MEDICARE

A PRIMER

2010

THE HENRY J. KAISER FAMILY FOUNDATION

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INTRODUCTION

Established in 1965, Medicare is a social insurance program, like Social Security, that provides health and financial security for individuals age 65 and older and for younger people with permanent disabilities. Prior to 1965, roughly half of all seniors lacked medical insurance; today, virtually all seniors have health insurance under Medicare. Medicare provides health insurance coverage to 47 million people – 39 million people age 65 and older and another 8 million people with permanent disabilities who are under age 65. The program helps to pay for many important health care services, including hospitalizations, physician services, and prescription drugs. Individuals contribute payroll taxes to Medicare throughout their working lives and generally become eligible for Medicare when they reach age 65, regardless of their income or health status.

Comprising an estimated 12 percent of the federal budget and 20 percent of total national health expenditures, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and health care spending in the U.S.[1] With the dual challenges of providing needed and increasingly expensive medical care to an aging population and keeping the program financially secure for the future, discussions about Medicare are likely to remain prominent on the nation's agenda in the years ahead.

[1] The Medicare share of the federal budget is from Office of Management and Budget (OMB), Budget of the U.S. Government, Fiscal Year 2011, February 2010. The Medicare share of national health expenditures is from Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT), National Health Expenditure Projections 2009-2019, February 2010.

MEDICARE: A PRIMER

What is Medicare? 1
Medicare is a federal entitlement program that provides health insurance coverage to 47 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.

Who is eligible for Medicare? 2
Individuals become eligible for Medicare when they reach age 65, if they or their spouse made payroll tax contributions for 10 or more years. People under age 65 qualify for Medicare after 24 months of receiving Social Security Disability payments, or if they have end-stage renal disease or Lou Gehrig's disease.

What are the characteristics of people with Medicare? 3
Medicare covers a diverse population. Most people with Medicare live on modest incomes and many have multiple chronic conditions.

What does Medicare cover and how much do beneficiaries pay for benefits? 5
Medicare covers basic health services, including hospital stays, physician visits, and prescription drugs. Most benefits are subject to deductibles and cost-sharing requirements. Medicare does not cover most long-term care services, vision or dental care, or hearing aids.

What is the Medicare prescription drug benefit? 7
Medicare helps cover the cost of prescription drugs offered through private drug plans. As of 2010, more than half of all beneficiaries are enrolled in a Part D drug plan, and 90 percent of all beneficiaries have some source of drug coverage.

What is Medicare Advantage? 9
Medicare Advantage plans are private health plans that receive payments from Medicare to provide Medicare-covered benefits to enrollees. As of 2010, nearly one-fourth of all beneficiaries are enrolled in a Medicare Advantage plan.

What types of supplemental insurance do beneficiaries have? 11
Most beneficiaries have some type of supplemental insurance to help pay Medicare's cost-sharing requirements and fill gaps in Medicare's benefit package. Sources of supplemental insurance include employer-sponsored insurance, state Medicaid programs (for those with limited incomes and assets), Medigap policies, and Medicare Advantage plans.

How do Medicare beneficiaries fare with respect to access to care? 13
The enactment of Medicare dramatically improved access to care for millions of elderly Americans. Beneficiaries generally enjoy broad access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures.

How much does Medicare cost and how is the money spent? 14
Spending on Medicare is estimated to account for 12 percent of federal spending in 2010. Inpatient hospital services comprise the largest share of Medicare benefit payments (27 percent), followed by payments to Medicare Advantage plans (24 percent) and physicians and other suppliers (18 percent), while the drug benefit accounts for 11 percent of total payments.

How is Medicare financed? 17
Funding for Medicare comes primarily from general revenues (40 percent), payroll taxes (38 percent), and premiums paid by beneficiaries (12 percent).

What are Medicare's future financing challenges? 18
With rising health care costs, an aging population, and a declining ratio of workers-to-retirees, financing care for future beneficiaries remains a challenge.

Medicare Benefits and Cost-Sharing Requirements, 2010 20

Age and Income Among Medicare Beneficiaries, 2008 21

Prescription Drug Coverage Among Medicare Beneficiaries, 2009 22

WHAT IS MEDICARE?

Medicare is the nation's health insurance program for Americans age 65 and older, and for younger adults with permanent disabilities.

Established in 1965 under Title XVIII of the Social Security Act, Medicare was initially established to provide health insurance to individuals age 65 and older, regardless of income or medical history. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities receiving Social Security Disability Insurance payments and people suffering from end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). As of 2010, 47 million people rely on Medicare for their health insurance coverage: 39 million people age 65 and over and 8 million people under age 65 with disabilities.

Medicare consists of four parts, each covering different benefits.

PART A, also known as the Hospital Insurance (HI) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is funded by a tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). In 2009, Part A accounted for approximately 36 percent of total Medicare benefit spending.[2] An estimated 45.6 million people were enrolled in Part A in 2009.

PART B, the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, home health, and preventive services. Part B is funded by general revenues and beneficiary premiums ($110.50 per month in 2010; $96.40 per month for beneficiaries held harmless from the premium increase – *see page 5 for additional information*). In 2009, Part B accounted for 27 percent of total benefit spending.[3] Medicare beneficiaries who have higher annual incomes (over $85,000 per individual; $170,000 per couple in 2010) pay a higher, income-related monthly Part B premium, ranging from $154.70 to $353.60 in 2010 depending on income. Part B is voluntary; some people age 65 and older (such as those with employer-sponsored health coverage) delay enrollment until they retire. An estimated 42.4 million people were enrolled in Part B in 2009.

PART C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed, and accounted for 23 percent of benefit spending in 2009. As of February 2010, 11.4 million beneficiaries are enrolled in Medicare Advantage plans.[4]

PART D is the outpatient prescription drug benefit, delivered through private plans that contract with Medicare, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. Authorized by the Medicare Modernization Act of 2003 (MMA) and launched in 2006, Part D plans are required to provide a "standard" benefit (or one that is equivalent) and may provide enhanced benefits. Individuals with modest income and assets are eligible for additional assistance with premiums and cost-sharing amounts. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 10 percent of benefit spending in 2009. As of February 2010, 27.6 million beneficiaries are enrolled in a Part D plan, 17.7 million of whom are enrolled in stand-alone PDPs.[5]

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[2] Congressional Budget Office (CBO), Medicare Baseline, March 2009.
[3] CBO, Medicare Baseline, March 2009.
[4] Centers for Medicare & Medicaid Services (CMS), Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations Monthly Summary Report, February 2010.
[5] CMS, Monthly Summary Report, February 2010.

WHO IS ELIGIBLE FOR MEDICARE?

Most people age 65 and older are automatically entitled to Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years (40 quarters).

Individuals age 65 and over qualify for Medicare if they are U.S. citizens or permanent legal residents. Individuals do not need to meet an income or asset test to qualify for Medicare, and qualify without regard to their medical history or preexisting conditions. Adults under age 65 with permanent disabilities are eligible for Medicare after receiving Social Security Disability Income (SSDI) payments for 24 months, even if they have not made payroll tax contributions for 40 quarters. People with end-stage renal disease (ESRD) or Lou Gehrig's disease are eligible for Medicare benefits as soon as they begin receiving SSDI payments, without having to wait 24 months. Individuals who are entitled to Part A do not pay premiums for covered services. Individuals age 65 and over who are not entitled to Part A, such as those who did not pay enough Medicare taxes during their working years, can pay a monthly premium to receive Part A benefits.

Individuals entitled to Part A and others age 65 and older may elect to enroll in Part B.

Part B is voluntary, but about 95 percent of beneficiaries with Part A are also enrolled in Part B. For most individuals who become entitled to Part A, enrollment in Part B is automatic unless the individual declines enrollment. Individuals age 65 and older who are not entitled to Part A may enroll in Part B. With the exception of the working aged (or their spouses) who may delay enrollment if they receive employment-based coverage, those who do not sign up for Part B when they are first eligible typically pay a penalty for late enrollment, in addition to the regular monthly premium, for the duration of their enrollment in Part B.

Individuals are eligible for Part C, or Medicare Advantage, if they are entitled to Part A and enrolled in Part B.

Beneficiaries may generally elect to enroll in a Medicare Advantage (MA) plan on an annual basis between November 15 and March 31 of the following year.

Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Part A and/or enrolled in Part B.

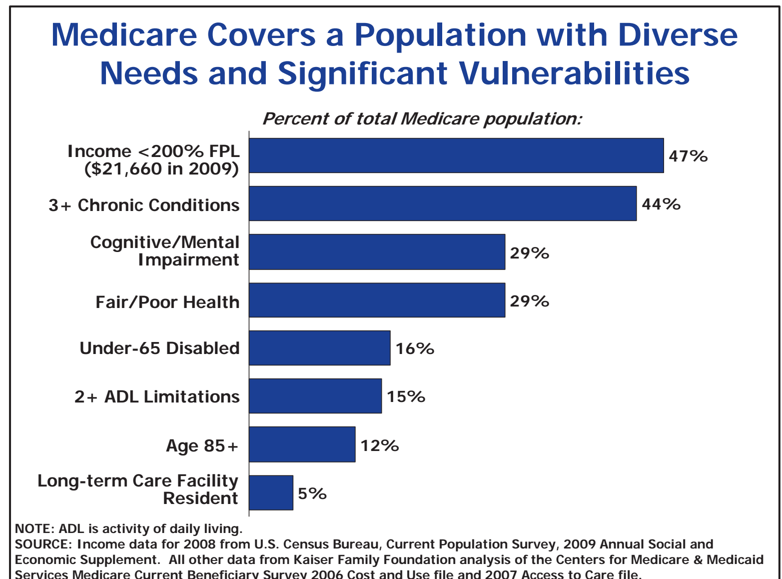
To get Part D benefits, beneficiaries must enroll in a stand-alone prescription drug plan (PDP) or Medicare Advantage prescription drug (MA-PD) plan. The enrollment period runs from November 15 to December 31 of each year for stand-alone prescription drug plans, and from November 15 through March 31 of the following year for Medicare Advantage drug plans. Similar to Part B, there is a permanent premium penalty for late enrollment for individuals who go for an extended period of time without drug coverage that is at least comparable to the Part D standard benefit ("creditable coverage").

