Medicare and Medicaid: A Brief Introduction

ECON 40565

Fall 2007

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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 this section, 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**
- **Medicaid -- Insurance for**
  - **Poor**
  - **Low income elderly**
  - **Blind/Disabled**
  - **Long term care**

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Insurance

- **Medicaid provides insurance to around 40 million people each year**
  - **Many are eligible for only a short time**
  - **Enter and exit welfare**
- **Medicare about another 40 million**

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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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The first Medicare recipient?

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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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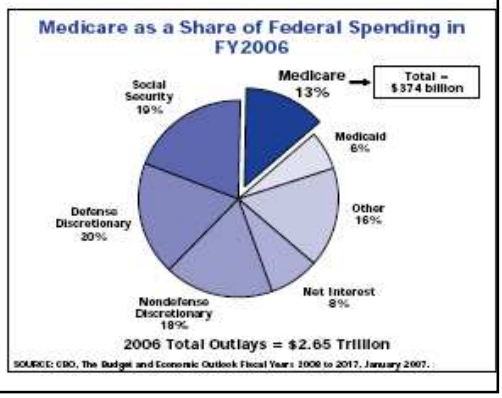
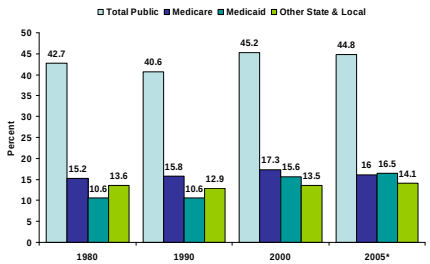


Table 3.1
Public Payors' Share of National Health Spending, 1980-2005

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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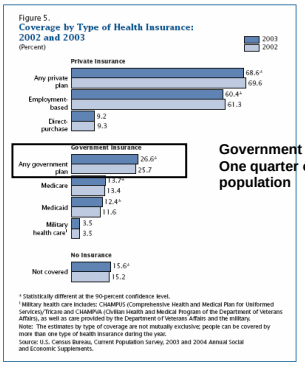


Government insures
One quarter of the population

Basics of Medicaid

- Federally mandated program that is run by the states
  - 51 different Medicaid programs
- Federal government determines
  - Minimum eligibility requirements (e.g., TANF recipients are by definition eligible)
  - Minimum benefit levels
- States determine
  - Eligibility
  - Scope of services
  - Payments rates for services
  - Administration of plan
- States can expand on federal mandates, they cannot restrict them

Eligibility

- Two ways to become eligible
  - Categorical eligibility
    - If you are on particular federal income transfer programs, you are automatically eligible
      - TANF (welfare)
      - Supplemental Security Income (Disability insurance)
  - Income/asset tests
    - Used for special groups
      - Children with low income
      - Pregnant women with low income
      - Elderly w/ high expenses or low income

Table 3.31
Medicaid Beneficiaries by Eligibility Group, 1975-2001

Children historically represent the largest eligibility group of Medicaid beneficiaries.

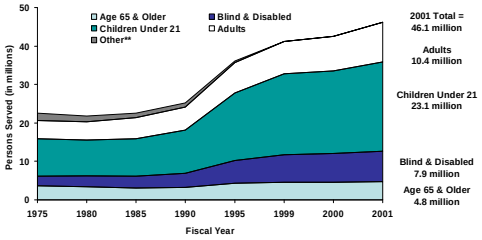
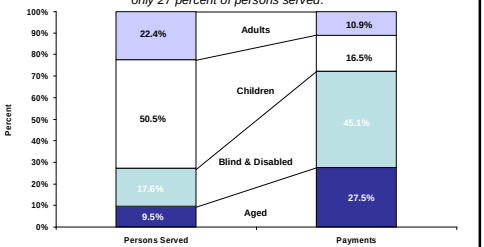


Chart 22
Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 2000

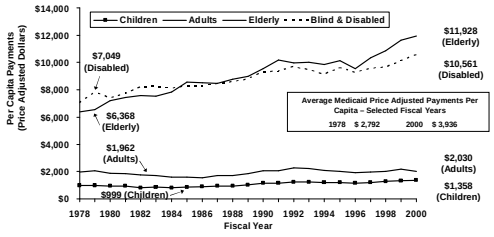
Payments for the elderly, blind and disabled account for 73 percent of total payments and only 27 percent of persons served.



