Medicare

ECON 40447
Fall 2009

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Introduction

- **Social insurance**
  - **Government run insurance programs**
  - **Typically**
    - **have subsidized premiums**
    - **have redistributive component**
- **Type of social insurance**
  - **Poverty programs**
  - **Old age (Social Security)**
  - **Disability**
  - **Health care/insurance**
  - **Unemployment**

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Definitions

- **Entitlements**
  - **Available to all who quality**
  - **Example. If you quality for Medicaid (and enroll), you receive benefits**
  - **In contrast, federally subsidized housing has a limited number of units, once units are gone, 'benefit' used up**
- **Mean tested**
  - **Eligibility is determined by income/asset limits**

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- **Federal government is the largest provider of health insurance in the country**
  - **Medicare**
  - **Medicaid**
  - **Veteran's Benefits**
  - **Military Insurance**
- **In these next 2 sections, we will discuss the first two**
- **Size of these programs make them important to consider**

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- **Medicare – insurance for**
  - **Elderly**
  - **Disabled**
  - **End stage renal disease (dialysis)**
- **Medicaid -- Insurance for people with medical needs and limited income**
  - **Poor and their children/ pregnant women**
  - **Low income elderly**
  - **Blind/Disabled**
  - **Long term care**

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Political Economy

- **Long fought battles**
  - **Medicare originally proposed by Truman in 1945**
  - **Medicaid was originally proposed to be part of original Social Security act of 1935**
    - **Was opposed by medical groups and private insurers**
- **Successful adoption as part of Johnson's 'war on poverty'**
  - **Medicare signed into law July 31, 1965**
  - **Medicaid Established in 1965**

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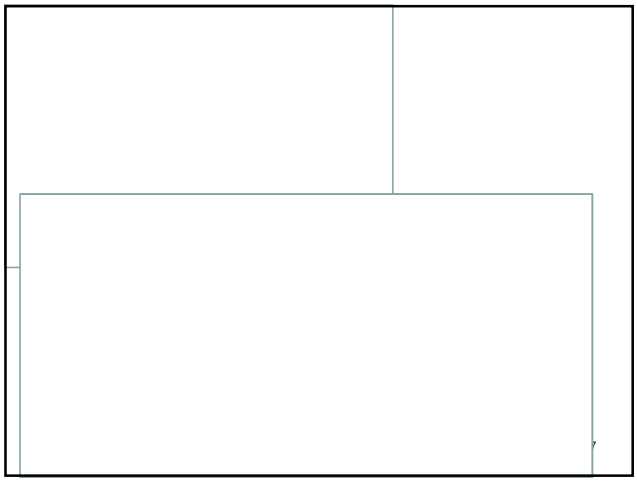

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Importance of M&M

- **Large fraction of Federal/State spending**
- **Large fraction of Health care spending**
- **Large Fraction of all people with insurance**

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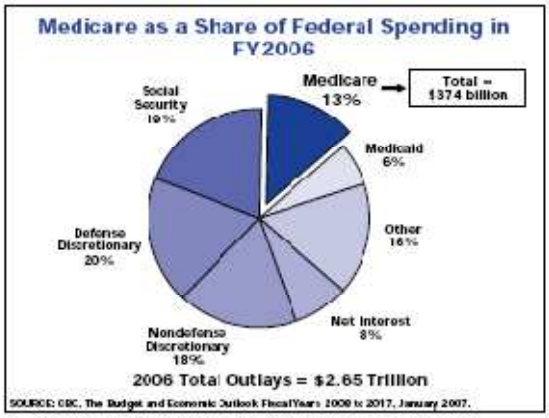
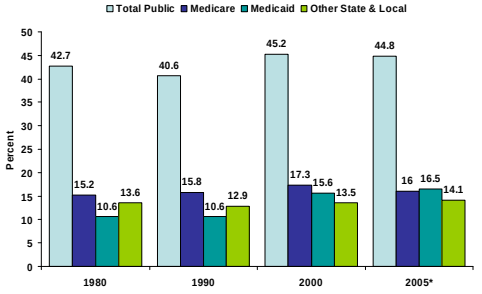


Table 3.1
Public Payors' Share of National Health Spending, 1980-2005

The share of national spending by public payors has increased slightly over the last two decades, driven by faster growth in Medicaid spending.