WHAT ARE THE CHARACTERISTICS OF PEOPLE WITH MEDICARE?

Medicare covers a population with diverse needs and circumstances. While many beneficiaries enjoy good health, a quarter or more have serious health problems and live with multiple chronic conditions, including cognitive and functional impairments.

Many Medicare beneficiaries live on modest incomes and most depend on Social Security as their primary source of income.

Almost half of all Medicare beneficiaries (47 percent) have an income below 200 percent of poverty ($21,660/individual and $29,140/couple in 2009), and 16 percent have an income below 100 percent of the poverty level.



There is a high prevalence of chronic conditions, cognitive impairments, and functional limitations among the Medicare population.

More than four in ten Medicare beneficiaries (44 percent) live with three or more chronic conditions. Among the most common conditions are hypertension and arthritis.

More than a quarter (29 percent) of all beneficiaries have a cognitive or mental impairment that limits their ability to function independently.

Approximately one in seven (15 percent) beneficiaries has multiple functional limitations, as defined as two or more limitations in activities of daily living (ADLs), such as eating or bathing.

Although the majority of the Medicare population is age 65 or over, 16 percent are under age 65 and permanently disabled.

These individuals tend to have lower incomes than other beneficiaries. About 40 percent are dually eligible for both Medicare and Medicaid. Because of their disabilities, they tend to have relatively high rates of health problems, including functional limitations and cognitive impairments.

Most beneficiaries live at home, but 5 percent live in a long-term care setting.

Five percent of Medicare beneficiaries (2.2 million) live in a long-term care setting, such as a nursing home or assisted living facility, but a larger share of beneficiaries who are age 85 or older do so (19 percent).[6] Two-thirds of beneficiaries living in long-term care settings are women, and nearly 60 percent are dually eligible for Medicare and Medicaid.

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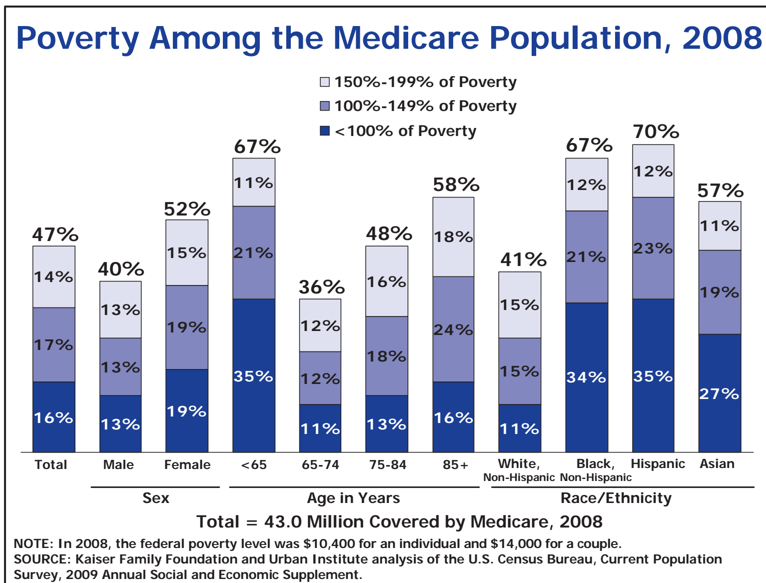
[4] Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use file, 2006.

Nearly half of all Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL), but poverty rates are especially high among those in racial/ethnic minority groups, women, people under age 65 with disabilities, and those ages 85 and older.

Race/ethnicity: Two-thirds of all African American beneficiaries and seven in ten Hispanic beneficiaries live on incomes below twice the poverty level, compared to 41 percent of White beneficiaries. Approximately one-third of African-American and Hispanic beneficiaries have incomes below the poverty level, more than three times the share of White beneficiaries (11 percent).

Age: Two-thirds of all Medicare beneficiaries with disabilities under age 65 live on incomes below twice the poverty level, and more than one-third live in poverty. Among people on Medicare age 65 and older, poverty rates increase with age. Nearly six in ten beneficiaries age 85 and older have annual incomes below twice the poverty level.

Sex: Poverty rates are substantially higher among women on Medicare than men. More than half of all female Medicare beneficiaries live on an annual income below twice the poverty level, substantially higher than the rate for men.



WHAT DOES MEDICARE COVER AND HOW MUCH DO BENEFICIARIES PAY FOR BENEFITS?

Medicare provides coverage of basic health services including care in hospitals and other settings, physician services, diagnostic tests, preventive services, and an outpatient prescription drug benefit. Beneficiaries generally pay varying deductibles and coinsurance amounts that are indexed to rise annually to keep pace with increases in program costs. ***(See page 19 for more detail about Medicare benefits and cost-sharing requirements for 2010.)***

PART A helps pay for inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities, and also covers hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility.

- Most beneficiaries do not pay a monthly premium for Part A services, but are subject to a deductible before Medicare coverage begins. In 2010, the Part A deductible for each "spell of illness" is $1,100 for an inpatient hospital stay.
- Beneficiaries are generally subject to a coinsurance for benefits covered under Part A, including extended inpatient stays in a hospital ($275 per day for days 61-90 in 2010) or skilled nursing facility ($137.50 per day for days 21-100 in 2010). There is no copayment for home health visits.

PART B helps pay for outpatient services, such as outpatient hospital care, physician visits, and other medical services, including preventive services such as mammography and colorectal screening. Part B also covers ambulance services, clinical laboratory services, durable medical equipment (such as wheelchairs and oxygen), kidney supplies and services, outpatient mental health care, and diagnostic tests, such as x-rays and magnetic resonance imaging.

- Beneficiaries enrolled in Part B are generally required to pay a monthly premium ($110.50 in 2010). However, a majority of beneficiaries (73 percent) are not required to pay the higher Part B monthly premium because there was no cost-of-living increase in Social Security benefits for 2010; the 2010 Part B monthly premium for these beneficiaries is $96.40, the same as in 2009.[7] New enrollees, higher-income beneficiaries, and low-income beneficiaries (who are not required to pay the monthly Part B premium themselves) are not held harmless from the Part B premium increase. *(See page 12 for additional information on additional assistance for low-income beneficiaries through the Medicare Savings Programs [MSPs]).*
- Beneficiaries with annual incomes greater than $85,000 for an individual or $170,000 for a couple in 2010 pay a higher, income-related monthly Part B premium, ranging from $154.70 to $353.60. The income thresholds are indexed annually to rise with the rate of inflation, which limits the number of beneficiaries who would otherwise be subject to the higher premium over time.
- Part B benefits are subject to an annual deductible ($155 in 2010), and most Part B services are subject to a coinsurance of 20 percent.

PART C (Medicare Advantage) plans generally pay for all benefits covered under Medicare Part A, Part B, and Part D. Private fee-for-service plans are not required to cover prescription drugs. *(See pages 9-10 for additional information about Medicare Advantage.)*

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[7] Henry J. Kaiser Family Foundation, "The Social Security COLA and Medicare Part B Premium: Questions, Answers, and Issues", October 2009, http://www.kff.org/medicare/7912.cfm.

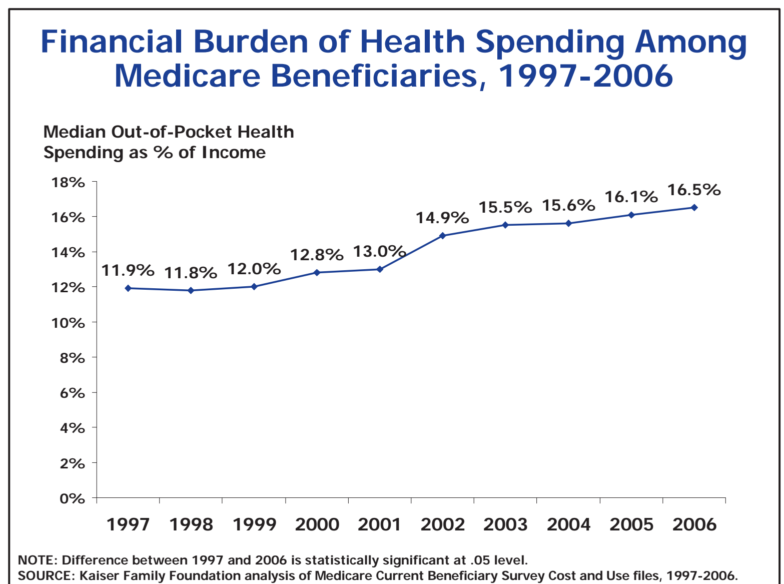
PART D helps pay for outpatient prescription drug coverage through private health plans. Plans are required to provide a "standard" benefit or one that is actuarially equivalent, and may offer more generous benefits. In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. *(See pages 7-8 for additional information about Part D.)*

Despite the important protections provided by Medicare, there are significant gaps in Medicare's benefit package.

Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities. Most notably, Medicare does not pay for custodial long-term care services either at home or in an institution, such as a nursing home or assisted living facility. Medicare also does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids.

In addition, Medicare has fairly high deductibles and cost-sharing requirements for covered benefits. Unlike typical large employer plans, Medicare does not have a stop-loss benefit that limits annual out-of-pocket spending. While many beneficiaries have supplemental insurance to help cover their Medicare-related expenses, they often pay premiums for supplemental coverage (including Medigap, Medicare Advantage plans, and employer-sponsored retiree health benefits). As a result, many beneficiaries face significant out-of-pocket costs for both premiums and non-premium expenses to meet their medical and long-term care needs. *(See pages 11-12 for additional information about supplemental insurance.)*

With health costs rising faster than income for Medicare beneficiaries, median out-of-pocket health spending as a share of income increased from 11.9 percent in 1997 to 16.5 percent in 2006.[8]



[8] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 1997-2006.