Note: (1) "Payments" describe direct Medicaid provider payments and Medicaid program expenditures for premium payments to third parties for managed care, as well as cost sharing on behalf of persons served who are dually enrolled in Medicaid and Medicare, but exclude DSH payments and Medicare premiums. (2) This chart excludes 3.7 million persons served with "unknown" basis of eligibility and 6.5 billion expenditures on behalf of persons served with "unknown" basis of eligibility in FY 2000. If included in the total above, "unknown" Medicaid persons served would have comprised about 9 percent of total persons served and about 4 percent of total

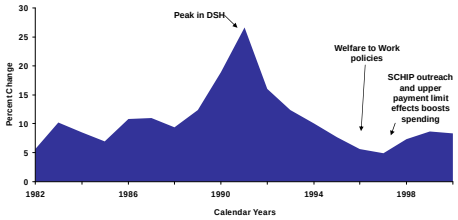
Chart 25
Average Medicaid Payments per Person Served in Price Adjusted Dollars, Fiscal Years 1978-2000

Per capita payments for the elderly and individuals with disabilities experienced larger growth between 1978 and 2000 than per capita expenditures for children and adults.



Growth in Medicaid Spending

Changing Medicaid eligibility rules and a spillover effect from outreach efforts under SCHIP led to increasing Medicaid spending in 1998 and 1999 followed by stabilization in 2000.



Note: DSH is disproportionate share hospital. SCHIP is the State Children's Health Insurance Program. For a discussion of changing eligibility policies, see K. Levit et al., "Health Spending in 1998: Signals of Change," *Health Affairs* (Jan/Feb 2000): 124-132.

Source: CMS, Office of the Actuary , National Health Statistics Group.

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Chart 15
Medicaid Expenditure Trends, in Price Adjusted Terms, Fiscal Years 1978-2001

Federal Medicaid spending grew at an average annual rate of 3.2 percent in the 1980s. In the early 1990s, outlay growth increased to 13.5 percent on average, tapering off to about 3 percent in the second half of the decade.

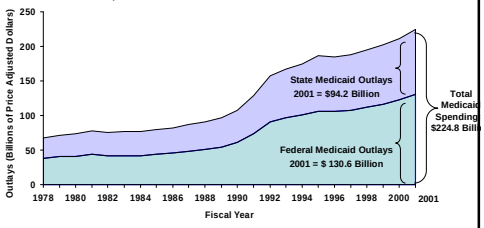

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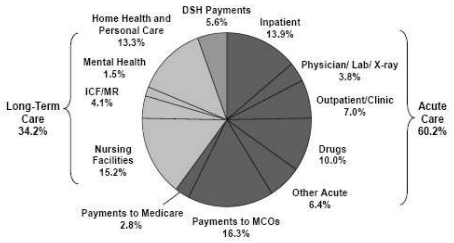
Figure 4

Medicaid Expenditures by Service, 2005



Total = $305.3 billion

SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Financing of Medicaid

- **Financed jointly by Feds and states**
  - **Both paid for out of general revenues**
- **Reimbursement rates across states vary depending on per capita income of state**

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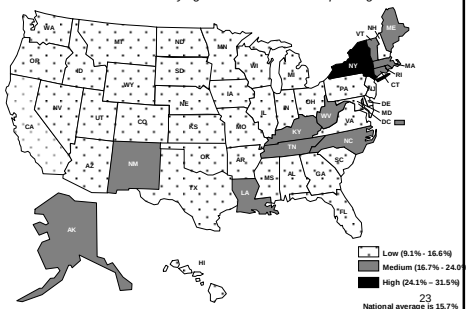
Table 3.41
Share of State Health Spending Financed by Medicaid, 1998

Medicaid finances a varying share of State health spending.



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SCHIP

- **State Children's Health Insurance Plan**
- **Designed to provide health insurance to children not poor enough for Medicaid but too poor to purchase health insurance**
- **States given autonomy to run program. Can use funds to**
  - **Run independent program**
  - **Use funds to expand Medicaid to include more kids**

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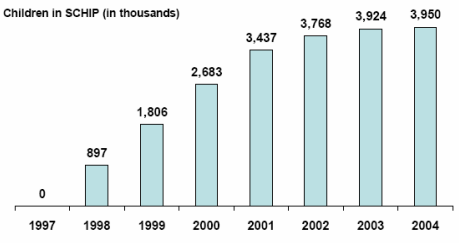
Figure 2

