A Brief Introduction to Medicare

Health Economics
Bill Evans

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

Definitions

- Entitlements
  - Available to all who qualify
  - For 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

Federal government is the largest single provider of health insurance in the country

- Medicare
- Medicaid
- Veteran’s Benefits
- Military Insurance

In these next 2 weeks, we will discuss the first two

Size of these programs make them important to consider
• 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

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

Importance of M&M
• Large fraction of Federal/State spending
• Large fraction of Health care spending
• Large Fraction of all people with insurance
Part A

- Hospitalization coverage
- Mandatory
- Provides coverage for
  - Inpatient
  - Short-term rehabilitation (post hospital) care
  - Hospice
- Financed by
  - Medicare tax
  - General revenues

Table 8. Coverage by Type of Health Insurance: 2010 and 2011

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any private plan</td>
<td>64.0</td>
<td>63.9</td>
</tr>
<tr>
<td>Any private plan alone</td>
<td>52.5</td>
<td>52.0</td>
</tr>
<tr>
<td>Employment-based</td>
<td>50.5</td>
<td>55.1</td>
</tr>
<tr>
<td>Employment-based alone</td>
<td>45.7</td>
<td>45.1</td>
</tr>
<tr>
<td>Direct-purchased</td>
<td>9.9</td>
<td>9.8</td>
</tr>
<tr>
<td>Direct-purchased alone</td>
<td>3.7</td>
<td>3.6</td>
</tr>
<tr>
<td>Any government plan</td>
<td>31.2</td>
<td>32.2</td>
</tr>
<tr>
<td>Any government plan alone</td>
<td>19.7</td>
<td>20.4</td>
</tr>
<tr>
<td>Medicare</td>
<td>14.6</td>
<td>15.2</td>
</tr>
<tr>
<td>Medicare alone</td>
<td>4.7</td>
<td>4.9</td>
</tr>
<tr>
<td>Medicaid</td>
<td>15.8</td>
<td>16.5</td>
</tr>
<tr>
<td>Medicaid alone</td>
<td>11.1</td>
<td>11.5</td>
</tr>
<tr>
<td>Military health care</td>
<td>4.2</td>
<td>4.4</td>
</tr>
<tr>
<td>Military health care alone</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Uninsured</td>
<td>18.3</td>
<td>18.7</td>
</tr>
</tbody>
</table>

Health Care Expenditures, 2011

- Medicare, 21.8%
- Other health insurance, 33.2%
- Private health insurance, 25.3%
- Out of pocket, 13.1%
- Other 3rd parties, 11.6%
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.
• Financed in part by general revenues

Part C

• Medicare+Choice
• Created in 1997
• Alternative to traditional A+B coverage
• Private insurance companies cover seniors/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 traditional A+B coverage

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
• Payments to MA greatly reduced by ACA

Part D: Prescription drugs

• Set to start January 2006
• Voluntary
• must pay premium to join
• Will discuss at length in a minute
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

• 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
Cost sharing in Medicare, 2012

- **Part A**
  - $1156 deductible
  - Days 1-60 no copay
  - 61-90 $289 copay
  - $578 for days 91-150
  - Zip after 150 days
  - Monthly premium of $451 for people w. < 30 quarters of qualified earnings

- **Part B**
  - Monthly premium of $99.9 (If Income>85K or $170K for a couple, pay higher premium)
  - $140 annual deductible
  - 20% coinsurance on physician services, outpatient care, ambulatory surgical, preventive
  - No coinsurance on lab services

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

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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent of Beneficiaries With Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>17%</td>
</tr>
<tr>
<td>1993</td>
<td>41%</td>
</tr>
<tr>
<td>1994</td>
<td>62%</td>
</tr>
<tr>
<td>1995</td>
<td>65%</td>
</tr>
<tr>
<td>1996</td>
<td>73%</td>
</tr>
<tr>
<td>1997</td>
<td>73%</td>
</tr>
<tr>
<td>1998</td>
<td>76%</td>
</tr>
<tr>
<td>1999</td>
<td>76%</td>
</tr>
</tbody>
</table>

- 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 (2003)

<table>
<thead>
<tr>
<th>Drug</th>
<th>What it treats?</th>
<th>Annual cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipitor</td>
<td>Cholesterol</td>
<td>$871</td>
</tr>
<tr>
<td>Novasc</td>
<td>Calcium</td>
<td>$549</td>
</tr>
<tr>
<td>Fosamax</td>
<td>Bone density</td>
<td>$894</td>
</tr>
<tr>
<td>Prilosec</td>
<td>Anti-ulcer</td>
<td>$1,684</td>
</tr>
<tr>
<td>Celebrex</td>
<td>Rheu. Arth.</td>
<td>$2,102</td>
</tr>
</tbody>
</table>

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
Most plans
- Skip the coinsurance and have copays instead
- Do not have a deductible
- Avg Monthly premium is about $30 ($10-$140)
  - Premiums 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

Costs?
- Original CBO estimates (Costs – revenues such as premiums and kickbacks from states)
  - $495 billion in 2004-2013
- Second set of numbers
  - $593 billion in 2004-2013
- Third set of estimates
  - $640 billion in 10 years
- Actual numbers were $410 billion
Savings?

- Increased use of generics
- Reduced growth of Rx prices
- Competition?
  - Part D is primarily provided by private providers

Offsets?

- Virtually all seniors now have Rx coverage
- Rx use way up
- Has access to Rx coverage reduced hospitalization rates?
- CMS has reduced Medicare’s 10-year projected costs by $137 billion
  - Much of it due to Medicare part D
The Future of Medicare

Medicare

- 2010
- 47 million recipients
- $524 bill. exp.
- 3.2% of GDP
- 16% of fed. budget

- 2040
- 87 million recipients
- 6% of GDP

Unfunded portion of Medicare will equal 2% of GDP.
Future problems

- Rising costs
- Rising number of elderly
- People are living longer
  - Older people spend a lot more on health care
- Falling fraction of people to tax
Per Person Health Care Spending, 2004

<table>
<thead>
<tr>
<th>Age group</th>
<th>Per Person Health Care Spending, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-18</td>
<td>$2,650</td>
</tr>
<tr>
<td>19-44</td>
<td>$3,370</td>
</tr>
<tr>
<td>45-54</td>
<td>$5,210</td>
</tr>
<tr>
<td>55-64</td>
<td>$7,887</td>
</tr>
<tr>
<td>65-74</td>
<td>$10,778</td>
</tr>
<tr>
<td>75-84</td>
<td>$16,389</td>
</tr>
<tr>
<td>85+</td>
<td>$25,691</td>
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</tbody>
</table>

Ratio: 20-64 Population/Medicare

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
</tr>
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<tbody>
<tr>
<td>1970</td>
<td>5.5</td>
</tr>
<tr>
<td>1980</td>
<td>4.7</td>
</tr>
<tr>
<td>1990</td>
<td>4.5</td>
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<tr>
<td>2000</td>
<td>4.3</td>
</tr>
<tr>
<td>2010</td>
<td>4.0</td>
</tr>
<tr>
<td>2020</td>
<td>3.2</td>
</tr>
<tr>
<td>2030</td>
<td>2.6</td>
</tr>
<tr>
<td>2040</td>
<td>2.5</td>
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