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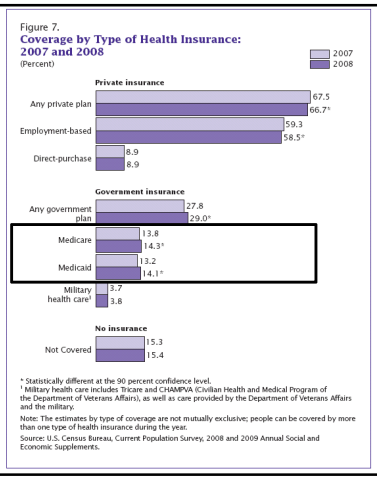

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Structure of Medicare

- **Four parts: A, B, C and D**
- **Part A: Hospitalization coverage**
  - **Mandatory**
  - **Provides coverage for**
    - **Inpatient**
    - **Short-term rehabilitation (post hospital) care**
    - **Hospice**

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- **Part B: Ambulatory care**
  - **Voluntary**
  - **Must pay monthly premium to enroll**
  - **Most seniors now enroll**
  - **Covers**
    - **Physician services**
    - **Outpatient medical services**
    - **Emergency room visits**
    - **Diagnostic tests, etc.**

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- **Part C: Medicare+Choice**
  - **Created in 1997 as par to Balanced Budget Act of 1997**
  - **Alternative to traditional A+B coverage**
  - **Private insurance companies supply insurance to elderly and are reimbursed at fixed rates for coverage**
    - **Companies paid per enrollee per month**
    - **Must take 'all comers' in a county**
  - **Usually HMO type coverage with some prescription drug plan**
  - **Has higher deductibles and copays than tradtional A+B coverage**

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Now Called Medicare Advantage

- **Restructured in 2003 as part of Balance Budget Amendment**
- **Created region Preferred Provider Organizations and Special Needs Plans for dual eligible**
- **Increased payments to plans to encourage enrollment after declining enrollment**
- **Problem: payments to MA, designed to save cost, are accelerating**

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How financed (2006)

- **Old system: 95% of county level Medicare spending**
- **Now, plans bid against country level benchmarks – based on**
  - **prior year's MA enrollment**
  - **National growth in Medicare spending**
- **If bid is in excess of county benchmark, enrollees pay difference**
- **If bid is below benchmark, plan keeps 75% of savings, must be returned to beneficiaries in benefits, Medicare keeps 25%**

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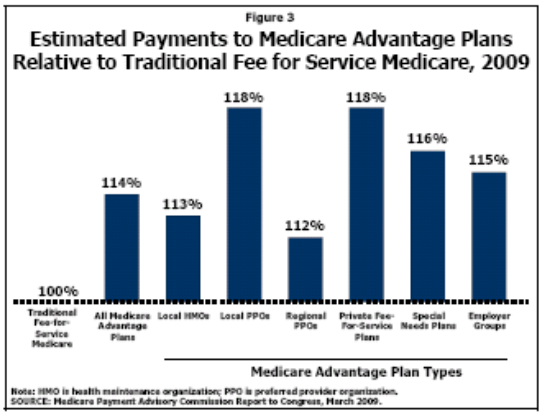