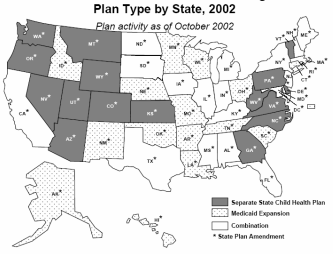
U.S. SCHIP Enrollment of Children
December of Each Year,1997 to 2004



Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured

KAISER COMMISSION ON Medicaid and the Uninsured

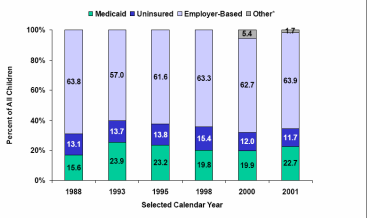
Table 3.36
State Children's Health Insurance Program
Plan Type by State, 2002
Plan activity as of October 2002



Number of Approved Separate State Child Health Plans: 16 (AZ, CO, DE, GA, KS, MT, NC, NV, OR, PA, UT, VT, VA, WA, VW, WY)
Number of Approved Medicaid Expansions: 21 (AK, AS, AR, CNMI, DC, GU, HI, ID, LA, MN, MO, NE, MN, OH, OK, PR, RI, SC, TN, VI, WI)
Number of Approved Combination Plans: 19 (AL, CA, CT, FL, IA, IL, IN, KY, MA, MD, ME, MI, MS, ND, NH, NJ, NY, SC, TX)

Source: CMS Center for Medicaid and State Operations.

Table 3.34
Health Insurance Coverage of Children, 1988-2001
The percentage of children without health insurance is declining.



*Other includes private non-group and other public insurance.
Notes: About 21% of children below poverty (or 2.5 million kids) had no health insurance in 2001.
Source: CMS, Office of Research, Development and Information and U.S. Bureau of the Census, March *Current Population Survey*.

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**

- **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.**

- **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**

Medicare Advantage

- **BBA 2003 restructured Part C**
- **Created region Preferred Provider Organizations and Special Needs Plans for dual eligible**
- **Increased payments to plans to encourage enrollment**

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How financed (2006)

- **County benchmarks established based on**
  - **prior year's MA enrollment**
  - **National growth in Medicare spending**
- **Plans bid to provide service, must tale all comers at posted prices**
- **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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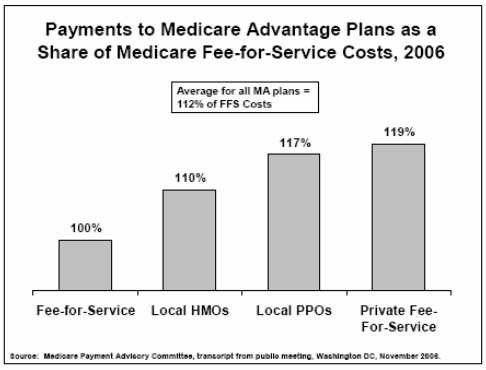

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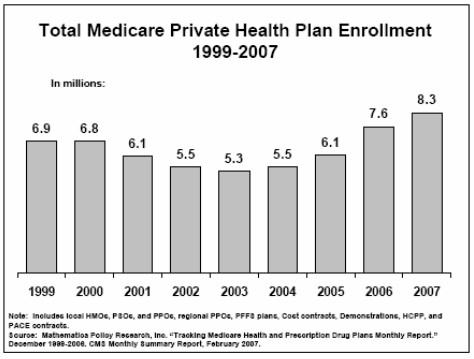

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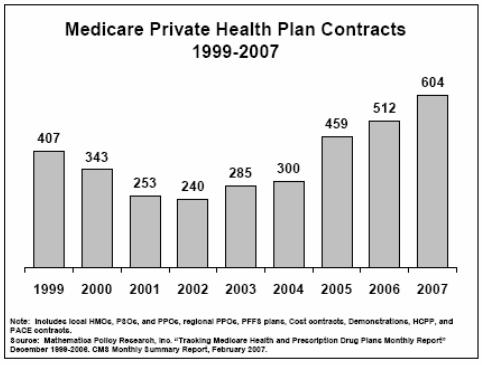

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- **Part D: Prescription drugs**
  - **Set to start January 2006**
  - **Voluntary**
  - **must pay premium to join**
  - **Will discuss at length in a minute**

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How is Medicare Financed?

