Medicare’s Future:

Selected Charts

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• Trends in Medicare Expenditures
• Medicare Performance
• Characteristics of Medicare Beneficiaries
• Medicare Beneficiary Expenses Not Covered by Medicare
• Medicare Experience with Private Plans
• Prescription Drugs
• Medicare Prescription Drug Improvement & Modernization Act of 2003
• Selected Commonwealth Fund Medicare Reports
Trends in Medicare Expenditures
National Health Expenditures by Source of Funds, 2002

Total National Health Expenditures = $1.6 trillion

- Medicare: $267 billion (17%)
- Medicaid: $250 billion (16%)
- Private Health Insurance: $550 billion (35%)
- Out-of-pocket: $212 billion (14%)
- Other public: $196 billion (13%)
- Other private: $78 billion (5%)

Medicare Spending as a Percent of Total Health Expenditures, 1970–2001

Number of Years Before HI Trust Fund Projected to Be Exhausted

Source: Congressional Research Service 1995 and Annual Medicare Trustees Reports.
Medicare Performance
Medicare Beneficiary Experience: Compared to Privately Insured Ages 19–64

- Medicare beneficiaries are less likely to report negative insurance experiences, including plan not covering care
- Medicare beneficiaries are less likely to report any access problems due to cost, including not getting needed specialist care
- Medicare beneficiaries are much more likely to report being very confident in their future ability to get care
- Even those most at risk, sick and poor Medicare beneficiaries, are more likely to rate their coverage as excellent

Experiences with Insurance Plan and Satisfaction with Quality of Care, by Insurance Status

Predicted Rating of Health Insurance Coverage, by Health, Poverty and Insurance Status, 2001

Percent rating coverage as “excellent”

- Medicare, age 65+
- Employer coverage, ages 19–64

Note: Sick: good/fair/poor health status with average number of chronic conditions for this group. Healthy: excellent/very good health status with average number of chronic conditions for this group. Models control for prescription drugs.

Experiences with Insurance Plan and Satisfaction with Quality of Care, by Prescription Drug Coverage

- Medicare 65+ without prescription coverage
- Medicare 65+ with prescription coverage

Rated Health Insurance as Excellent
- 22% without prescription coverage
- 36% with prescription coverage

Any Medical Bill Problems
- 29% without prescription coverage
- 15% with prescription coverage

Very Confident in Future Ability to Get Quality Care
- 40% without prescription coverage
- 54% with prescription coverage

Note: Model adjusted for poverty status, self-reported health status, and chronic conditions.
Percent Annual Per Enrollee Growth in Medicare Spending and Private Health Insurance and FEHBP Premiums for Common Benefits

Characteristics of Medicare Beneficiaries
Income as a Share of Poverty for Various Medicare Beneficiary Groups, Relative to Poverty Level, 1999

<table>
<thead>
<tr>
<th>Group</th>
<th>&lt;100%</th>
<th>100%–135%</th>
<th>135%–150%</th>
<th>150%–200%</th>
<th>200%–250%</th>
<th>250%+</th>
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</thead>
<tbody>
<tr>
<td>All Beneficiaries</td>
<td>19%</td>
<td>13%</td>
<td>5%</td>
<td>12%</td>
<td>10%</td>
<td>41%</td>
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<tr>
<td>Elderly</td>
<td>17%</td>
<td>12%</td>
<td>5%</td>
<td>12%</td>
<td>11%</td>
<td>44%</td>
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<tr>
<td>Widowed, Single, and Divorced</td>
<td>28%</td>
<td>19%</td>
<td>6%</td>
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<tr>
<td>Black and Other</td>
<td>41%</td>
<td>19%</td>
<td>4%</td>
<td>12%</td>
<td>6%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Note: ASPE Definition, Insurance Unit excludes full-year facility beneficiaries.

Source: Marilyn Moon, Urban Institute analysis of 1999 MCBS.
Profile of Medicare Beneficiaries, by Poverty and Health Status

Two of Three Have Low Incomes or Health Problems*

12% with health problems and income >200% of poverty

26% in excellent/good health with income <200% of poverty

30% with health problems and incomes <200% of poverty

32% in excellent/good health with income >200% of poverty

* In fair or poor health or disabled, under-65.

Beneficiaries with Disabling Health Conditions as a Percentage of Beneficiary Population and Total Medicare Expenditures, 1997

Note: All figures exclude ESRD beneficiaries and the Medicare expenditures also exclude HMO beneficiaries.

Medicare Beneficiary Expenses Not Covered by Medicare
Sources of Supplemental Coverage Among Non-Institutionalized Medicare Beneficiaries, 2000

- Employer: 37%
- None: 8%
- Multiple Plans: 9%
- Medicare HMO Only: 12%
- Public Plans Only*: 15%
- Medigap Plans Only: 19%

* Includes Medicaid, Veteran Affairs, and various other programs.

