law, no more than 25 percent of SMI's revenues can come from premium payments.
- In 2003, the average amount reimbursed per enrollee in Part B was \$3,219.
- Administrative costs for Part B were \$2.3 billion, or 1.8 percent of expenditures.

▶ **Federal Budgetary Processes**

- Currently, the U.S. Department of the Treasury credits the Medicare and Social Security trust funds with any annual excess of Medicare and Social Security tax revenues over the amount spent for current benefits. By law, these assets must be invested in special securities issued by the Treasury. The government then spends these “assets” to ease fiscal pressures on other programs. The trust fund surpluses are not reserved for future Medicare and Social Security benefits but are bookkeeping entries showing how much the Medicare and Social Security programs have lent to the Treasury (or alternatively, what is owed to Medicare and Social Security, including interest, by the Treasury). When the trust funds go into negative cash flow, the Treasury must start repaying the money.
- For budgetary purposes, the date on which the trust funds go into negative cash flow (i.e., the benefit payments exceed the income from payroll taxes and the taxation of benefits) is significant because it marks the point at which the government must provide cash from general revenues to the programs rather than receive surplus cash from them to fund other current spending.

Cost-Sharing Provisions

▶ **Part A Hospital Insurance (HI)**

- Part A requires an enrolled individual to pay various deductibles and co-pays, depending on the facility where the service is provided and the length of stay.
- *In-patient Hospital Deductible*—For a hospital stay of 1–60 days in 2004, a patient is liable for an \$876 deductible. For a hospital stay of 61–90 days in 2004, the patient is liable for a \$219 co-pay per day. For a hospital stay of more than 90 days in 2004, a patient is liable for a \$438 co-pay per day.
- *Skilled Nursing Facility*—There is no deductible or co-pay for the first 20 days of a skilled nursing facility stay. If the stay lasts for 21 days or longer, the patient is liable for a \$109.50 co-pay per day in 2003.
- *Part A Premium*—For an individual who is age 65 or older and not otherwise covered by the Medicare program, the monthly premium in 2004 to be covered by Part A is \$343.
- The use of Medicare benefits is calculated based on benefit periods and reserve days. The benefit period is the block of time used to determine how much of a deductible and/or co-pay the beneficiary owes. A benefit period begins and ends when he or she has been out of the hospital for 60 consecutive days. For example, if a beneficiary enters the hospital on November 10, 2004, and is released on November 24, 2004, he or she is liable for \$876. If

the beneficiary is re-admitted to the hospital on December 20, 2004, and released on December 26, 2004, he or she does not have to pay another \$876. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period in this example runs until January 24, 2005.

- There is no limit on the number of benefit periods a beneficiary may use in a lifetime, except for hospice care, which entitles a beneficiary to two 90-day periods and one 30-day period.
- Reserve days are used for hospital stays beyond 90 days. A beneficiary is entitled to only 60 reserve days.

▶ **Part B: Supplementary Medical Insurance (SMI)**

- Since Part B of Medicare is voluntary, participants are required to make a monthly contribution to the premium. Part B premiums are automatically deducted from the enrollee's Social Security benefit, provided the enrollee receives Social Security benefits. Under current law, no more than 25 percent of SMI's revenues can come from premium payments.
- The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires the Medicare Part B premium to be related to income starting in 2007. By 2011, premiums will increase with income. Medicare beneficiaries with income under \$80,000 (\$160,000 for a married couple) will continue to be required to pay 25 percent of the cost of Part B. However, beneficiaries with income between \$80,000 and \$100,000 will be required to pay 35 percent of the premium, and beneficiaries with income of at least \$200,000 will be responsible for 80 percent of the premium to enroll in Part B. These income levels will also be indexed to general inflation.
- *Premiums*—In 2004, the monthly premium is \$66.60.
- *Annual Deductible*—This is applied to all Part B services except home health care services. In 2004, the annual deductible is \$100.
- *Coinsurance*—Coinsurance payment in 2004 is 20 percent.