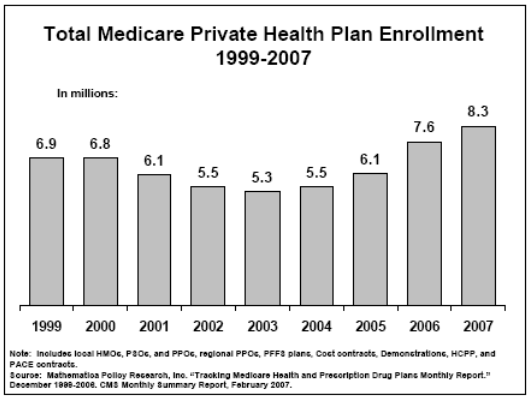

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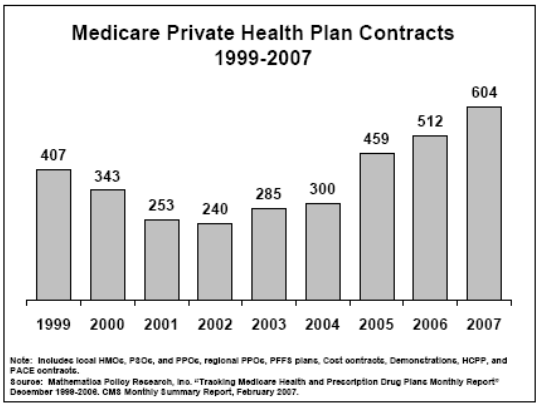

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- **Part D: Prescription drugs**
  - **Set to start January 2006**
  - **Voluntary**
  - **must pay premium to join**
  - **Will discuss at length in a minute**

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How is Medicare Financed?

- **Part A**
  - **Payroll tax**
    - **2.9% of all earnings**
    - **Employers/employees share equally (1.45%)**
  - **Annual reserves placed in the Hospital Insurance Trust Fund**
    - **Have built up reserves**
    - **Currently, revenues < costs**
    - **In not to distant future, trust fund will be exhausted**

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- **Part B**
  - **Monthly premiums**
    - **Currently set at $96.40**
    - **Premiums increase for people with higher incomes (>$85K for ind/$170K for couples)**
  - **General revenues from federal government**
    - **Historically been about 75% of expenses**
  - **SMI trust fund works similar to HI trust fund**
- **Part D**
  - **Monthly premiums and general revenues**

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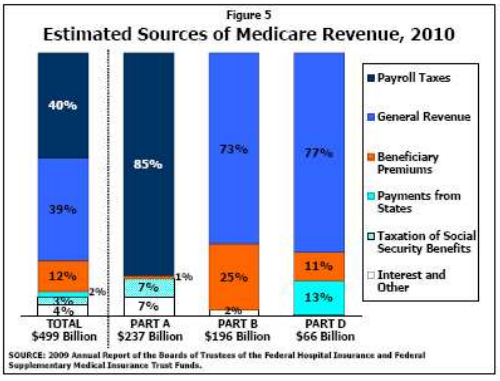

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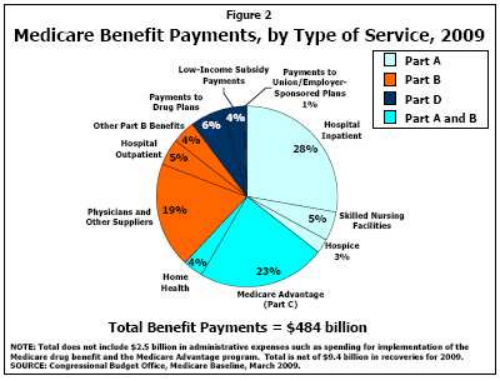

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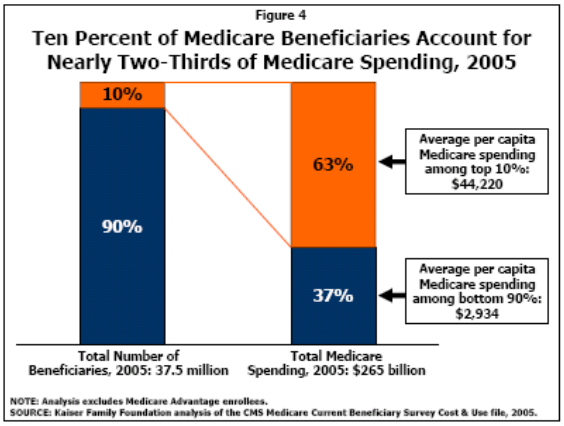

What does the previous slide suggest about where Medicare savings must come?