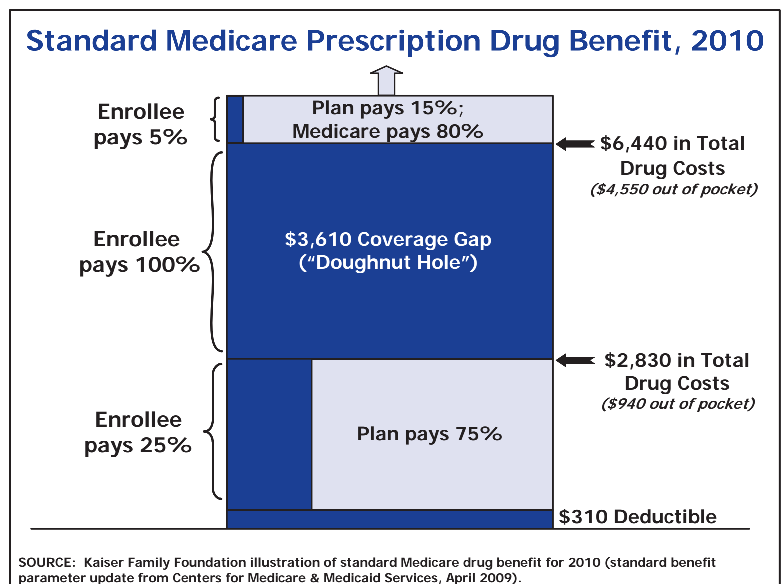
WHAT IS THE MEDICARE PRESCRIPTION DRUG BENEFIT?

Medicare beneficiaries have access to an outpatient prescription drug benefit (Part D) offered through private health plans, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs.

In 2010, 1,576 stand-alone prescription drug plans (PDPs) are available nationwide, up from 1,429 in 2006 (excluding the territories). Beneficiaries in most states have a choice of at least 45 stand-alone PDPs and multiple MA-PD plans.

Medicare Part D drug plans are required to offer either the standard benefit that is defined in law, or an alternative that is equal in value ("actuarially equivalent"). Plans can also offer enhanced benefits.

The standard benefit in 2010 has a $310 deductible and 25 percent coinsurance up to an initial coverage limit of $2,830 in total drug costs, followed by a coverage gap (the so-called "doughnut hole").



SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2010 (standard benefit parameter update from Centers for Medicare & Medicaid Services, April 2009).

Enrollees with at least $2,830 in total costs pay 100 percent of their drug costs until they have spent $4,550 out of pocket (excluding premiums). At that point, the individual pays 5 percent of the drug cost or a copayment ($2.50/generic or $6.30/brand for each prescription) for the rest of the year.

The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

In 2010, only 11 percent of PDPs offer the standard benefit, most charge copayments instead of 25 percent coinsurance, and 60 percent charge a deductible, with 36 percent charging the full $310 deductible amount.[9] Plans vary widely in terms of formularies (the list of covered drugs), the placement of drugs on formulary tiers, cost-sharing requirements, and utilization management tools (such as prior authorization requirements).

Most Part D plans have a coverage gap.

In 2010, 80 percent of PDPs offer no gap coverage, while for the 20 percent of PDPs offering gap coverage, this coverage is limited primarily to generic drugs only. An estimated 3.4 million Medicare beneficiaries (14 percent of all Part D enrollees) reached the coverage gap in 2007 and faced the full cost of their prescriptions.[10]

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[9] Hoadley J, Cubanski J, Hargrave E, Summer L, and Neuman T, "Medicare Part D Spotlight: Part D Plan Availability in 2010 and Key Changes Since 2006," Kaiser Family Foundation, November 2009, http://www.kff.org/medicare/7986.cfm.

[10] Hoadley J, Hargrave E, Cubanski J, and Neuman P, "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008, http://www.kff.org/medicare/7811.cfm.

Monthly Part D premiums are not uniform nationwide, but vary across plans and regions, and have increased significantly on average since 2006.

In 2010, the national average monthly Part D premium for all plans (including PDPs and MA-PD plans) is $31.94 (*unweighted* by enrollment). Actual PDP premiums vary across plans and regions, ranging from a low of $8.80 in Oregon and Washington to a high of $120.20 in Delaware, Maryland, and Washington, D.C.[11] The average *weighted* monthly PDP premium in 2010 (assuming beneficiaries remain in their current plan between 2009 and 2010) is $38.94.[12] This is an 11 percent increase from the weighted average monthly premium of $35.09 in 2009, and a 50 percent increase from $25.93 in 2006, the first year of the Medicare Part D drug benefit.

Individuals with modest incomes and assets are eligible for additional assistance with Part D premiums and cost-sharing requirements.

Beneficiaries with income below 150 percent of poverty ($16,245 for an individual; $21,855 for a couple in 2009) and limited assets ($12,510/individual; $25,010/couple in 2010) are eligible for the low-income subsidy (LIS), or "extra help", which helps pay for all or some of the Part D monthly premium, the annual Part D deductible, and prescription drug co-payments.

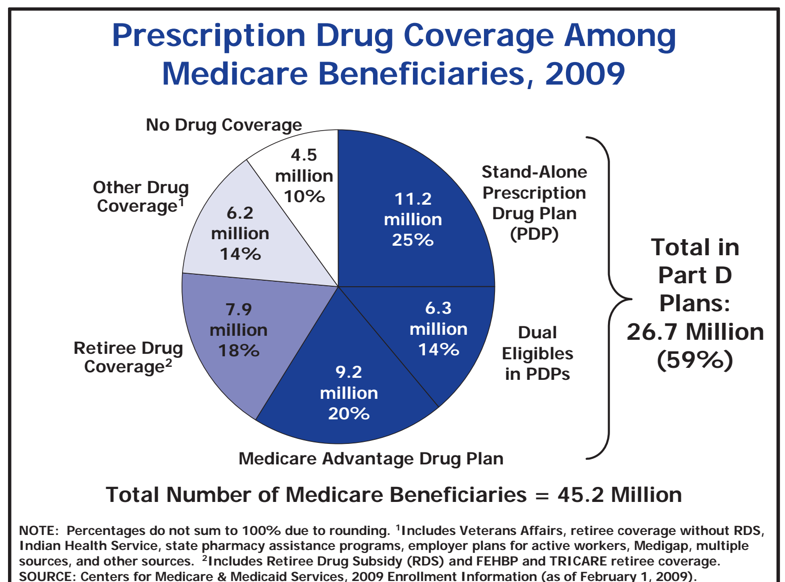
The Centers for Medicare & Medicaid Services (CMS) estimates that of the 12.5 million beneficiaries potentially eligible for low-income subsidies as of February 2009, 2.3 million beneficiaries (18 percent) were not yet receiving them.[13]

Approximately 90 percent of all Medicare beneficiaries have "creditable" prescription drug coverage.

More than 27 million Medicare beneficiaries are enrolled in a Part D plan, as of February 2010. Of this total, nearly two-thirds (64 percent) are enrolled in stand-alone prescription drug plans. This includes more than 6 million dual eligibles, many of whom were automatically enrolled in stand-alone drug plans.

Nearly 20 percent of all Medicare beneficiaries (7.9 million) receive prescription drug coverage from a creditable employer or union plan (including FEHB for federal retirees and TRICARE for military retirees). The total includes 6 million beneficiaries whose employers receive tax-free subsidies equal to 28 percent of drug expenses between $310 and $6,300 per retiree in 2010 through the Medicare Retiree Drug Subsidy (RDS) program.

As of February 2009, approximately 4.5 million 10 beneficiaries lack a known source of creditable drug coverage.



NOTE: Percentages do not sum to 100% due to rounding. [1]Includes Veterans Affairs, retiree coverage without RDS, Indian Health Service, state pharmacy assistance programs, employer plans for active workers, Medigap, multiple sources, and other sources. [2]Includes Retiree Drug Subsidy (RDS) and FEHBP and TRICARE retiree coverage.
SOURCE: Centers for Medicare & Medicaid Services, 2009 Enrollment Information (as of February 1, 2009).

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[11] The national average monthly premium amount is from CMS, "Release of the 2010 Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, the Part D Regional Low-Income Premium Subsidy Amounts, and the Medicare Advantage Regional PPO Benchmarks," August 2009.
[12] Weighted by 2009 enrollment; Hoadley J, Cubanski J, Hargrave E, Summer L, and Neuman T, "Medicare Part D Spotlight: Part D Plan Availability in 2010 and Key Changes Since 2006," Kaiser Family Foundation, November 2009, http://www.kff.org/medicare/7986.cfm.
[13] U.S. Department of Health and Human Services (DHHS), February 1, 2009.

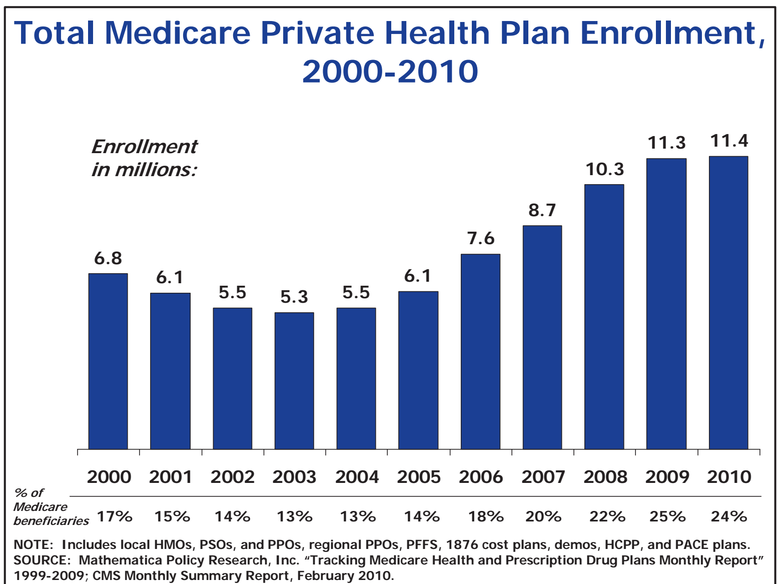
WHAT IS MEDICARE ADVANTAGE?

Medicare Advantage (MA), also known as Medicare Part C, is a program that allows beneficiaries to enroll in private health plans to receive Medicare-covered benefits.

