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AGING SECURELY: ADDRESSING OUR HEALTH AND RETIREMENT NEEDS

Medicare @ 50

JULY 2015

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http://actuary.org/files/Medicareat50_Sustainability_0715.pdf

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ESSENTIAL ELEMENTS
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MEDICARE AT 50

Who Are the Beneficiaries?

Medicare is not a "one-size-fits-all" program; it serves a diverse population with diverse needs. Several paths can lead to Medicare eligibility, including turning age 65, becoming permanently disabled, and being diagnosed with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS). Each of these avenues can signal particular health care needs. And even within eligibility categories, beneficiary characteristics and needs can differ. As a result, any program changes should be considered in light of how they impact the broad range of Medicare beneficiaries.

MOST AMERICANS ARE ELIGIBLE FOR MEDICARE UPON TURNING AGE 65

If a worker has paid Medicare taxes for 10 years, Medicare coverage is available upon turning 65. That worker's spouse is also eligible for Medicare upon turning 65. Individuals not eligible based on their own or their spouses' work history can buy into Medicare at a full or partial premium as long as they resided in the country legally for five years. In 2014, nearly 45 million Americans age 65 and older were enrolled in Medicare.[1]

1 2015 Medicare Trustees Report. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf

INDIVIDUALS YOUNGER THAN 65 MAY BE ELIGIBLE THROUGH DISABILITY OR ESRD

Individuals younger than 65 become eligible for Medicare after receiving Social Security disability benefits for two years. Individuals diagnosed with ALS do not need to wait two years; they are eligible as soon as Social Security disability benefits begin. Individuals diagnosed with ESRD are also eligible for Medicare, as long as they, a spouse, or a parent paid Medicare taxes for a required amount of time. Coverage usually begins three months after dialysis starts. In 2014, nearly 9 million Americans younger than 65 were enrolled in Medicare through disability or ESRD status.[2]

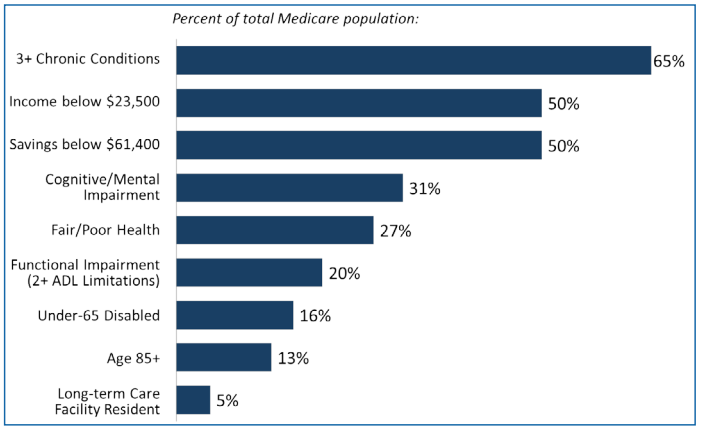
SOME MEDICARE BENEFICIARIES ARE DUALLY ELIGIBLE FOR MEDICAID

Medicare beneficiaries with low incomes can also qualify for additional assistance through Medicaid. These individuals typically are referred to as "dual eligibles." Various levels of assistance are available, and eligibility requirements differ by state. Partial-benefit dual eligibles receive Medicaid assistance for the payment of Medicare premiums and also may receive assistance paying their Medicare deductibles and coinsurance, depending on their income. Full-benefit dual eligibles also qualify for full Medicaid benefits, which cover services not covered by Medicare, such as certain long-term care services.[3] In 2011, 10 million Medicare beneficiaries were dually eligible for Medicaid; nearly three-quarters of those were full-benefit dual eligibles.[4]

PARTICULARLY VULNERABLE MEDICARE SUBGROUPS

Many Medicare beneficiaries have characteristics associated with high health care needs, increasing the importance of access to affordable health care services. Nearly two-thirds of Medicare beneficiaries have three or more chronic conditions, and nearly one-third have a cognitive or mental impairment. One in four reports being in fair or poor health, and one in five has limitations with at least two activities of daily living, which include eating, bathing, toileting, dressing, and functional mobility. The increased need for health care services often is coupled with a reduced ability to pay for those services. Median income for the Medicare population is $23,500 and median assets are $61,400, indicating that many beneficiaries have limited resources to rely upon if faced with high out-of-pocket health costs.

FIGURE 1: CHARACTERISTICS OF THE MEDICARE POPULATION



NOTE: ADL is activity of daily living.
SOURCE: Urban Institute and Kaiser Family Foundation analysis, 2013; Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2010 Cost and Use file.

2 2015 Medicare Trustees Report.

3 For more information on Medicaid eligibility and benefits by type of dual-eligible beneficiary, see the MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (December 2013). Available at: http://medpac.gov/documents/data-book/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf.