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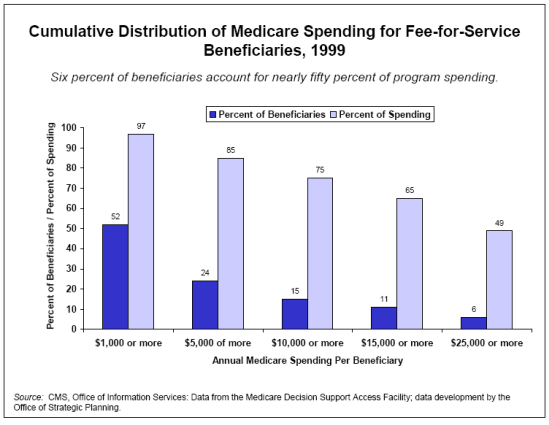

Cost sharing in Medicare

- **Part A**
  - **$1068 deductible**
  - **Days 1-60 no copay**
  - **61-90 $267 copay**
  - **$535 for days 91-150**
  - **Zip after 150 days**
- **Part B**
  - **Monthly premium of $96.40 (If Income>$80K or $160K for a couple, pay higher premium)**
  - **$135 annual deductible**
  - **20% coinsurance on physician services, outpatient care, ambulatory surgical, preventive**
  - **Outpatient: 80% of approved amount, $1068 maximum**
  - **No coinsurance on lab services**

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Does the structure the items covered and the coinsurance rates in Medicare make ECONOMIC sense?

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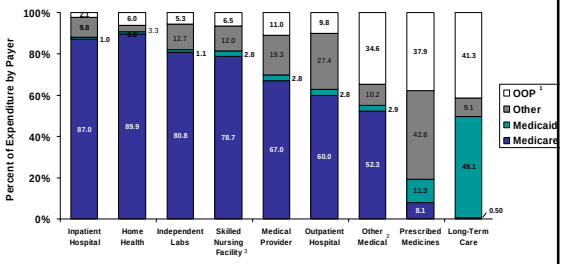
Table 3.13
Sources of Payment for Medicare Beneficiaries by Type of Service, 1999

Medicare pays a large proportion of the total payments for the services it covers.



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Motivation for Part D

- Rx important in medical treatment of elderly
  - Seniors represent 13% of the population
  - 1/3 of all scripts
  - 42% of spending on Rx drugs
- Among the elderly, 85% receive a Rx during the year
- Growing fraction w/ Rx Coverage
- Purchased through
  - Retiree benefits
  - Medigap policy

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Rx Spending Among Elderly

- Per capita annual spending, 2003
  - $2,300 total
  - $1,000 will be out of pocket
- Expenditures vary considerably
  - Those who lack coverage, $1,300
  - Those in fair or poor health, $3,100
  - 11% have > $5,000 in total spending
  - 5% have >$4,000 in out of pocket

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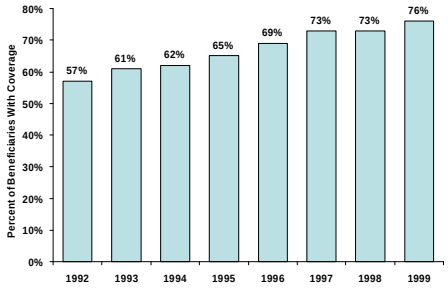
Table 3.20
Medicare Beneficiaries With Drug Coverage, 1992-1999

The proportion of the Medicare population with some drug coverage during at least part of the year increased from 1992 to 1999.



