

MEDICARE

INTRODUCTION

Medicare is the government's premier program providing health coverage to qualified elderly and disabled Americans regardless of their income or medical history. Thirty-five million seniors and 6 million non-elderly disabled people—over 41 million in all—rely on Medicare for health coverage. Between 35 – 40% of beneficiaries have no private health insurance. With enrollment rates rising as the Baby Boomers retire, a slow-growing workforce, and increases in medical costs, the future of Medicare funding could be bleak.¹ This paper provides some background to Medicare and the financial challenges it faces.

THE MEDICARE PROGRAM & CURRENT FINANCING

Medicare was established in 1965 when Congress amended the Social Security Act to include Title 18, "Health Insurance for the Aged." In 1972, Medicare expanded to include disabled persons under the Disability Insurance program. Today, Medicare consists of four parts:

- **Part A - Hospital Insurance ("HI").** Most individuals aged 65 and over are automatically entitled to Medicare Part A if they or their spouse are eligible for Social Security payments. People under 65 who qualify for Social Security payments based on a disability are usually eligible for Part A after a two-year waiting period. People with end-stage renal disease are eligible immediately for Part A regardless of their age. The HI program covers inpatient hospital services, skilled nursing facility, hospice and some home health care.
- **Part B - Supplementary Medical Insurance ("SMI").** SMI is optional; beneficiaries have the option to enroll in Part B, and must pay a premium for services. Ninety-five percent of Part A beneficiaries voluntarily enroll in Part B. SMI covers physician care, outpatient hospital services, lab tests, medical supplies and some home health care. Twenty-five percent of financing comes from beneficiary premiums; the remaining 75% comes from general government revenues. SMI accounted for over 33% of Medicare benefit spending in 2004.
- **Part C - Formerly known as "Medicare+Choice," Part C has been renamed "Medicare Advantage."** Part C refers to managed care plans that provide both Part A and B benefits to enrollees. It accounted for 14% of benefit spending in 2004.
- **Part D - In 2003, Congress passed Part D, the Medicare Prescription Drug Improvement and Modernization Act ("MMA"),** which increased the Part B deductible, and created coverage for prescription drugs. It took effect in 2006 and is financed through monthly beneficiary premiums (25.5%) and general revenues (74.5%). The Centers for Medicare and Medicaid Services ("CMS") provide oversight, but the actual program is administered by private insurance companies and pharmaceutical benefit management companies.

FUNDING CHALLENGES

Medicare faces the same demographic challenges as Social Security – retiring Baby Boomers and a slow-growing work force – plus the additional challenge of rising health care costs. (It should be noted that

Medicare spending growth is actually slower than private health insurance spending growth).² Seniors already spend an average of 20% of their income on health care.

- **Part A – HI:** Funded like Social Security,³ Medicare Part A is financed by a 2.9% payroll tax paid for by employees and employers. **The 2004 Social Security Trustees report projects that the trust funds for Hospital Insurance will be exhausted in 2019.** By the end of 2078, the unfunded obligation of the HI trust fund is estimated to be \$8.2 trillion.⁴
- **Part B – SMI:** The SMI trust fund is financed year-by-year from premium payments by beneficiaries and general revenues from the federal budget. Since Part B is voluntary, participants are required to pay a monthly premium. Under current law, no more than 25% of SMI's financing can come from premiums. The MMA will bring changes to how Part B is funded. Starting in 2007, premium payments will be related to the amount of income. By 2011, premiums will increase with income.⁵
- **Part D:** A new 10-year estimate projects that the **prescription drug benefit will cost \$724 billion**, though it was originally touted at \$400 billion. The Administration says that the discrepancy is attributable to technical difference, such as the time frame at issue. Regardless, the 2004 Trustees Report concluded that Medicare's long-term liabilities jumped by more than a third (\$17 trillion) in that year.

GENERAL CONVENTION RESOLUTIONS RELATED TO MEDICARE

- 1976-C044 – Support and Fund the Mission to the City Through Urban Churches.
- 1985-A088 – Encourage National and Congregational Support of Community Health Services.
- 1985-A086 – Express and Encourage Support for Ministry and Services to the Aging.
- 1991-A010 – Advocate Legislation for Comprehensive Health Care.
- 1994-A057 – Adopt Church Principles on Access to Health Care.
- 2000-A078 – Call on Lawmakers and Physicians to Provide Adequate and Comprehensive Hospice and Palliative Care.

EXECUTIVE COUNCIL RESOLUTIONS RELATED TO MEDICARE

- NAC 024 – In Support of Protection of Medicaid and Medicare as part of America's Social Safety Net.

OTHER RESOURCES

- Episcopal Public Policy Network - <http://www.episcopalchurch.org/eppn>
- The Washington Post – (collection of special reports on Medicare) - <http://www.washingtonpost.com/wp-dyn/politics/specials/fiscal/medicare/>
- American Public Health Association - <http://www.apha.org/index.cfm>
- U.S. Social Security Administration - <http://www.ssa.gov/>
- The Henry J. Kaiser Family Foundation - <http://www.kff.org/medicare/index.cfm>
- Employee Benefits Research Institute - <http://www.ebri.org/>

ENDNOTES

¹ Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Program*. Available at <<http://www.ssa.gov/OACT/TRSUM/trsummary.html>> (last viewed on 17 May 2005). “As we reported last year, Medicare's financial difficulties come sooner--and are much more severe--than those confronting Social Security. While both programs face essentially the same demographic challenge, underlying health care costs per enrollee are projected to rise faster than the wages per worker on which the payroll tax is paid and on which Social Security benefits are based. As a result, while Medicare's annual costs are currently 2.6 percent of GDP, or about 60 percent of Social Security's, they are now projected to surpass Social Security expenditures in 2024 and reach almost 14 percent of GDP in 2079.”

² The Henry J. Kaiser Family Foundation, *Medicare Spending and Financing Fact Sheet*, April 2004. Available at <<http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=52969>> (last viewed on 17 May 2005). For the years between 1985 and 2002, spending grew at an annual rate of 5.8% under Medicare versus 7.4% for comparable benefits under private health insurance. Medicare also had lower administrative costs, accounting for less than 2% of Medicare spending in 2002 versus 13% for private health insurers.

³ The Treasury Department credits the Medicare trust funds with any surplus of Medicare tax revenues over the amount spent for current benefits. By law, this surplus must be invested in special securities issued by the Treasury. The surpluses are not reserved for future Medicare programs. Rather, the Treasury lends these assets to the government to spend on other programs. Bookkeeping entries show what the Treasury owes to Medicare. The Treasury must start repaying the money when the benefit payments exceed the income from payroll taxes and the taxation of benefits (*i.e.*, when the trust funds go into a negative cash flow).

⁴ Employee Benefit Research Institute, *The Basics of Medicare Updated with the 2004 Board of Trustees Report*, April 2004. Available at <<http://www.ebri.org/facts/0404factb.pdf>> (last viewed on 17 May 2005).

⁵ Under the MMA, Medicare beneficiaries with income under \$80,000 (\$160,000 for a married couple) will continue to pay 25% of the cost of Part B. Beneficiaries with income between \$80,000 and \$100,000 will be required to pay 35% of the premium, and beneficiaries with income of at least \$200,000 will be responsible for 80% of the premium. These income levels will be indexed to inflation.