4 CMS Medicare-Medicaid Coordination Office, "Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011," 2013. Available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf

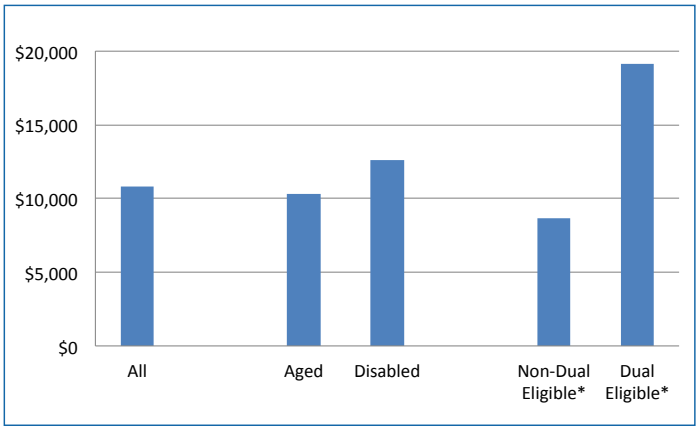
ABOUT THIS SERIES

In the *Medicare at 50* series, the American Academy of Actuaries explores various aspects of the Medicare program and potential implications for future policymaking. Together, these papers provide a comprehensive overview of the current status of the Medicare program and of issues that should be considered when making future changes.

MEDICARE SPENDING VARIES BY SUBGROUP

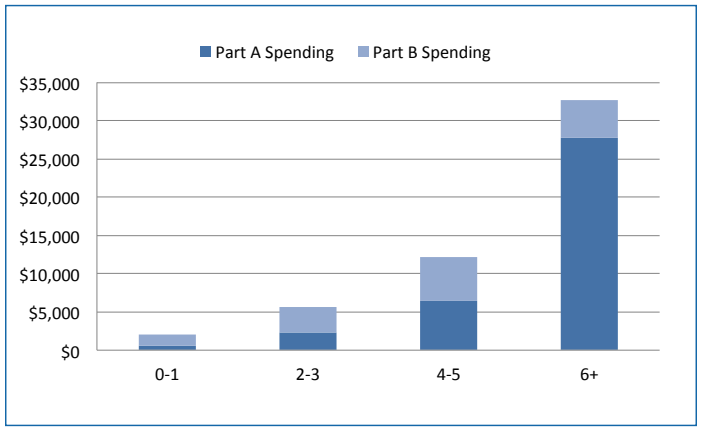
Medicare spending is on average higher for disabled beneficiaries than beneficiaries aged 65 and older and for dual eligibles than for non-dual eligibles. Spending per beneficiary differs even more dramatically by the number of chronic conditions, increasing from about $2,000 for those with zero or one chronic health condition to over $32,000 for those with six or more conditions. The nature of the services received also differs by chronic condition, with a larger share of spending going toward inpatient hospital care and other Part A services for those with more chronic conditions.

FIGURE 2. AVERAGE MEDICARE SPENDING BY BENEFICIARY GROUP, 2011



*Reflects traditional fee-for-service Medicare beneficiaries only.
SOURCE: MedPAC Data Book: Health Care Spending and the Medicare Program (June 2015)

FIGURE 3. AVERAGE MEDICARE SPENDING BY NUMBER OF CHRONIC CONDITIONS, 2010



NOTES: Reflects traditional fee-for-service Medicare beneficiaries only. Part A spending includes inpatient, post-acute, and hospice services. Part B spending includes outpatient, evaluation and management, procedures, imaging and testing, and DME and other Part B services.
SOURCE: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition.

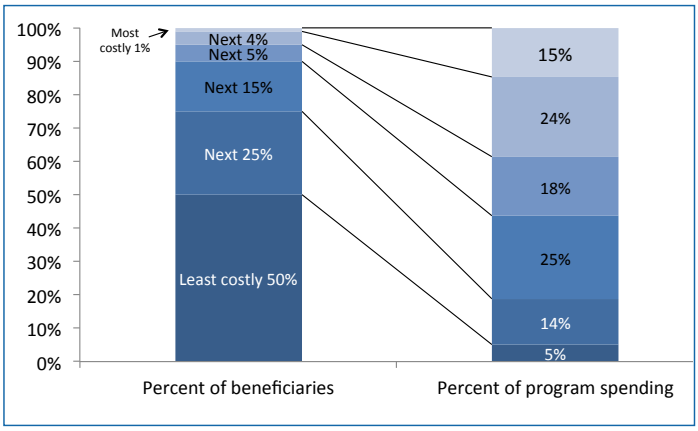
A SMALL SHARE OF MEDICARE BENEFICIARIES ACCOUNTS FOR A LARGE SHARE OF MEDICARE SPENDING

The most costly 5 percent of Medicare's traditional fee-for-service (FFS) program beneficiaries account for nearly 40 percent of Medicare FFS spending. The most costly 25 percent of beneficiaries account for over 80 percent of spending. The least costly 50 percent of beneficiaries account for only 5 percent of spending.

MEDICARE BENEFICIARIES ARE A DIVERSE GROUP

Health care needs and spending vary across Medicare beneficiaries. Therefore, when evaluating whether and how the program is meeting the needs of the beneficiaries, it is important to consider not just the average beneficiary, but also the entire range of beneficiaries. Similarly, when contemplating changes to the program, it is important to assess the impacts on especially vulnerable groups, including those with limited financial resources and those with special health care needs. The diversity among beneficiaries also highlights the need for accurate risk adjustment to properly compensate health care providers and plans, as well as related protections to help ensure that the health care needs of high-cost or otherwise vulnerable beneficiaries are met.

FIGURE 4. DISTRIBUTION OF MEDICARE BENEFICIARIES AND SPENDING, 2011



NOTE: Reflects traditional fee-for-service beneficiaries only.
SOURCE: MedPAC Data Book: Health Care Spending and the Medicare Program (June 2015)