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- **Coverage rates**
  - **53% had full year coverage**
  - **70% had coverage at some point in the year**
- **Rates do not vary much by**
  - **Income**
  - **Health status**
  - **Role of Medicaid important here**

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Top 5 drugs among the elderly

Drug	What it treats?	Annual cost
Lipitor	Cholesterol	$871
Novasc	Calcium	$549
Fosamax	Bone density	$894
Prilosec	Anti-ulcer	$1,684
Celebrex	Rheu. Arth.	$2,102

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Medicare Presc. Drug Improvement and Modernization Act 2003

- **Signed 12/8/2003**
- **Effective 1/1/2006**
- **Voluntary drug plan – 'Part D'**
- **1st time Rx were part of Medicare**
- **Coverage provided by private entities**
  - **Stand alone if meet certain criteria**
  - **As part of Part A/B coverage (Medicare Advantage plans)**
  - **Gov't fall back plan in areas without choice**

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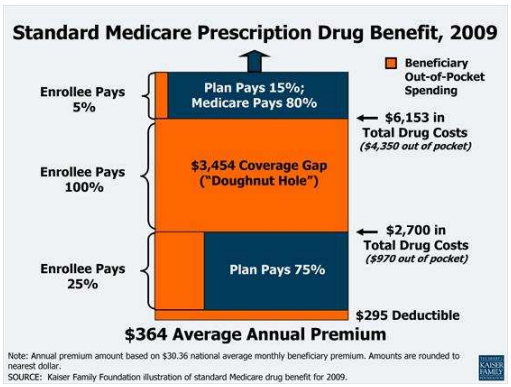

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- **Most plans**
  - **Skip the coinsurance and have copays instead**
  - **Do not have a deductible**
- **Avg Monthy premium is about $30 ($10-$140)**
  - **Premiuns increase 1%/month if you wait to enroll**
- **Low income can receive assistance**
- **Plans not required to cover all drugs –**
  - **Weight loss, hair growth, cough/cold relief, vitamins prohibited**
  - **Required 2 per therapeutic class**
- **1400 plans now available**

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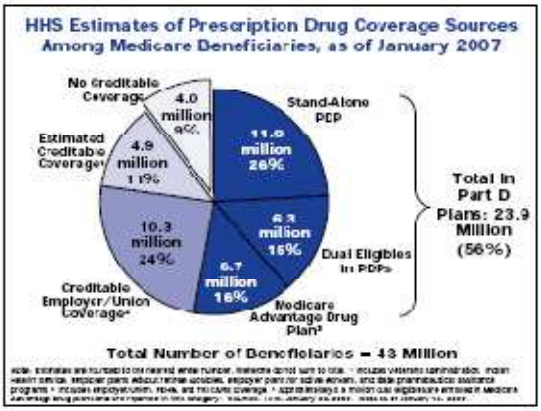

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Costs?

- **Original CBO estimates (Costs – revenues such as premiums and kickbacks from states)**
  - **$27 billion in 2006**
  - **$67 billion by 2013**
  - **$495 billion in 2004-2013**
- **Most recent numbers**
  - **$593 billion in 2004-2013**

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Table 9: Simulated Effects

	Model	With drug benefit	Without drug benefit	Difference
Prescription drug spending	Simple two-part model	$830	$673	$157
	Discrete factor with Income interaction	$821	$673	$148
Medicare Part A spending	Simple two-part model	$2,602	$2,737	-$135
	Discrete factor with Income interaction	$2,422	$2,772	-$350
Medicare Part B spending	Simple two-part model	$1,817	$1,786	$31
	Discrete factor with Income interaction	$1,729	$1,803	-$74

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The Future of Medicare

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Does not look good

- **Expenditures in program will soar**
- **Four factors**
  - **Aging of baby boom generating**
  - **Increasing lifespan**
  - **Rising medical care costs**
  - **Increasing benefits**

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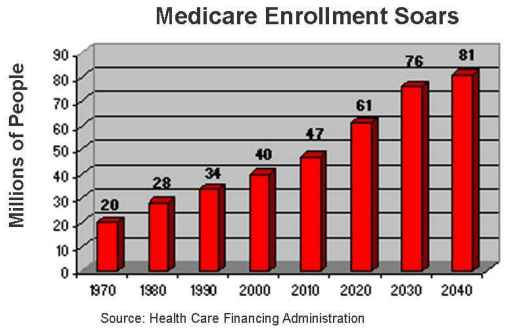

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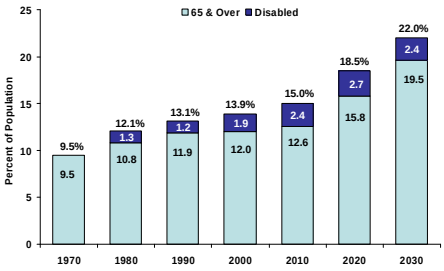
Table 3.7
Medicare Beneficiaries as a Share of the U.S. Population, 1970-2030

The U.S. population will age rapidly through 2030, when 22 percent of the population will be eligible for Medicare.