Private plans, such as health maintenance organizations (HMOs), have been an option under Medicare since the 1970s. In addition to HMOs, Medicare now contracts with a variety of other types of private health plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, or those with certain severe and disabling conditions. On average, Medicare beneficiaries are able to choose from among 33 Medicare Advantage plans in 2010. As of February 2010, most Medicare Advantage enrollees (75 percent) are in HMOs or PPOs, while 15 percent are enrolled in PFFS plans, 7 percent are in Regional PPOs, and the remainder are in other MA plan types.[14]

In recent years, the number of Medicare Advantage plans and beneficiaries enrolled in these plans has increased rapidly.

Private plans are playing a larger role in Medicare through a revitalization of the Medicare Advantage program attributable to increased payments to plans and new marketing and outreach opportunities associated with the Medicare drug benefit. After a steep decline between 1999 and 2003, the program has seen a rapid increase in both the number of plans and enrollees. The number of Medicare enrollees in private health plans has more than doubled from 5.3 million in 2003 to 11.4 million, as of February 2010.



NOTE: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS, 1876 cost plans, demos, HCPP, and PACE plans.
SOURCE: Mathematica Policy Research, Inc. "Tracking Medicare Health and Prescription Drug Plans Monthly Report" 1999-2009; CMS Monthly Summary Report, February 2010.

Enrollment rates in Medicare Advantage plans vary widely across states.

In 2009, less than 5 percent of beneficiaries in 3 states (Alaska, Delaware, and Vermont) were enrolled in Medicare Advantage plans while at least 30 percent of beneficiaries in 10 states (Arizona, California, Colorado, Hawaii, Minnesota, Nevada, Oregon, Pennsylvania, Rhode Island, and Utah) were in such plans. Nationwide, half of all Medicare Advantage enrollees lived in 6 states (California, Florida, New York, Ohio, Pennsylvania, and Texas) in 2009.[15]

Medicare Advantage plans generally provide all benefits covered under traditional Medicare, but many plans offer additional benefits.

Medicare Advantage plans receive payments from the federal government to provide all Medicare-covered benefits to enrollees. Plans are required to use any extra payments to provide additional benefits to enrollees in the form of lower premiums, lower cost sharing, or extra benefits and services. Examples

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[14] Kaiser Family Foundation analysis of enrollment data from CMS, Monthly Summary Report, February 2010.
[15] Kaiser Family Foundation analysis of CMS Medicare Advantage State/County Penetration file, November 2009.

include vision, hearing, preventive dental care, free preventive services, podiatry, chiropractic services, and gym memberships.

The majority of Medicare Advantage plans provide prescription drug coverage.

Medicare Advantage plan sponsors are generally required to offer at least one plan with basic drug coverage, and in 2010 most Medicare Advantage plans offer drug coverage. Private fee-for-service plans are not required to provide drug coverage, but in 2010, about 70 percent of PFFS plans do so. About half of all Medicare Advantage drug plans offer some coverage in the coverage gap, mainly for generic drugs only; 28 percent cover generic drugs only, and 21 percent cover generics and some brand-name drugs.

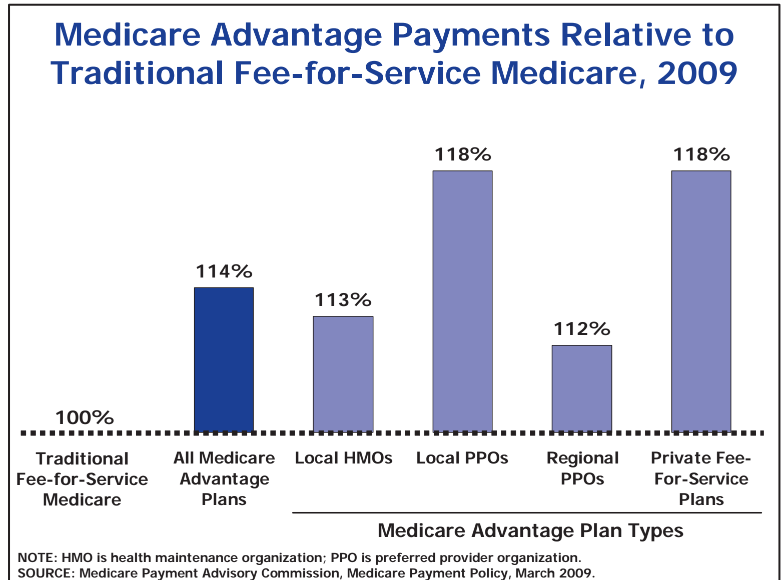
Medicare Advantage plan premiums and cost-sharing requirements vary widely across plans, and have increased in recent years.

Medicare Advantage enrollees generally pay the monthly Part B premium and often pay an additional premium directly to their plan. In 2010, the *unweighted* average premium for MA-PD plans is $56 per month, but varies by plan type and is lower for HMOs ($40) than for private fee-for-service plans ($74).[16] The *weighted* average monthly premium for MA-PD plans in 2010 is $48, a 32 percent increase from 2009.[17]

Most Medicare Advantage plans limit beneficiaries' out-of-pocket expenses, but cost-sharing requirements vary widely across Medicare Advantage plans in 2010. For example, out-of-pocket costs for a five-day inpatient stay for a Medicare Advantage enrollee average $880, but range across plans from $0 to $3,325. Moreover, average cost sharing for some Medicare-covered services has increased significantly between 2008 and 2010 among Medicare Advantage plans – up 15 percent for specialist office visits and up 36 percent for an average-length inpatient hospital stay.[18]

Medicare pays private plans more per enrollee than average costs would be in the Medicare fee-for-service program.

An analysis by the Medicare Payment Advisory Commission (MedPAC) found that Medicare payments to private health plans on behalf of enrollees in 2009 averaged 114 percent of Medicare fee-for-service costs for the counties where MA enrollees reside.[19] PFFS plans were paid 118 percent of traditional Medicare fee-for service costs, before adjusting for enrollee risk.



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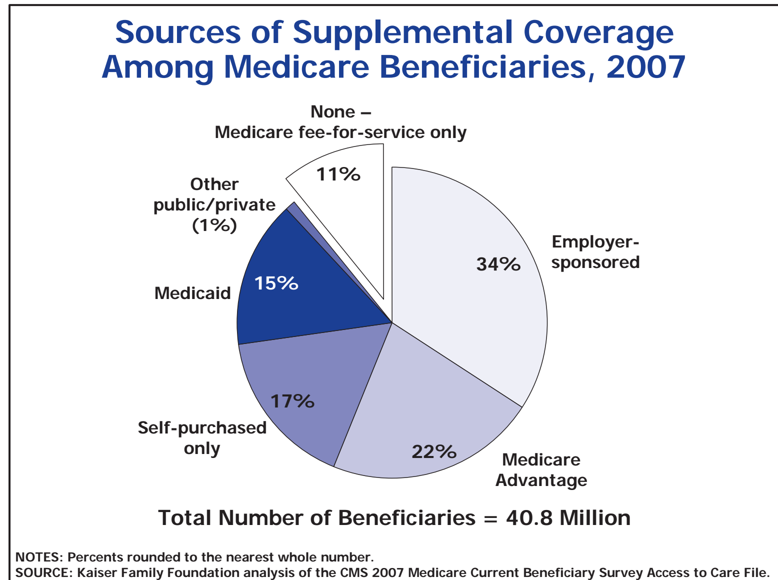
[16] Gold M, Phelps D, Jacobson G, Neuman T, Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums, Kaiser Family Foundation, November 2009, http://www.kff.org/medicare/8007.cfm.
[17] Weighted by 2009 enrollment; Gold M, et al, Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums, November 2009.
[18] Gold M, Hudson M, Jacobson G, Neuman T, Medicare Advantage 2010 Data Spotlight: Benefits and Cost Sharing, Kaiser Family Foundation, February 2010, http://www.kff.org/medicare/8047.cfm.
[19] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare Payment Policy," March 2009.

WHAT TYPES OF SUPPLEMENTAL INSURANCE DO BENEFICIARIES HAVE?

Many Medicare beneficiaries have some type of supplemental insurance coverage to help fill the gaps in Medicare's benefit package and help with Medicare's cost-sharing requirements.

Employer and union-sponsored plans are a leading source of supplemental coverage, providing health benefits to about one in three Medicare beneficiaries.



In 2007, 34 percent of Medicare beneficiaries had coverage from an employer-sponsored health plan.[20] The vast majority of these beneficiaries received supplemental coverage as part of a retiree health benefits plan. For retirees on Medicare, employer plans remain an important source of health benefits, including prescription drug coverage. Employer plans also often provide additional benefits, including limits on retirees' out-of-pocket health expenses. For an estimated 1.3 million Medicare beneficiaries who are working (or have working spouses), employer plans are their primary source of health insurance coverage.[21] For these individuals, Medicare is the secondary payer.

Access to retiree health benefits is on the decline, however. The share of large firms offering retiree health benefits has dropped by more than half over the past two decades, from 66 percent in 1988 to 29 percent in 2009.[22]

Medicare Advantage plans are a source of supplemental coverage for people on Medicare.

Enrollment in private Medicare Advantage health plans has been increasing in recent years. In 2006, 19 percent of Medicare beneficiaries (about 8 million people) were enrolled in a Medicare Advantage plan, but by February 2010, Medicare Advantage enrollment had increased to 24 percent of the Medicare population, or 11.4 million beneficiaries.[23] Most Medicare Advantage plan enrollees (87 percent) receive prescription drug coverage through their plan. Many receive additional benefits that are not covered under traditional Medicare, such as vision, hearing, preventive dental care, podiatry, and gym memberships.

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[20] Kaiser Family Foundation analysis of the CMS 2007 Medicare Current Beneficiary Survey Access to Care File. The hierarchy for assigning sources of supplemental coverage is: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Self-purchased only, 5) Other public/private coverage, and 6) No supplemental coverage (Medicare fee-for-service only). Beneficiaries with multiple sources of coverage were assigned to the source of coverage that is higher up in the hierarchy.
[21] DHHS, February 2009.
[22] Kaiser Family Foundation/HRET Employer Health Benefits 2009 Annual Survey, http://ehbs.kff.org/.
[23] CMS, Monthly Summary Report, February 2010.

Medigap policies – also called Medicare Supplement Insurance – are sold by private insurance companies and help cover Medicare's cost-sharing requirements and fill gaps in the benefit package.

Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. In 2007, about one in five Medicare beneficiaries had an individually-purchased Medicare supplemental insurance policy.[24] Currently there are 12 different standard Medigap plans (labeled Plan A-L), each offering coverage of a different set of benefits. Premiums vary by plan type and may vary by insurer, age of the enrollee, and state of residence.

Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is a source of supplemental coverage for 8 million Medicare beneficiaries with low incomes and modest assets in 2009. These beneficiaries are known as *dual eligibles* because they are dually eligible for Medicare and Medicaid.

Medicaid helps to make Medicare affordable for low-income beneficiaries, given gaps in the benefit package, premiums, deductibles, and other cost-sharing requirements. Most dual eligibles—6.3 million in 2009—qualify for full Medicaid benefits, including long-term care and dental services.[25] Dual eligibles also get help with Medicare's premiums and cost-sharing requirements, and receive subsidies that help pay for drug coverage under Medicare Part D plans.

Some dual eligibles—1.8 million in 2009—do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements through the Medicare Savings Programs (MSP), administered under Medicaid.[26] Eligibility for this assistance is based on a beneficiary's income and resources (generally less than $8,100 for an individual and $12,910 for a couple).

Medicaid and Medicare Savings Programs Eligibility Pathways and Benefits for Medicare Beneficiaries

Pathway	Income Eligibility Levels[1] (individual/couple)	Asset Limit[2] (individual/couple)	Covered Costs and Services
Full Medicaid	<74% of poverty (SSI income eligibility; varies by state)	$2,000/ $3,000 (varies by state)	Medicaid benefits, Medicare Part A and Part B premiums and cost-sharing
Qualified Medicare Beneficiary (QMB)	<100% of poverty ($10,830/$14,570)	$8,100/ $12,910	Medicare Part B premiums and cost-sharing
Specified Low-Income Medicare Beneficiary (SLMB)	100%-120% of poverty ($12,996/$17,484)	$8,100/ $12,910	Medicare Part B premiums
Qualified Individual (QI)	120%-135% of poverty ($14,621/$19,670)	$8,100/ $12,910	Medicare Part B premiums
Qualified Disabled and Working Individual (QDWI)	<200% of poverty ($21,660/$29,140)	$4,000/ $6,000	Medicare Part A premiums

NOTE: [1]Applicants are allowed a $20 disregard from any income before their income is measured against the poverty levels. [2]Asset limits for QMB, SLMB, and QI include $1,500 per person for burial expenses. SSI is Supplemental Security Income.

Another 1.6 million beneficiaries receive supplemental assistance (including prescription drug benefits) through the Veterans Administration and other government programs.[27]

[24] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2007.
[25] DHHS, February 2009.
[26] DHHS, February 2009.
[27] DHHS, February 2009.

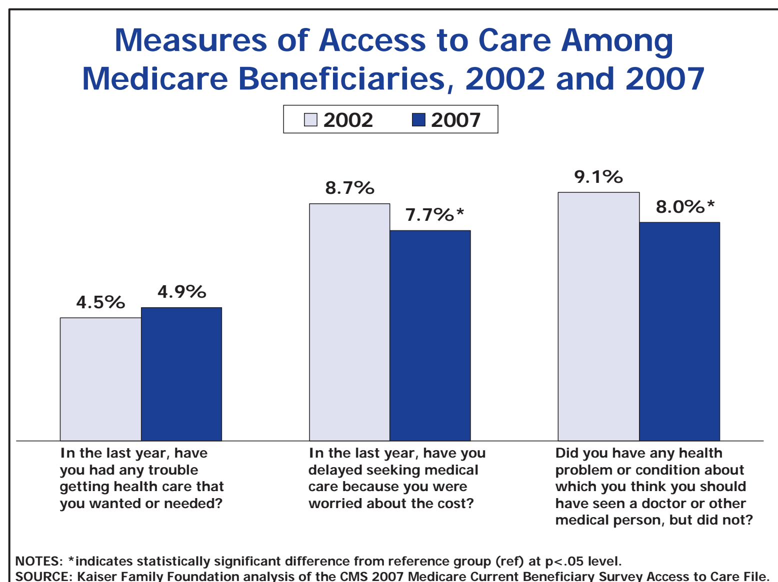
HOW DO MEDICARE BENEFICIARIES FARE WITH RESPECT TO ACCESS TO CARE?

The enactment of Medicare dramatically improved access to care for millions of elderly Americans.

Prior to the enactment of Medicare in 1965, less than half of all elderly people had insurance to help pay for hospital and other medical services.[28] Many were unable to get health insurance either because they could not afford the premiums or because they were denied coverage based on their age or pre-existing health conditions. Medicare significantly improved access to care for elderly Americans and is now a vital source of health and financial security for nearly all elderly Americans, as well as millions of people with permanent disabilities.

Beneficiaries generally enjoy broad access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures. Yet there is some evidence of access problems among certain demographic subgroups.

Access to care: A relatively small share of Medicare beneficiaries report experiencing problems accessing needed medical care, with modest decreases reported in some measures of access difficulties over the past several years. For example, only 5 percent of all beneficiaries reported trouble getting health care in 2007 (the most recent year for which data are available), while 8 percent said they delayed seeking medical care due to cost, and 8 percent said they had a serious medical problem for about which they should have seen a doctor but did not.[29]



Rates of access problems are higher among certain subgroups of the Medicare population, including Black and Hispanic beneficiaries, the nonelderly disabled, those with low incomes, and those living in rural areas.[30] A larger share of beneficiaries without supplemental coverage than those with supplemental coverage report access problems, which suggests that Medicare's cost-sharing requirements pose financial barriers to care for some individuals.

Finding a physician: Medicare beneficiaries are about as likely as privately insured individuals to report problems finding a primary care doctor or specialist who would see them. Among the small share of Medicare beneficiaries (6 percent) who reported looking for a new primary care physician in 2008, 28 percent reported a problem finding one.[31] A 2006 survey found 97 percent of physicians reported accepting new Medicare patients, but a smaller share (80 percent) reported accepting all or most new Medicare patients.[32]

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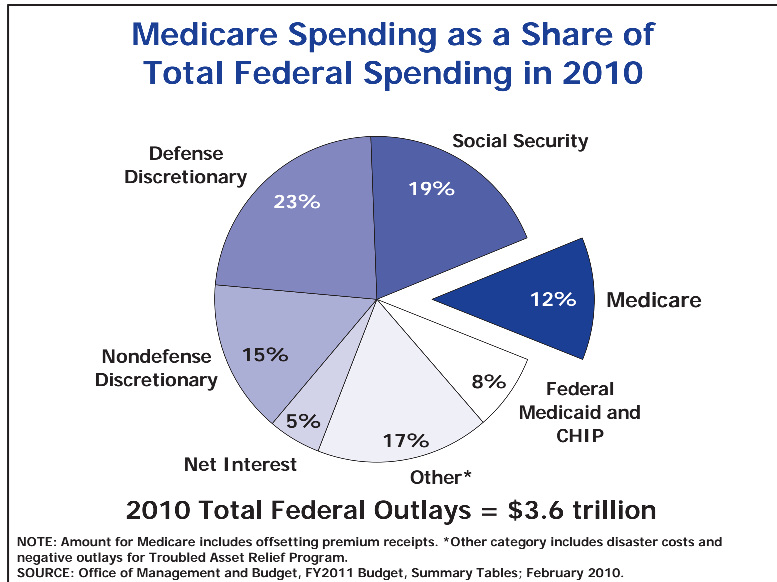
[28] M. Gornick, et al, "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," Health Care Financing Review, 1985 Annual Supplement.
[29] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2007.
[30] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2007.
[31] MedPAC, "Report to the Congress: Medicare Payment Policy," March 2009.
[32] MedPAC, "Report to the Congress: Medicare Payment Policy," March 2009.

HOW MUCH DOES MEDICARE COST AND HOW IS THE MONEY SPENT?

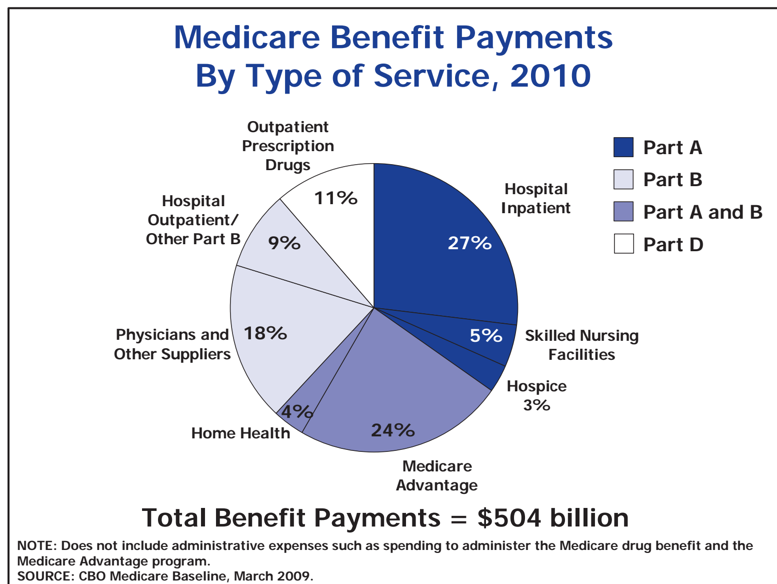
Spending on Medicare is estimated to account for 12 percent of total federal spending in 2010.

Federal spending for fiscal year 2010 is expected to total $3.6 trillion, with spending on Medicare comprising 12 percent of that amount.[33] Of the three main entitlement programs—Social Security, Medicare, and Medicaid—Medicare is second largest in terms of the share of federal spending on each program. Social Security is largest, at 19 percent of federal spending in 2010. Spending on Medicaid and CHIP (the Children's Health Insurance Program) represents 8 percent of federal spending.



Medicare benefit payments are estimated to total $504 billion in 2010.