- **Part A**
  - **Payroll tax**
    - **2.9% of all earnings**
    - **Employers/employees share equally**
  - **Annual reserves placed in the Hospital Insurance Trust Fund**
    - **Currently, revenues > costs**
    - **In not to distant future, Costs>revenues and trust fund will be exhausted**

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- **Part B**
  - **Monthly premiums**
    - **Currently set at $78.20**
  - **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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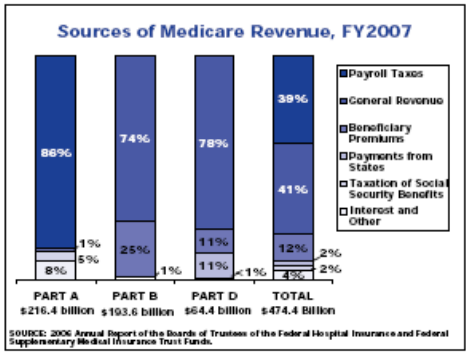

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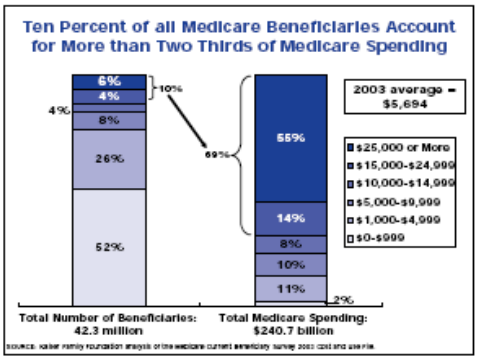

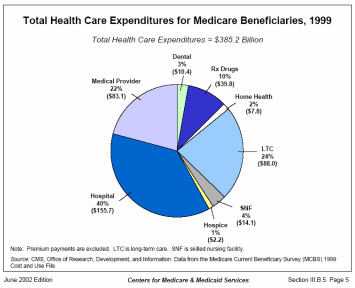

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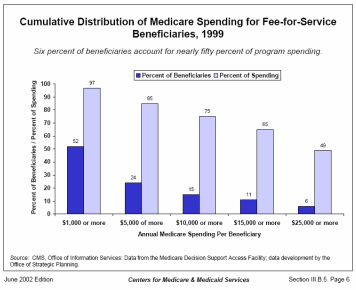

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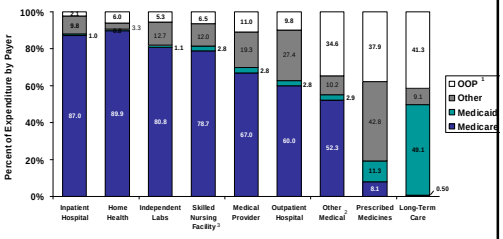
Cost sharing in Medicare

- **Part A**
  - **$992 copayment for the 1st stay in a benefit period**
  - **Days 1-60 fully covered**
  - **61-90 $248 copay**
  - **Zip after 90 days**
- **Part B**
  - **Monthly premium of $93.50 (If Income>$80K or $160K for a couple, pay higher premium)**
  - **$131 annual deductible**
  - **20% coinsurance on physician services, outpatient care, ambulatory surgical, preventive**
  - **50% coinsurance on outpatient mental health**
  - **No coinsurance on lab services**

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.



Motivation for Part D

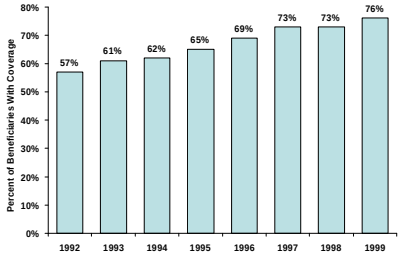
- **Rx important in medical treatment of elderly**
  - **Seniors represent 13% of the population**
  - **1/3 of all scripts**
  - **42% of spending on Rx drugs**
- **Among the elderly, 85% receive a Rx during the year**
- **Growing fraction w/ Rx Coverage**
- **Purchased through**
  - **Retiree benefits**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

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**

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.



- **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**

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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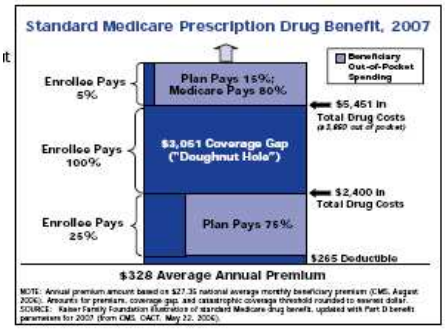