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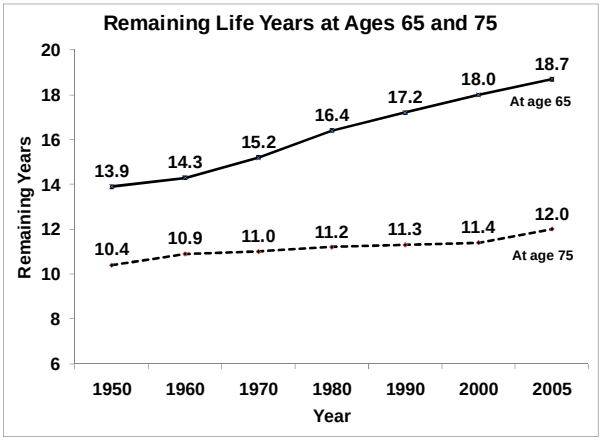

Per Capita Health Care Spending by Age (2004)

Age Group	Spending Per capita
O-18	$2,650
19-44	$3,370
45-54	$5,210
55-64	$7,887
64-75	$10,778
75-84	$16,389
85+	$25,691

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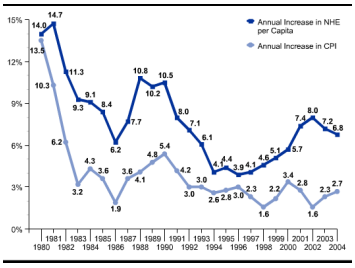
% Change in NHE and CPI



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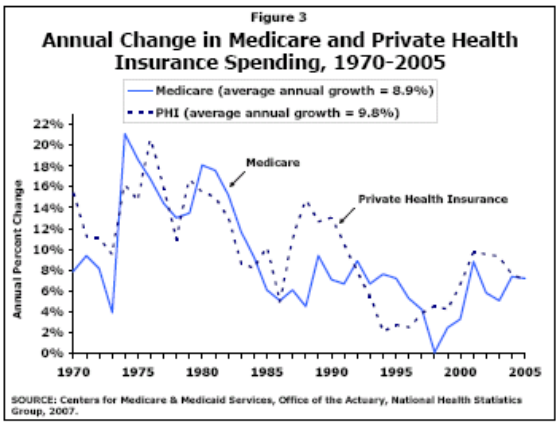

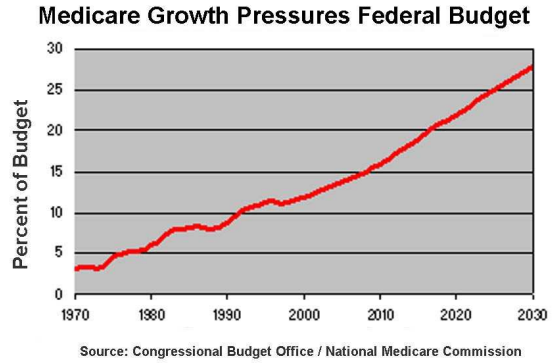

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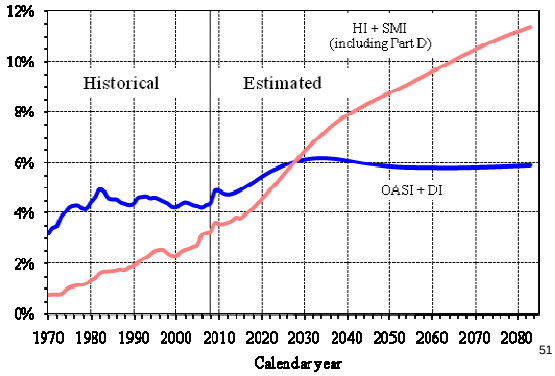
SS and Medicare Costs as % of GDP