Source: Analysis of 2000 MCBS by Bruce Stuart for The Commonwealth Fund.
Percentage of All Firms with 200 or More Workers that Offer Retiree Health Benefits to Medicare Age Retirees

Average out-of-pocket spending 2002 = $3,757

* Urban Institute 2002 Simulation Model: Out of pocket includes: Part B premium, Medicare cost sharing, other premiums and non-covered services, drugs, vision and dental.
Distribution of Out-of-Pocket Expenditures Among Elderly Medicare Beneficiaries, 1999

- Prescription Drugs: 18.1%
- Cost-Sharing for Medicare Services: 15.6%
- Part B Premium: 25.0%
- Other Services: 25.5%
- Other: 7.2%
- Supplemental Insurance Premiums

Note: Excludes HMO, ESRD, and Facility beneficiaries.
Source: Marilyn Moon, Urban Institute analysis of 1999 MCBS.
Projected Out-of-Pocket Health Care Spending as a Share of Income, 2000 and 2025

- *No insurance beyond U.S. Medicare basic benefits.*
Medicare Experience with Private Plans
Enrollment in Medicare Managed Care/ Medicare+Choice Plans by Beneficiaries, 1995–2003

Percent of Medicare beneficiaries enrolled

Medicare+Choice: Lessons

- **Risk and Payment Issues**
  - Expensive for Medicare program because of favorable risk selection and payment rules
  - Incentives to “cream skim” and avoid risk

- **Overall Failure to Date**
  - Private plans do not participate in many states and geographic areas
  - Wide geographic variability in premiums and benefits
  - Unstable participation by private plans and providers
  - High out-of-pocket burden on sick
  - No standard benefit; impossible to compare plan benefits

Medicare+Choice Enrollees as a Percent of Medicare Beneficiaries, by State, 2003

Medicare+Choice Primary Care Provider Turnover Rates by State

Percentage of Primary Care Providers Who Did Not Stay in Plan at Least One Year

National Average: 14%

### 2001 Premium and Selected Benefit Copayments: Tampa Medicare+Choice Plans

<table>
<thead>
<tr>
<th>Plan V₁</th>
<th>Plan V₂</th>
<th>Plan W</th>
<th>Plan X₁</th>
<th>Plan X₂</th>
<th>Plan Y</th>
<th>Plan Z₁</th>
<th>Plan Z₂</th>
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<td>Enrollment limit</td>
<td>No</td>
<td>No</td>
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<td>Specialist</td>
<td>$5-$200</td>
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<td>$40/visit</td>
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<td>Outpatient rehabilitation services</td>
<td>$40/visit</td>
<td>$40/visit</td>
<td>$25/visit</td>
<td>$10-$15/visit</td>
<td>$10-$15/visit</td>
<td>$25/visit</td>
<td>$15/visit</td>
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<td>Inpatient hospital care</td>
<td>$500 per admis.; $200/day for days 7–30 at network hospital</td>
<td>$500 per admis.; $200/day for days 7–30 at network hospital</td>
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<td>Bone mass measurement</td>
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<td>Formulary drugs</td>
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<tr>
<td>30–31–day supply</td>
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<tr>
<td>Generic copay</td>
<td>$10</td>
<td>$5</td>
<td>$5</td>
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<td>$8</td>
<td>$7 (31-day)</td>
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<td>Brand copay</td>
<td>$20 preferred</td>
<td>$20</td>
<td>$15</td>
<td>Not covered</td>
<td>$40</td>
<td>$5</td>
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<td>$15</td>
<td>$30</td>
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<td>Brand copay</td>
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<td>$60</td>
<td>$45</td>
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<td>$120</td>
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<tr>
<td>Cap</td>
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<td></td>
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<tr>
<td>Generic</td>
<td>$150/3 months generic and preferred &amp; non-preferred brand</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>$500/year</td>
<td>$125/3 months non-formulary generic &amp; all brand</td>
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<tr>
<td>Brand</td>
<td>$35</td>
<td>$35</td>
<td>$30</td>
<td>Not covered</td>
<td>$30</td>
<td>$30</td>
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<tr>
<td>Non-formulary 30–31–day supply</td>
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<td>Generic copay</td>
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<td>$105</td>
<td>$90</td>
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<tr>
<td>Brand copay</td>
<td>$40</td>
<td>See above</td>
<td>See above</td>
<td>Not available</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>90–day mail order</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic copay</td>
<td>$10</td>
<td>$105</td>
<td>$90</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Brand copay</td>
<td>$80</td>
<td>See above</td>
<td>See above</td>
<td>Not available</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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1. Plan Y has a $3,500 out-of-pocket limit protection for combined inpatient and outpatient services, not including certain office visit copays, prescription drugs, medical supplies, and selected other benefits.
2. $40 specialist per visit copay, except $10 visit to Allergy physicians, $15 specimen to hospital pathologists, $5 X-ray; $50 other radiation services, $5 $100 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copay for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.
3. $1,000 per admission and $300/day for days 7–30 at non-participating hospitals.
Average Annual Out-of-Pocket Cost-Sharing for Medicare+Choice Enrollees, 1999–2003

Note: Results are weighted by plan enrollment. Out-of-pocket cost estimates include the Medicare Part B premium, the Medicare+Choice premium, spending for physician and hospital copayments, and outpatient prescription drugs not covered by the M+C package.