Medigap

- Although Medicare eases many financial worries for the elderly, it does not cover 100 percent of all medical services. Medicare's deductibles and co-payments can be high, particularly for long hospital stays.
- Medicare does not cover all medical services. Most notable are eye exams and glasses, hearing aids, and dental services.
- To help meet these additional expenses, Medicare beneficiaries frequently purchase what is known as Medigap policies. A Medigap policy is purchased in the individual market.
- In the 1970s and 1980s, Medicare enrollees encountered problems with purchasing health insurance to supplement Medicare. In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress charged the National Association of Insurance Commissioners (NAIC) with developing a variety of Medigap policies. NAIC developed 10 policies ranging from a basic coverage plan, Plan A, to comprehensive coverage, Plan J. Insurance carriers are not required to offer all 10 policies, but if a carrier offers Medigap policies, they must be from the 10 policies designed by NAIC. Exceptions to this rule are for carriers in Massachusetts, Minnesota, and Wisconsin, states that had Medigap laws in place before OBRA '90.
- The Centers for Medicare & Medicaid Services maintains an interactive Web page designed to assist an enrollee in obtaining Medigap coverage. The Web site is at the following link:
www.medicare.gov/MGCompare/Home.asp

Covered Services

▶ **Part A: Hospital Insurance (HI)**

- *Hospitalization*—Covered services include semiprivate room and board, general nursing, miscellaneous hospital services and supplies, inpatient psychiatric hospital care.

- *Posthospital Skilled Nursing Facility Care*—To receive this service, the individual must have been in the hospital for at least three days and enter facility within 30 days after hospital discharge.
- *Home Health Care*—Covered services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies.
- *Hospice Care*—Covered services include medical and support services from a Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief, and other services not otherwise covered by Medicare. Hospice care is usually given in the home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed.
- *Blood*—Covered services include pints of blood received at a hospital or skilled nursing facility during a covered stay.

▶ **Part B: Supplementary Medical Insurance (SMI)**

- *Medical and Other Services*—Covered services include doctors' services (not routine medical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs). Part B covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.
- *Clinical Laboratory Services*—Services include blood tests, urinalysis, and more.
- *Home Health Care*—Services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies, and other services.
- *Outpatient Hospital Services*—Services include hospital services and supplies received as an outpatient as part of a doctor's care.
- *Blood*—Covered services include pints of blood received as an outpatient or as part of a Part B covered service.

Part D Prescription Drugs

- The Medicare Prescription Drug Improvement and Modernization Act of 2003 created Part D, a prescription drug benefit.
- Starting in May 2004, a prescription drug discount card program will be available and will continue through December 31, 2005. For individuals with income of \$12,569 or less and for married couple with income of \$16,862 or less a \$600 credit is added to the discount card.
- Starting Jan. 1, 2006, the comprehensive prescription drug benefit will be available. General guidelines for cost-sharing arrangements are as follows:
 - A deductible of the first \$250.
 - On drug purchases of \$251 through \$2,250, Medicare pays 75 percent of the costs.
 - On drug purchases of \$2,251 through \$3,600, the individual pays 100 percent of the costs.
 - On drug purchases of \$3,601 and higher, Medicare pays 95 percent of the costs.
 - Assistance for low-income individuals will be available. The income limits are to be set in 2005.

Medicare Advantage

- The Medicare Prescription Drug Improvement and Modernization Act of 2003 changed the name of the Medicare+Choice program to Medicare Advantage.
- The Medicare Advantage program was created by Congress in the Balanced Budget Act of 1997 to allow more types of health insurance plans, including managed care plans, to serve Medicare beneficiaries. As of March 2003, 5.3 million Medicare beneficiaries (approximately 14 percent of Medicare beneficiaries) were enrolled in a Medicare HMO. Since 1998, most HMO contracts with the Centers for Medicare & Medicaid Services have operated under the Medicare Advantage program.
- In 1999, 97 plans either withdrew or reduced their service areas, directly affecting 407,000 enrollees. In 2000, 99 plans withdrew, affecting 327,000 enrollees. In 2001, withdrawals and service area

reductions affected an estimated 934,000 enrollees. In 2002, 536,000 enrollees were affected by withdrawals and service area reductions.

- In late 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare Advantage program. Under BIPA, as of March 1, 2001, the floor or minimum payment for Medicare Advantage plans in counties in large urban areas is \$525 while for all other counties it is \$475. Early data suggest that the BIPA minimum payments are having a greater impact in the large urban areas than in the counties with the lower minimum payment.

Trustees in 2004

- Treasury Secretary John W. Snow acts as the Managing Trustee. The other trustees include: Elaine Chao, Secretary of Labor; Tommy G. Thompson, Secretary of Health and Human Services; Jo Anne B. Barnhart, Commissioner of Social Security; John L. Palmer, and Thomas R. Saving.
- The 2004 trustees report is available on the Internet at www.cms.hhs.gov/publications/trusteesreport/

For additional detailed information on the Medicare program, go to www.medicare.gov/ which is maintained by the Centers for Medicare & Medicaid Services, part of the U.S. Department of Health and Human Services.

Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund* (Washington, DC: U.S. Government Printing Office, 2004).

¹Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income.