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2009 Medicare Trust Fund Report

http://ssaonline.us/OACT/TRSUM/index.html

- Assets (end of 2007) $326 billion
- Income 2008 $231 billion
- Expenditures $236 billion
- Net change in assets $-5 billion

- Trust fund estimates that:
  - Assets will fall below 100% of spending in 2011
  - Trust fund exhausted by 2017 – 2 years earlier than originally thought

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Medicare Sources as % of GDP

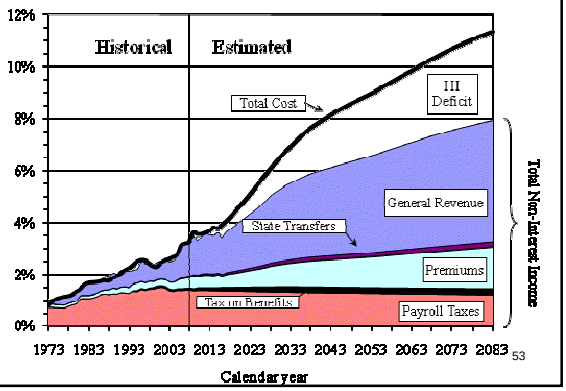

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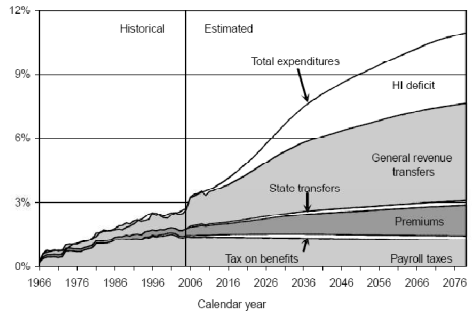
Figure II.D2.—Medicare Sources of Non-Interest Income and Expenditures as a Percentage of the Gross Domestic Product



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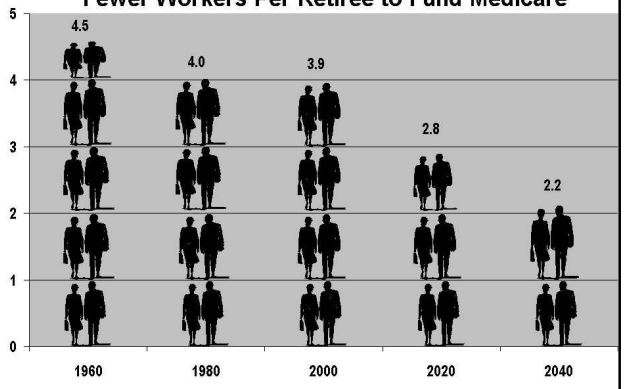
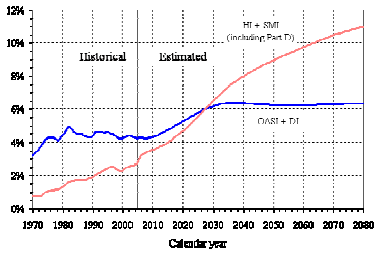
Fewer Workers Per Retiree to Fund Medicare



Source: Health Care Financing Administration

Chart B-Social Security and Medicare Cost as a Percentage of GDP



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What are the options?

- Increase revenues by
  - Higher payroll taxes
  - More means-testing of premiums
- Reduce costs by
  - Reducing benefits
  - Reducing growth in costs (HMO-style)
  - Cost saving technology
  - Increase retirement age
  - Means-test benefits

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Projected revenues needed under different Scenarios, now until 2030

- Current conditions: 108%
- Hold HC costs increased to CPI: 83%
- Raise eligible age to 67: 101%
- Raise eligible age to 70: 87%
- Institute $300 Part B deductible: 99%

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Options to maintain solvency over next 75 years

- Raise payroll tax immediately from 2.9% to 6.78%
- Immediate 53 percent reduction in program outlays
  - or some combination of the two

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