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- Most plans
  - Skip the coinsurance and have copays instead
  - Do not have a deductible
- Avg Monthy premium is $27.35 ($9.50-$135.70)
  - Premiuns increase 1%/month if you wait to enroll
- Low income can receive assistance
- Plans not required 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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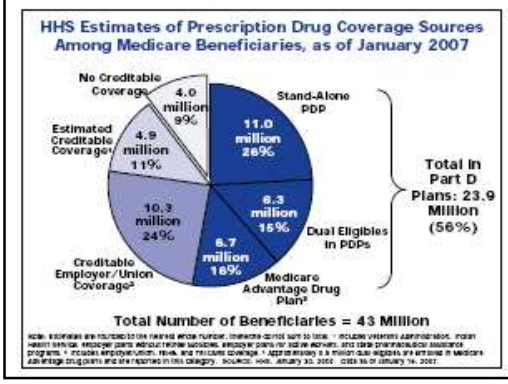

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Costs?

- 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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Research Issues

- **Future changes in drug costs**
  - **Private carriers required to bargain with Rx manufacturers over price**
  - **Help constrain costs?**
- **Rx manufacturers worried the cost reductions will hurt innovation**
- **Fed's interactions w/ states**
  - **Many seniors are on Medicaid – 'dually eligible'**
  - **Receive Rx coverage through Medicaid**
  - **Now Medicare will pick up Rx tab**
  - **Medicare taxes states for the amount they would have paid**

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The Future of Medicare

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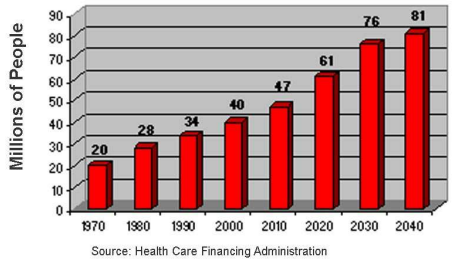
Medicare Enrollment Soars



Source: Health Care Financing Administration

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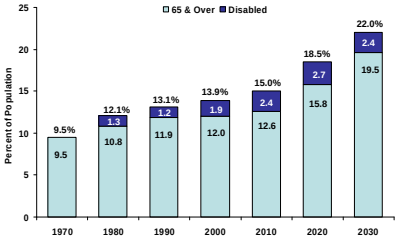
Table 3.7
Medicare Beneficiaries as a Share of the U.S. Population, 1970-2030

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



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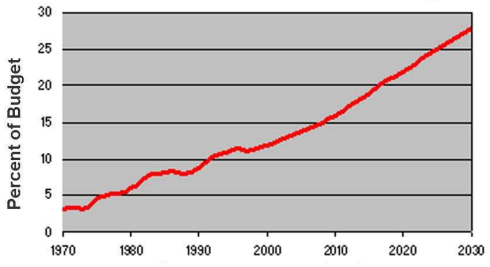
Medicare Growth Pressures Federal Budget



Source: Congressional Budget Office / National Medicare Commission

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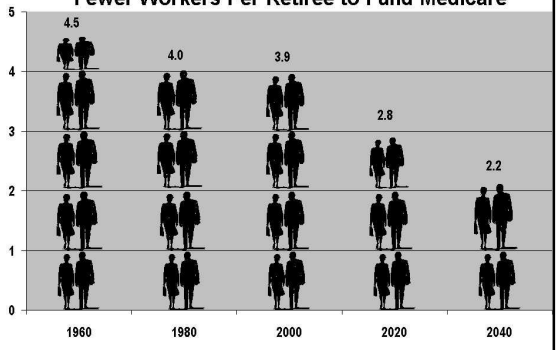
Fewer Workers Per Retiree to Fund Medicare



Source: Health Care Financing Administration

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

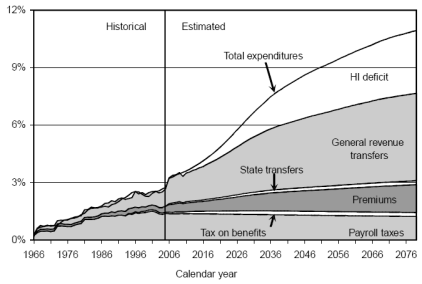


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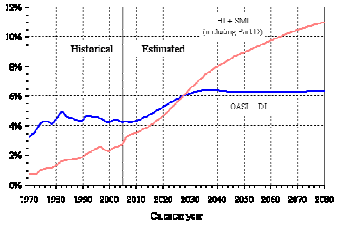
Chart B-Social Security and Medicare Cost as a Percentage of GDP



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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, 1998-2030

- 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 for finance: Solvency in 2030

- Raise payroll tax from 2.9 to 4.84%
- Raise income taxes on all brackets by 8.3%

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