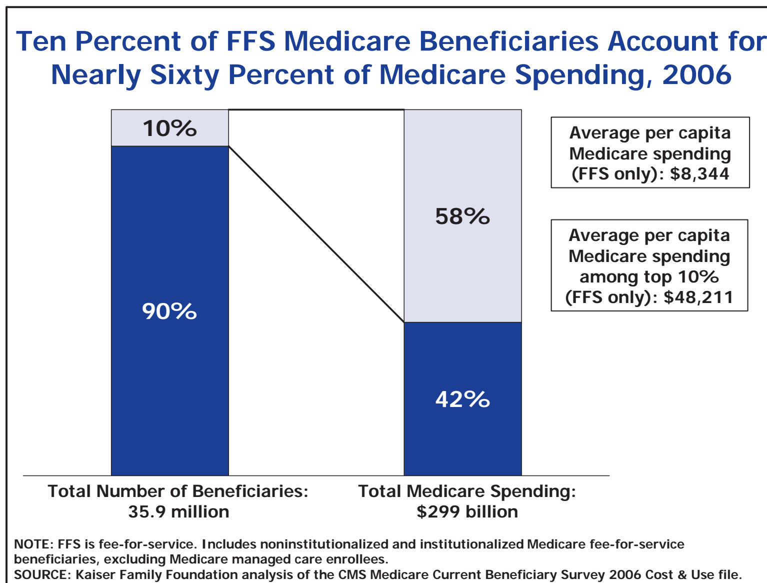
Inpatient hospital services comprise the largest share of Medicare benefit payments (27 percent), followed by payments to Medicare Advantage plans (24 percent), and physician and other suppliers (18 percent). Spending on the Part D prescription drug benefit accounts for 11 percent of total benefit payments in 2010. CBO projects that under current law, in 2019, Medicare Advantage payments will account for 22 percent of Medicare benefit payments and prescription drugs another 15 percent of Medicare benefit payments (assuming no change in payment policies or other provisions of current law).[34]



[33] OMB, Budget of the U.S. Government, Fiscal Year 2011, February 2010.
[34] CBO, Medicare Baseline, March 2009.

Medicare spending is concentrated among a small share of beneficiaries, and varies by eligibility category.

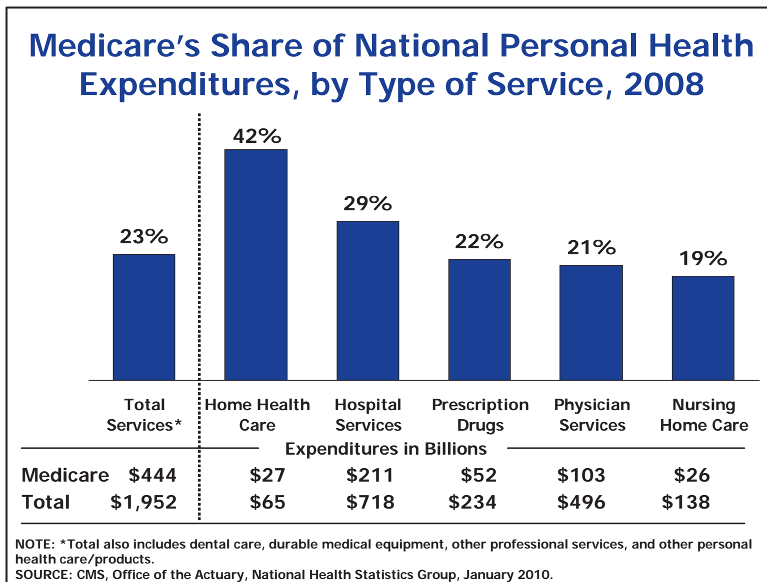
A small share of Medicare beneficiaries accounts for a majority of Medicare spending. Ten percent of beneficiaries in the fee-for-service program accounted for nearly 60 percent of Medicare spending in 2006 (the most recent year for which data are available). At the other end of the spectrum, 22 percent of all fee-for-service beneficiaries had total spending less than $1,000, accounting for just 1 percent of total expenditures. Twelve percent of beneficiaries incurred no expenditures at all.[35]



In 2006, Medicare spending per fee-for-service beneficiary averaged $8,344. Per capita payments were slightly higher for people age 65 or older ($7,963) than for beneficiaries under age 65 with disabilities ($7,807) (excluding those with ESRD). Per capita spending was highest for those beneficiaries with ESRD – $48,460 on average in 2006 – who comprise less than one percent of the total Medicare population.[36]

Medicare spending accounted for more than one-fifth of the $1.9 trillion in personal health care expenditures in the U.S in 2008.

Medicare's share of national personal health care expenditures varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2008, Medicare accounted for 42 percent of home health care spending and 29 percent of all hospital spending. Medicare accounted for 22 percent of total national prescription drug spending in 2008 – a significant increase from just 2 percent in 2005, the year before the Part D drug benefit went into effect.

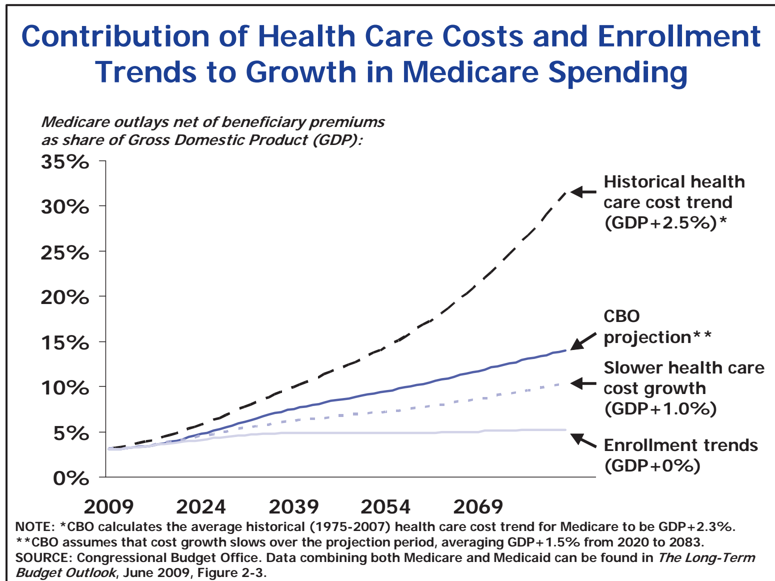


[35] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.
[36] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.

Total Medicare spending is projected to nearly double from $528 billion in 2010 to $1,038 billion in 2020, according to CBO.[37]

The annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services and higher prices for health care services. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2008 was slightly lower for Medicare (8.3 percent) than for private health insurance (9.3 percent) for common benefits (excluding prescription drugs).[38]

The Congressional Budget Office has estimated that a larger share of future growth in Medicare spending as a share of the Gross Domestic Product will result from growth in health care costs rather than from growth in enrollment.



Contribution of Health Care Costs and Enrollment Trends to Growth in Medicare Spending

NOTE: *CBO calculates the average historical (1975-2007) health care cost trend for Medicare to be GDP+2.3%. **CBO assumes that cost growth slows over the projection period, averaging GDP+1.5% from 2020 to 2083.
SOURCE: Congressional Budget Office. Data combining both Medicare and Medicaid can be found in *The Long-Term Budget Outlook*, June 2009, Figure 2-3.

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[37] These estimates exclude offsetting receipts (primarily premiums paid by beneficiaries).
[38] CMS, OACT, National Health Statistics Group, 2010.

HOW IS MEDICARE FINANCED?

Funding for Medicare comes primarily from payroll tax revenues, general revenues, and premiums paid by beneficiaries. Other sources include taxation of Social Security benefits, payments from states, and interest.

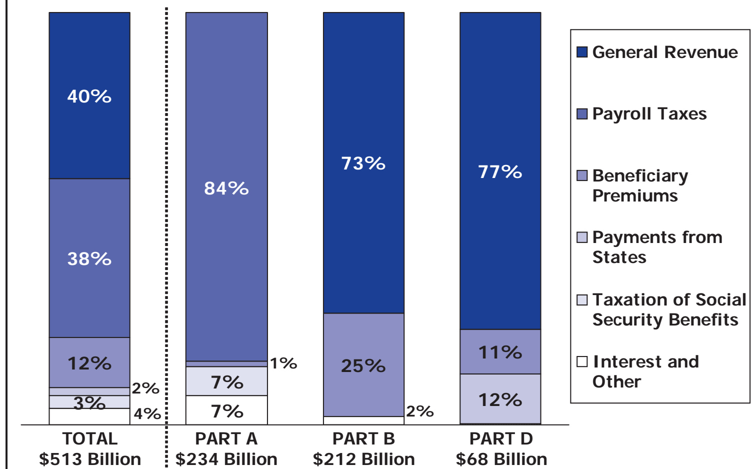
Medicare is funded as follows:

- **Part A,** the Hospital Insurance (HI) Trust Fund, is financed largely through a dedicated tax of 2.9 percent of earnings paid by employers and their employees (1.45 percent each). In 2010, these taxes are estimated to account for 84 percent of the $234 billion in revenue to the Part A Trust Fund.

- **Part B,** the Supplementary Medical Insurance (SMI) Trust Fund, is financed through a combination of general revenues and premiums paid by beneficiaries. Premiums are automatically set to cover 25 percent of revenues in the aggregate. In 2010, Part B revenue is estimated to be $212 billion.

- **Part C** is not separately financed.

- **Part D** is financed through general revenues, beneficiary premiums, and state payments for dual eligibles (who received drug coverage under state Medicaid programs prior to 2006). In 2010, Part D revenue is projected to be $68 billion, 77 percent of which will be from general revenues, 11 percent from premiums, and 12 percent from state payments.



SOURCE: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; fiscal year estimates.

WHAT ARE MEDICARE'S FUTURE FINANCING CHALLENGES?

