

FACTS from EBRI

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Health Insurance and the Elderly

Medicare

- In 1965, Title 18, “Health Insurance for the Aged,” of the Social Security Act 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.
- The Medicare program extends nearly universal health insurance coverage to the elderly. In 2001, Medicare covered 96.1 percent of the elderly. Only 0.8 percent of the elderly were without health insurance in 2001. To qualify for Medicare a person must have worked for at least 10 years at Medicare-covered employment (30 quarters of Medicare-covered employment). A person who does not meet these requirements may pay a premium to be covered by Part A. In 2003, this premium amount was \$316 per month. A person is automatically enrolled in Medicare Part A Hospital Insurance program on the first day of the month in which he or she reaches age 65.
- Examples of elderly persons not participating in Medicare Part A are federal government employees hired before March 1984 and state and local government employees hired before March 1986 whose employer was not participating in the Social Security and Medicare programs.

Financing of Medicare

- 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. In 2002, total income for the HI trust fund was \$178.6 billion: \$152.7 billion came from payroll taxes, \$8.3 billion from taxation of Social Security benefits, \$14.4 billion from interest and other income,¹ \$1.6 billion from premium payments, and \$1.6 billion from miscellaneous revenue.
- In 2002, the average amount reimbursed per enrollee in Part A was \$3,689.

Covered Services

- Medicare covers most medical services with the notable exception of outpatient prescription drugs and long-term care. Medical services covered by Medicare are subject to various out-of-pocket costs detailed below.

Out-of-Pocket Costs—Part A

- In-patient Hospital Deductible—For a hospital stay of 1–60 days in 2003, a patient is liable for an \$840 deductible. For a hospital stay of 61–90 days in 2003, the patient is liable for a \$210 co-pay per day. For a hospital stay of more than 90 days in 2003, a patient is liable for a \$420 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 \$105 co-pay per day in 2003.
- 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 Nov. 10, 2003, and is released on Nov. 24, 2003, he or she is liable for \$840. If the beneficiary is

re-admitted to the hospital on Dec. 20, 2003, and released on Dec. 26, 2003, he or she does not have to pay another \$840. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period for this example runs until Jan. 24, 2004.

Out-of-Pocket Costs—Part B

- Medicare beneficiaries are required to pay a monthly premium if they wish to participate in the Part B program. 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.
- Premiums—In 2003, the monthly premium is \$58.70.
- Annual Deductible—This is applied to all Part B services except home health care services. In 2003, the annual deductible is \$100.
- Coinsurance—The coinsurance payment in 2003 is 20 percent.
- Because Medicare's out-of-pocket expenses can be high and the program does not cover prescription drugs, most elderly persons have a second source of coverage to complement Medicare. In 2001, 68.9 percent of the elderly had more than one source of health insurance, down from 75.6 percent in 1987.

Medicare+Choice

- The Medicare+Choice 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+Choice 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 them from withdrawing from the Medicare+Choice program. Under BIPA, as of March 1, 2001, the floor or minimum payment for Medicare+Choice 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.

Employment-Based Retiree Health Insurance

- In 2001, 32.2 percent of the elderly had employment-based health insurance coverage in addition to Medicare, up from 28.7 percent in 1987.
- In December 1990, the Financial Accounting Standards Board (FASB) approved Financial Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions." FAS 106 requires companies to record unfunded retiree health benefit liabilities on their financial statements in order to comply with generally accepted accounting standards, beginning with fiscal years after December 15, 1992. FAS 106 has caused many employers to re-examine their role in providing health benefits for current and future retirees.
- By law, employers are under no obligation to provide retiree health benefits, except to current retirees who can prove that they were previously promised a specific benefit. As a result, coverage from a former employer or union has not changed despite FAS 106. It appears that the changes employers

have made to retiree health benefits in response to FAS 106 were more likely to affect future retirees than current retirees.

- In 2002, 27 percent of employers with 500 or more employees offered health benefits in retirement to retirees age 65 and over, a slight increase from 2001 when 23 percent offered such coverage. Mercer Human Resources Consulting (MHRC) states the increase in 2002 could be due to a change in methodology with regard to retiree health benefits. MHRC stated, “It is unlikely that there has been a reversal in the long-term decline in retiree coverage; it is possible the decline has plateaued.” However, in 1993, 40 percent of employers with 500 or more employees offered retiree health coverage to retirees age 65 and over.
- In 2002, of those employers that offered health insurance to retirees age 65 and over, the average annual cost per retiree was \$3,180, up from \$1,786 in 1993.
- In 2002, 19 percent of employers with 500 or more employees that offered retiree medical insurance only to retirees age 65 and over paid the premium, down from 23 percent in 1993.

Individually Purchased Medigap Policies

- In 2001, 26.6 percent of the elderly had individually purchased or Medigap health insurance coverage in addition to Medicare, down from 38.9 percent in 1987.
- 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 Medicare supplemental, or Medigap, policies. NAIC developed 10 policies ranging from a basic coverage plan, Plan A, to comprehensive coverage, Plan J (see table). 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 insurance carriers in Massachusetts, Minnesota, and Wisconsin, states that had Medigap laws in place before OBRA '90.

10 Standardized Medigap Insurance Plans										
Benefits	A	B	C	D	E	F ^a	G	H	I	J ^a
Basic Benefits	X	X	X	X	X	X	X	X	X	X
Part A: Skilled Nursing Coinsurance		X	X	X	X	X	X	X	X	
Part A: Hospital Deductible		X	X	X	X	X	X	X	X	X
Part B: Deductible			X			X				X
Part B: Excess Doctor Charges						100%	80%		100%	100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery			X			X		X	X	
Outpatient Prescription Drugs								b	b	c
Preventive Screening					X					X

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, www.cms.hhs.gov/medigap/

^a Plans F and J also have a high-deductible option under which covered individuals must pay a deductible (\$1,620 in 2002) before the plan pays anything.

^b The benefit has a \$250 calendar year deductible and 50 percent of outpatient prescription drug charges up to a maximum of \$1,250 in benefits per calendar year.

^c The benefit has a \$250 calendar year deductible and 50 percent of outpatient prescription drug charges up to a maximum of \$3,000 in benefits per calendar year.

- Premium costs for Medigap policies vary widely by state and by Medigap plan, A–J. Data from Weiss Ratings, Inc., a consumer advocacy group on financial issues, shows an average annual premium for Plan A was \$1,056.54 in 2003. The average annual premium for Plan J was \$2,273.73 in 2003.

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.

For more information, contact Ken McDonnell, (202) 775-6342, or see EBRI’s Web site at www.ebri.org

Source: *EBRI Databook on Employee Benefits*, fourth edition, 1997 and Paul Fronstin, "Retiree Health Benefits: Trends and Outlook," *EBRI Issue Brief* no. 236 (August 2001); and Mercer Human Resources Consulting, *National Survey of Employer-Sponsored Health Plans: 2002 Survey Report* (New York, NY: Mercer Human Resources Consulting, 2003)

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