Fact Sheet

Setting the Record Straight about Medicare

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As the nation considers the future of Medicare, it is important to separate the facts from misconceptions about Medicare coverage, costs to beneficiaries, and efficiency of the program. For older Americans and people with disabilities, Medicare represents a major pillar of health security. It provides them with access to essential health services and has substantially reduced the financial burden associated with serious illness. Yet, Medicare is not overly generous; the program provides fewer benefits than most employer-sponsored health insurance and covers only about half of beneficiaries' total health care costs. In the past, Medicare spending per beneficiary has grown more slowly than private health insurance. In the next 10 years, while Medicare spending will grow because the number of beneficiaries continues to grow as the boomers age, Medicare spending per beneficiary is projected to grow at about the same rate as the overall economy.

Medicare is a federal health insurance program for older people and those with disabilities. Traditional Medicare has several parts: Part A covers hospital care, skilled nursing care, home health care, and hospice care; Part B covers physician, laboratory, and imaging services; Part D covers prescription drugs. Part C, also known as Medicare Advantage, allows private health plans to contract with Medicare to cover all standard Medicare benefits in a single package.

Medicare has had an enormous impact on health insurance coverage for the elderly.

- Before Medicare was enacted in 1965, only 25 percent of older people had meaningful private hospital insurance.[1]
- Upon implementation of Medicare, hospital insurance coverage for older people rose to almost 100 percent.
- The introduction of Medicare was responsible for a striking and substantial decline in the financial burden of out-of-pocket spending by older people for health care associated with serious illness.[2]

Contrary to what many people think, Medicare does not cover all health care expenses.

- Medicare does not cover the cost of care for dental, vision, or hearing conditions.
  - The need for eyeglasses and hearing aids is particularly common among older people. The cost of these items and services contributes substantially to their out-of-pocket expenses.
- Medicare does not cover long-term nursing home care or personal care in the home for beneficiaries.
  - While most people prefer to remain at home for as long as possible, some older people may require nursing home care.
  - The cost of a private room in a nursing home averages

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$78,000 per year[3] and can impose a serious financial burden on Medicare beneficiaries and their families.

  - Medicare does not cover personal care and supports for beneficiaries who choose to stay in their home and need help with daily activities such as bathing, eating, dressing, and so on.

- Medicare does not cover all prescription drug costs.
  - Even after implementation of Part D, many younger beneficiaries with disabilities report having difficulty getting medication because it was not covered by their drug plan, needing prior authorization before getting a medication, and delaying getting or skipping medications due to cost.[4]

Medicare benefits are not "free." Medicare beneficiaries must pay substantial premiums, deductibles, and coinsurance out of pocket.

- Many working people realize that their payroll taxes contribute to the Medicare program. However, they may not realize that benefits are not "free" once they become eligible for Medicare.
- In fact, Medicare covers only about half of beneficiaries' total health care costs.[5]
- For Medicare beneficiaries, half of whom have annual income of about $22,000,[6] typical out-of-pocket costs in 2007 were as follows:[7]
  - Half of all beneficiaries paid at least $3,138 in out-of-pocket costs, which amounted to about 17 percent of their income.
  - Some beneficiaries paid even more: 10 percent of beneficiaries, more 4 million people, spent over $7,861 on health care.
  - Among beneficiaries with disabilities under age 65, half paid at least $1,762 in out-of-pocket costs, about 14 percent of income, primarily due to higher rates of dual coverage under Medicaid as well as Medicare.
  - Beneficiaries who enter the Part D coverage gap or "doughnut hole" have to pay the full cost of their prescriptions as well as their Part D premiums. Fortunately, recent legislation helps reduce out-of-pocket prescription drug costs for more than 3 million beneficiaries who fall into the Part D doughnut hole.
- Unlike most employer-sponsored health insurance, Medicare provides no coverage for catastrophic medical expenses—no limit on annual out-of-pocket spending.
- Due to the "gaps" in Medicare coverage, many beneficiaries buy "Medigap" coverage to help with the deductibles and coinsurance that Medicare does not cover.
  - On average, this Medigap coverage costs about $2,000 per year.[8]

Out-of-Pocket Costs for Medicare Beneficiaries

	Median	Mean	Top 10 percent
All Beneficiaries	$3,138	$4,559	$7,861

Not everyone pays the same amount for Medicare.

- About 4 percent of upper income beneficiaries are required to pay higher Medicare Part B and Part D premiums, as shown in the text box below.[9]
- In 2012, those with the highest income will pay premiums of as much as $3,840 per year for Part B and about $1,200 per year for Part D.
- The poorest beneficiaries (those near the poverty level) may qualify for Medicaid assistance to cover the cost of their Medicare premiums and cost sharing.

Medicare controls health care costs as effectively as the private sector.

- In 2010, total health care spending in the United States amounted to about $2.6 trillion, of which Medicare accounted for about 20 percent.[10]
- Growth rates in per capita spending for Medicare and private health insurance have been quite similar over the long term, even though Medicare covers an older and sicker population that costs more than the population covered by private insurance.[11]
- From 1970 to 2009, Medicare's average annual per enrollee growth rate of 9 percent was lower than the growth rate of 10 percent for private

Medicare Part A, Part B, and Part D Deductibles, Coinsurance, and Premium Amounts, 2012