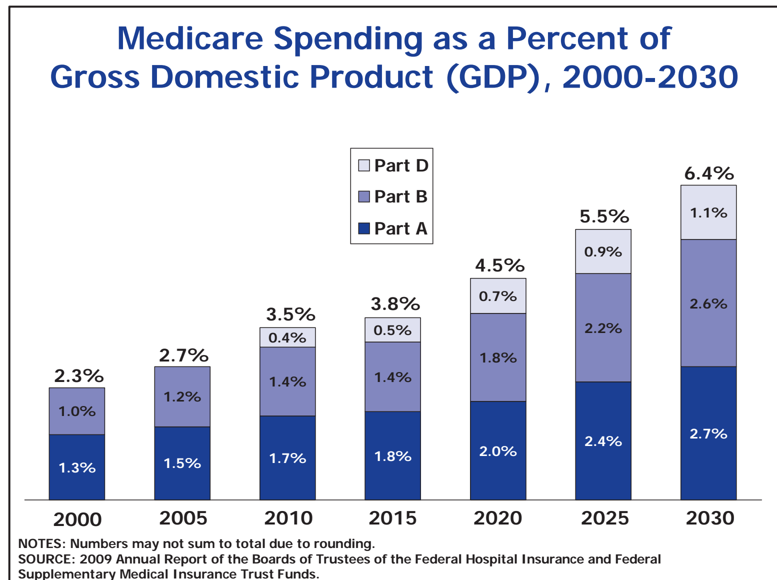
Looking to the future, Medicare is expected to face significant financing challenges due to increasing health care costs, the aging of the U.S. population, the declining ratio of workers to beneficiaries, and various economic factors.

In light of the recent economic downturn and pressures to reduce the federal budget deficit, policymakers are likely to turn their attention to ways to reduce federal spending on entitlement programs, including Medicare, Medicaid, and Social Security. Over the long term, several factors – including rising health care costs, an aging population, a decline in the number of workers per beneficiary, and increasing life expectancy – will present fiscal challenges for Medicare. From 2010 to 2030, the number of people on Medicare is projected to rise from 46 million to 79 million, while the ratio of workers per beneficiary is expected to decline from 3.7 to 2.4.[39]

Sustained increases in health care costs are placing upward fiscal pressure on Medicare, as for other payers. Annual growth in Medicare spending is largely influenced by the same factors that affect health spending in general: increasing prices of health care services, increasing volume and utilization of services, and new technologies. Moving forward, system-wide efforts to curtail overall health care costs would help to improve Medicare's financial outlook.

A number of measures are used to assess the long-term financial status of Medicare.

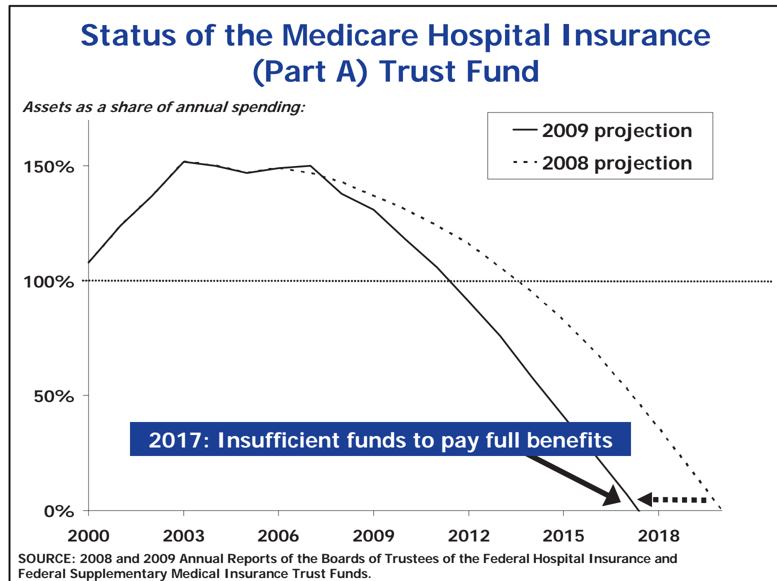
- **Medicare spending as a share of gross domestic product (GDP)** is one of several measures reported by the Medicare Trustees in their annual report to the Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. If current trends continue, Medicare expenditures as a share of GDP are projected to rise from 3.5 percent of GDP in 2010 to 6.4 percent of GDP in 2030.



- **Solvency of the Part A (HI) Trust Fund** is another measure that has been used to present a picture of Medicare's financial health. This indicator looks exclusively at Part A, and does not take into account spending or financing for other parts of the Medicare program. According to the Medicare Trustees, Part A spending has exceeded income since 2008, and the HI Trust Fund reserves are projected to be depleted in 2017.[40]

[39] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 2009.
[40] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 2009.

The projected insolvency of the Medicare HI Trust Fund generally fluctuates from year to year because the projections are highly sensitive to changes in both Medicare policy and the overall economy. Reductions in Medicare Part A spending, if enacted by the Congress, could help to extend the solvency of the Part A Trust Fund beyond the current date of depletion. Conversely, lower-than-projected payroll tax revenue as a result of the current economic downturn and the higher rate of unemployment could hasten the depletion of the Trust Fund.



- **The amount of general revenues as a share of total Medicare spending** is another way to measure Medicare's fiscal health, established under the Medicare Modernization Act of 2008. Each year, the Medicare Trustees are required to examine general revenues as a share of total Medicare spending, and make a determination as to whether general revenues are projected to exceed 45 percent of total outlays within a seven-year timeframe. If the Trustees make this determination two years in row, a "Medicare funding warning" is issued, indicating that general revenues are becoming a substantial share of total financing for Medicare. In response, the President is required to submit proposed legislation to Congress, which must consider this legislation on an expedited basis.

  In 2009, for the fourth year in a row, the Medicare Trustees projected that general revenues will exceed 45 percent of total Medicare spending within seven years (by 2014) and a "Medicare funding warning" was issued. However, in January 2009, the U.S. House of Representatives passed a resolution to suspend congressional consideration of funding warning legislation for the 111th Congress.[41]

Ensuring Medicare's financial stability over the long term is a pressing challenge for policymakers. Medicare provides essential coverage for 47 million beneficiaries, many of whom have multiple chronic conditions and significant health needs. Securing access to affordable health care for seniors and people with disabilities while addressing Medicare's fiscal pressures is a high priority for the future.

[41] H. Res. 5, January 6, 2009.

MEDICARE BENEFITS* AND COST-SHARING REQUIREMENTS, 2010

PART A	
Deductible	$1,100 per benefit period
Inpatient hospital	
Days 1-60	No coinsurance
Days 61-90	$275 per day
Days 91-150	$550 per day (for up to 60 lifetime reserve days)
After 150 Days	Not covered
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$137.50 per day
After 100 Days	Not covered
Home Health	No coinsurance; no limit on number of visits
Hospice	No coinsurance for hospice care; copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	Up to 190 days in a lifetime
PART B	
Deductible	$155
Premium	$110.50/month; higher for those with incomes above $85,000/single or $170,000/couple; $96.40/month for those held harmless from the premium increase
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance; certain limits may apply
Clinical laboratory services	No coinsurance
Home health care	No coinsurance; no limit on number of visits
Outpatient mental health services	45% coinsurance (gradually decreasing to 20% in 2014)
One-time "Welcome to Medicare" physical exam	20% coinsurance; covered within first 12 months of Part B enrollment; Part B deductible does not apply
Preventive services*	
Flu shot, Pneumococcal shot	No coinsurance; limit of one flu shot per flu season
Hepatitis B shot, colorectal and prostate cancer screening, pap smear, mammogram, cardiovascular screening, abdominal aortic aneurysm (AAA) screening, bone mass measurement, diabetes screening and monitoring, glaucoma screening, smoking cessation	20% coinsurance after annual Part B deductible is met; however, Part B deductible and coinsurance are waived for some preventive services
PART D	
Information below applies to the standard Part D benefit; benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.	
Deductible	$310
Premium	$31.94 national average monthly premium *(unweighted PDP and MA-PD plan average)*
Initial coverage *(up to $2,830 in total drug costs)*	25% coinsurance
Coverage gap *(between $2,830 and $6,440 in total drug costs)*	100% coinsurance (not covered)
Catastrophic coverage *(above $4,550 in out-of-pocket spending)*	Minimum of $2.50/generic, $6.30/brand; or 5% coinsurance

NOTE: *This table does not include all Medicare-covered benefits or preventive services; for a complete listing, see http://www.medicare.gov/Coverage/Home.asp and http://www.medicare.gov/Health/Overview.asp.
SOURCES: CMS, www.medicare.gov, Medicare & You 2010, Your Guide to Medicare's Preventive Services.

AGE AND INCOME AMONG MEDICARE BENEFICIARIES, 2008

STATE	Total Number of Beneficiaries[1]	Age: 19-64	Age: 65-74	Age: 75-84	Age: 85 and older	Income as Percent of Federal Povery Level (FPL)[2]: <100% FPL	100-150% FPL	150-200% FPL	200%+ FPL
U.S. Total	*45,460,044*	6,809,144	18,682,883	12,522,255	4,185,781	6,965,217	7,375,012	6,294,135	21,565,699
Alabama	827,093	183,103	335,585	229,492	55,106	148,015	143,876	109,956	401,437
Alaska	63,027	12,238	28,384	11,962	4,334	7,024	9,743	8,361	31,790
Arizona	897,251	140,316	369,558	210,086	81,633	115,150	140,237	94,737	451,468
Arkansas	521,219	104,851	193,557	107,969	40,293	82,085	101,589	59,207	203,789
California	4,627,259	504,921	1,941,947	1,221,581	516,476	684,811	867,183	541,787	2,091,144
Colorado	602,816	79,734	257,430	153,152	47,876	72,775	81,741	67,501	316,175
Connecticut	557,506	66,801	220,342	142,409	75,960	62,236	75,245	71,806	296,225
Delaware	144,539	20,788	59,626	39,129	12,334	20,335	23,999	18,607	68,937
District of Columbia	76,599	15,244	28,852	19,444	8,329	17,340	13,135	8,646	32,749
Florida	3,279,821	458,063	1,462,260	1,040,904	328,549	531,236	507,064	504,141	1,747,336
Georgia	1,199,155	253,071	497,303	266,494	65,193	228,625	201,656	186,662	465,117
Hawaii	200,620	22,297	75,362	70,009	26,651	40,908	30,468	24,102	98,839
Idaho	221,969	21,101	106,997	69,634	15,799	22,569	31,296	30,179	129,487
Illinois	1,807,442	292,572	639,312	494,171	169,612	245,328	262,890	233,024	854,425
Indiana	984,615	135,113	377,747	287,356	101,474	116,306	155,511	140,304	489,571
Iowa	511,349	61,982	197,627	122,435	56,577	48,885	73,976	81,857	233,904
Kansas	425,671	50,160	163,887	112,448	40,370	48,630	65,583	51,947	200,705
Kentucky	726,720	177,663	310,827	171,419	53,728	129,635	135,228	115,970	332,805
Louisiana	672,450	135,051	272,810	184,714	58,152	146,859	158,690	115,131	230,045
Maine	259,111	41,806	104,065	72,058	25,646	31,633	45,741	36,180	130,021
Maryland	764,681	90,162	313,190	201,716	95,407	118,269	93,911	91,017	397,278
Massachusetts	1,039,712	147,743	380,056	301,590	115,192	155,377	172,864	155,245	461,094
Michigan	1,616,141	258,493	628,471	497,753	124,209	192,170	225,065	243,964	847,728
Minnesota	768,835	88,373	311,606	209,772	89,172	78,427	82,260	102,192	436,044
Mississippi	487,570	105,032	194,779	118,785	28,283	109,450	84,963	56,765	195,701
Missouri	985,584	195,299	423,223	270,894	71,984	142,855	173,693	155,332	489,521
Montana	164,858	26,140	61,929	53,378	17,134	20,717	27,019	32,047	78,798
Nebraska	275,323	30,826	94,772	77,567	23,062	24,887	31,729	34,148	135,463
Nevada	343,181	44,403	162,155	80,723	26,590	41,005	38,891	49,480	184,494
New Hampshire	211,728	24,194	83,718	54,106	10,936	20,892	22,144	26,496	103,422
New Jersey	1,304,443	176,886	519,333	368,052	139,113	215,515	174,799	185,259	627,811
New Mexico	304,026	40,857	123,244	73,451	29,734	57,599	43,017	38,392	128,278
New York	2,941,286	417,109	1,219,092	871,182	287,758	565,849	484,981	365,187	1,379,124
North Carolina	1,446,804	256,894	610,982	366,278	140,792	234,975	274,864	203,308	661,799
North Dakota	107,393	6,793	41,427	27,500	9,016	10,916	17,032	12,187	44,601
Ohio	1,867,801	246,778	746,755	528,404	120,526	257,952	297,261	256,569	830,681
Oklahoma	591,983	91,251	233,612	175,019	56,835	87,437	93,129	85,501	290,650
Oregon	602,129	61,430	255,269	154,838	60,577	68,721	78,536	85,675	299,180
Pennsylvania	2,250,461	289,075	854,735	719,230	212,648	289,590	371,958	383,094	1,031,046
Rhode Island	180,185	30,829	63,150	45,804	21,417	24,291	26,902	25,871	84,136
South Carolina	747,824	146,961	361,571	187,679	49,021	138,177	138,204	121,999	346,851
South Dakota	134,510	12,775	62,218	37,925	15,176	17,704	19,261	13,706	77,422
Tennessee	1,029,963	175,617	447,739	287,989	80,117	180,502	196,933	172,785	441,243
Texas	2,906,243	498,970	1,351,779	759,316	240,692	624,498	546,920	390,992	1,288,348
Utah	274,047	37,412	107,670	69,528	32,114	22,958	43,329	40,586	139,850
Vermont	108,212	13,633	43,803	28,924	11,444	14,793	18,415	13,890	50,706
Virginia	1,112,094	186,776	461,395	302,621	90,739	174,313	124,682	149,346	593,189
Washington	938,951	118,021	370,932	255,760	76,739	104,754	108,283	106,721	501,693
West Virginia	376,877	80,551	141,800	94,140	31,008	51,938	67,769	61,661	166,130
Wisconsin	892,933	124,286	332,319	254,541	86,086	107,915	157,345	122,657	409,315
Wyoming	78,034	8,699	36,682	20,928	8,168	10,385	14,001	11,957	38,134

NOTE: NSD is not sufficient data.

[1]Excludes beneficiaries living in the territories and beneficiaries who were pending assignment to a particular state of residence.

[2]In 2008, the federal poverty level was $10,400 for an individual and $14,000 for a couple.

SOURCES: Total Number of Beneficiaries from CMS MA State/County Penetration File, November 2009. Age and income estimates from the U.S. Census Bureau, Current Population Survey, 2008 and 2009 Annual Social and Economic Supplements (pooled data from 2007 and 2008).

PRESCRIPTION DRUG COVERAGE AMONG MEDICARE BENEFICIARIES, 2009

STATE	Total Number of Beneficiaries[1]	Beneficiaries Enrolled in Part D Plans: Medicare Advantage Prescription Drug Plans[2]	Stand-Alone Prescription Drug Plans (PDPs)[3]	Dual Eligibles Enrolled in PDPs	Part D Low-Income Subsidy Recipients (Including Dual Eligibles)	Beneficiaries with Creditable Employer or VA Coverage[4]	Unknown/ No Source of Drug Coverage[5]
U.S. Total	*45,460,044*	*9,169,814*	*17,482,135*	*6,310,798*	*9,644,633*	*12,040,989*	*6,767,106*
Alabama	827,093	160,237	317,824	89,020	226,670	236,142	112,890
Alaska	63,027	445	23,621	12,453	14,337	25,986	12,975
Arizona	897,251	312,055	223,667	109,574	157,348	224,375	137,154
Arkansas	521,219	51,987	257,320	65,452	134,647	129,441	82,471
California	4,627,259	1,501,678	1,624,337	1,083,316	1,191,551	861,797	639,447
Colorado	602,816	174,861	168,264	55,214	94,864	166,097	93,594
Connecticut	557,506	81,330	220,264	70,328	102,936	172,044	83,868
Delaware	144,539	4,379	66,550	10,382	24,931	50,341	23,269
District of Columbia	76,599	7,463	27,668	16,205	21,399	24,850	16,618
Florida	3,279,821	887,906	1,030,510	304,056	615,697	881,964	479,441
Georgia	1,199,155	134,747	558,611	140,997	296,245	296,650	209,147
Hawaii	200,620	64,669	63,611	26,946	36,101	40,003	32,337
Idaho	221,969	41,408	82,239	20,311	36,138	58,662	39,660
Illinois	1,807,442	130,159	855,794	251,889	348,969	495,138	326,351
Indiana	984,615	86,049	443,678	88,636	173,645	285,922	168,966
Iowa	511,349	47,039	288,578	59,222	83,703	113,811	61,921
Kansas	425,671	35,384	220,858	39,812	69,345	94,976	74,453
Kentucky	726,720	67,693	343,444	92,268	195,280	197,865	117,718
Louisiana	672,450	130,965	275,679	96,332	193,205	157,634	108,172
Maine	259,111	19,016	137,014	49,106	85,897	60,475	42,606
Maryland	764,681	49,523	277,533	64,200	124,622	289,068	148,557
Massachusetts	1,039,712	181,126	405,895	218,335	250,934	294,816	157,875
Michigan	1,616,141	308,546	533,468	202,507	277,466	485,864	288,263
Minnesota	768,835	222,268	287,876	101,400	129,305	160,507	98,184
Mississippi	487,570	29,441	280,908	75,553	161,909	104,595	72,626
Missouri	985,584	173,207	426,996	137,719	198,433	231,230	154,151
Montana	164,858	18,449	73,934	13,673	25,934	42,631	29,844
Nebraska	275,323	24,130	151,180	33,025	44,273	65,818	34,195
Nevada	343,181	99,481	85,982	20,763	48,652	97,819	59,899
New Hampshire	211,728	7,138	88,202	19,020	32,695	67,955	48,433
New Jersey	1,304,443	124,501	545,884	157,031	225,005	417,551	216,507
New Mexico	304,026	66,524	117,344	35,333	69,214	67,900	52,258
New York	2,941,286	708,866	976,221	574,267	735,184	793,594	462,605
North Carolina	1,446,804	199,528	635,754	224,534	345,546	340,540	270,982
North Dakota	107,393	5,190	69,585	9,812	17,310	20,784	11,834
Ohio	1,867,801	342,815	596,226	193,351	327,995	668,862	259,898
Oklahoma	591,983	69,512	277,167	83,730	124,833	142,344	102,960
Oregon	602,129	193,484	183,383	55,601	97,992	123,777	101,485
Pennsylvania	2,250,461	687,469	702,277	289,209	407,325	533,261	327,454
Rhode Island	180,185	59,661	59,562	30,282	41,532	37,503	23,459
South Carolina	747,824	79,342	313,681	115,334	172,353	237,560	117,241
South Dakota	134,510	8,055	78,793	12,009	22,015	31,111	16,551
Tennessee	1,029,963	196,179	447,509	189,678	289,609	228,055	158,220
Texas	2,906,243	459,758	1,143,911	348,285	700,502	825,289	477,285
Utah	274,047	63,790	83,298	25,084	35,199	78,112	48,847
Vermont	108,212	1,657	56,994	18,132	26,793	32,076	17,485
Virginia	1,112,094	104,636	456,963	107,773	203,904	350,387	200,108
Washington	938,951	141,672	334,885	104,667	154,307	262,304	200,090
West Virginia	376,877	60,296	164,364	43,395	88,861	102,670	49,547
Wisconsin	892,933	151,356	309,376	114,322	141,781	228,214	203,987
Wyoming	78,034	3,169	38,499	5,985	11,026	21,560	14,806

NOTE: [1]Excludes beneficiaries livinig in the territories and beneficiaries who were pending assignment to a particular state of residence.

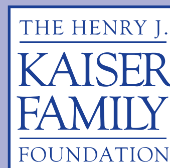
[2]Includes approximately 1.7 million beneficiaries who are receiving the low-income subsidy.

[3]Includes approximately 8.0 million beneficiaries who are receiving the low-income subsidy.

[4]Includes beneficiaries with Retiree Drug Subsidy, FEHBP, TRICARE, VA, and Active Workers.

[5]Estimates of unknown/no drug coverage are the residual difference between the Total column and the combined total of Medicare Advantage, PDP, and other creditable sources of drug coverage for each state.

SOURCE: Total Number of Beneficiaries from CMS MA State/County Penetration File, November 2009. State-level prescription drug coverage estimates from Centers for Medicare & Medicaid Services (CMS) Management Information Integrated Repository (MIIR), as of February 1, 2009.



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