Part A (Hospital, Skilled Nursing and Home Health)	Part B (Physician, Labs, Imaging)	Part D (Outpatient Prescription Drugs)
Hospital Deductible $1,156 per benefit period	**Deductible** $140 per year	**Deductible** $320 per year
Hospital Coinsurance $289 per day for the 61st to 90th day of each benefit period $578 per day for the 91st to 150th day of each benefit period	**Coinsurance** 20 percent of Medicare allowable charges	**Initial Coverage Limit** (i.e., spending needed to reach doughnut hole) $2,930 total drug spending ($973 out-of-pocket)
Skilled Nursing Facility $144.50 per day for the 21st to 100th day of each benefit period	**Part B Monthly Premium** $99.90 for individuals with incomes under $85,000 and married couples with incomes under $170,000 Beneficiaries with higher incomes pay between $139.90 and $319.70	**Out-of-pocket Threshold** (i.e., spending needed to reach catastrophic coverage) $4,700 out-of-pocket ($6,658 total drug spending)
		Coverage Gap $3,728
		Average Monthly Premium $30.00 Beneficiaries with higher incomes pay between $41.60 and $96.40

Source: Centers for Medicare and Medicaid Services, Fact Sheet: Medicare Premiums, Deductibles for 2012; Oct. 27, 2011. Prepared by AARP Public Policy Institute.

health insurers.[12] While this difference may not appear great on an annual basis, over three decades (1970–2000), the cumulative difference amounted to 44 percent.[13]

- Administrative costs for the Medicare program have historically been less than 2 percent, much lower than administrative costs of private insurers.[14]

Medicare spending will continue to increase because the number of beneficiaries enrolled in the program is growing rapidly.

- From 2012 to 2021, Medicare's per capita spending is projected to grow at about the same rate as the general economy (i.e., gross domestic product).[15]
- However, total Medicare spending will grow more rapidly than the economy because Medicare enrollment is growing and will continue to grow.
- From 2000 to 2010, Medicare enrollment increased by about 8 million beneficiaries, or about 20 percent. Over the next decade, Medicare enrollment is expected to increase by about 15 million beneficiaries, or about 30 percent. By 2035, Medicare enrollment will have doubled to more than 90 million beneficiaries.[16]
- On the other hand, the aging of the population—that is, changes in beneficiary age mix—has had a negligible effect on the growth of Medicare spending. Longer life expectancy has not led to higher lifetime health expenditures—put another way, for older people, better health results in longer life but not necessarily in higher Medicare expenditures. Lower annual expenditures from age 70 until death among healthier people offset the greater time they have to accumulate Medicare costs.[17] This relationship does not hold for non-Medicare long-term care expenses.

The Affordable Care Act added benefits to the Medicare program.

- The Affordable Care Act added several benefits to Medicare, such as annual wellness visits, closing the doughnut hole, and eliminating deductibles and coinsurance for certain preventive care services.
- The Affordable Care Act also slowed the growth of Medicare spending by about 12 percent (from 6.8 percent to 6.0 percent) over 10 years (2010–2019) and extended the life of the Medicare Trust Fund.

Endnotes

[1] Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare." *Quarterly Journal of Economics* 122, 3 (2007): 1–37.

[2] Amy Finkelstein and Robin McKnight, "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending," *Journal of Public Economics* 92 (2008): 1644–1669.

[3] Genworth 2011 Cost of Care Survey, http://www.genworth.com/content/products/long_term_care/long_term_care/cost_of_care.html.

[4] J. Cubanski and P. Neuman, "Medicare Doesn't Work As Well for Younger Disabled Beneficiaries As It Does for Older Enrollees," *Health Affairs,* September 2010.

[5] AARP Public Policy Institute analysis of the 2007 Medical Current Beneficiary Survey, Cost and Use files.

[6] Urban Institute and Kaiser Commission estimates based on Census Bureau's March 2011 Current Population Survey; Medicare Current Beneficiary Survey 2008; "Medicare at a Glance," Kaiser Family Foundation, Fact Sheet #1066-14, Nov 2011.

[7] Data are from the 2007 *Medicare Current Beneficiary Survey,* calculated by AARP Public Policy Institute, January 2012. Out-of-pocket spending data include spending on Medicare and non-Medicare covered services, as well as premiums.

[8] Data represent national average Medigap costs for 2009. MedPAC, *Report to Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, June 2011).

[9] Centers for Medicare and Medicaid Services, "Fact Sheet: Medicare Premiums, Deductibles for 2012," October 27, 2011.

[10] S. P. Keehan et al., "National Health Spending Projections Through 2020," *Health Affairs* 20, 8 (2011): 1594–1605. During this time, total health care spending grew at an historically low rate of 3.9 percent.

[11] MedPAC, *Data Book,* Chart 1-7 (Washington, DC: MedPAC, June 2011).

[12] Ibid.

[13] C. Boccuti and M. Moon, "Comparing Medicare and Private Insurers," *Health Affairs* 22, 2, (2003): 230–7. These comparisons are not based on exactly comparable service use because older beneficiaries typically use more skilled nursing and home health care than younger families and, during this period, private insurers covered prescription drugs while Medicare did not. When spending for comparable services is compared, the gap between the two is narrower.

[14] Congressional Budget Office, *Medicare Baseline, March 2011*; *Health Care Financing Review,* Statistical Supp., "Brief Summary" (Washington, DC: Congressional Budget Office, November 1, 2008).

[15] Data show comparable growth rates during this period from both the Congressional Budget Office, *Long-Term Budget Outlook,* June 2011 (p. 44); and *The Medicare Trustees Report,* 2011, Table III A5 (p. 55) (Washington, DC: Board of Trustees of the Federal Hospital Insurance Trust Fund, May 13, 2001).

[16] *The Medicare Trustees Report,* 2011, Table III A3 (p. 51).

[17] Lubitz et al., "Health, Life Expectancy and Health Care Spending Among the Elderly," *New England Journal of Medicine* 349 (2003):1048–55.

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Fact Sheet