Estimated Total Annual Out-of-Pocket Spending for Medicare+Choice Enrollees by Health Status, 1999–2003

Percentage of Medicare+Choice Enrollees with Any Cost-Sharing for Inpatient Hospital Admissions, 1999–2002

Prescription Drug Coverage in Medicare+Choice, 2001–2003

Percentage of enrollees

- 2001:
  - No Prescription Drug Coverage: 8%
  - Generic Prescription Drug Coverage Only: 62%
  - Brand-Name and Generic Prescription Drug Coverage: 30%

- 2003:
  - No Prescription Drug Coverage: 31%
  - Generic Prescription Drug Coverage Only: 29%
  - Brand-Name and Generic Prescription Drug Coverage: 40%


Prescription Drugs
Sources of Supplemental Coverage for Prescription Drugs Among Non-Institutionalized Medicare Beneficiaries, 2000

- Employer: 33%
- Medicare HMO Only: 13%
- Medigap Plans Only: 9%
- Public Plans Only*: 17%
- Multiple Plans: 4%
- No Rx Benefit: 24%

* Includes Medicaid, Veteran Affairs, and various other programs.

Source: Analysis of 2000 MCBS by Bruce Stuart for The Commonwealth Fund.
Prescription Drugs: Barely One-Half Covered All Year

Prescription Drug Coverage of Medicare Beneficiaries in 1996*

Percent of Beneficiaries

- *Noninstitutionalized beneficiaries enrolled in Medicare throughout 1996.*

Percentage of 65–to–69-Year-Old Medicare Beneficiaries with Employer-Sponsored Medical and Drug Coverage, 1996 and 2000

- **Medical Coverage**
- **Drug Coverage**

<table>
<thead>
<tr>
<th></th>
<th>1996</th>
<th>2000</th>
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<tr>
<td><strong>All Ages</strong></td>
<td>45.5</td>
<td>39.4</td>
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<tr>
<td><strong>Men Ages</strong></td>
<td>40.1</td>
<td>35.4</td>
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<tr>
<td><strong>Women Ages</strong></td>
<td>44.2</td>
<td>36.2</td>
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<tr>
<td><strong>Medical Coverage</strong></td>
<td>49.8</td>
<td>40.9</td>
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<tr>
<td><strong>Women Ages</strong></td>
<td>41.4</td>
<td>38.3</td>
</tr>
</tbody>
</table>

Projected Prescription Drug Spending of Medicare Beneficiaries, 2006

Percent of Beneficiaries

81% 71% 47% 21% 13%

Level of Prescription Spending

> $275 > $695 > $2,000 > $4,500 > $5,800

Note: Community-residing beneficiaries only.
Source: Dennis Shea and Bruce Stuart, Projections from cost-estimating model based on 1999 MCBS for The Commonwealth Fund.
Projected Distribution of Medicare Beneficiaries and Total Drug Expenditures, 2006 (updated 6/27/03)

Source: Actuarial Research Corporation analysis for the Kaiser Family Foundation, June 2003.
Factors Accounting for Growth in Prescription Drug Spending per Capita, 1980–2011

Note: Data for 2000–2011 are projections.
”Other” includes quality and intensity of services, and age-gender effects.
Change in Distribution of Medicare Beneficiaries, by Level of Drug Spending from 1995 to 1999

Note: Excludes beneficiaries living in nursing facilities.
Share of Total Drug Expenditures by Medicare Beneficiaries’ Spending Levels

Percentage of Total Expenditures

Per Capita Drug Expenditures

Source: Marilyn Moon, Urban Institute analysis of the 1999 MCBS.
Prescription Drug Use and Spending Among Medicare Beneficiaries, by Entitlement Status, 1998

Mean annual number of prescriptions filled

Mean annual Rx spending

### Annual Prescription Fills and Average Drug Spending, by Number of Chronic Conditions

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Prescription Fills</th>
<th>Average Drug Spending (2006 dollars)</th>
<th>Percentage with More than $2,000 in Drug Spending</th>
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<tr>
<td>0</td>
<td>8</td>
<td>$1,346</td>
<td>18%</td>
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<td>1</td>
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<td>$1,819</td>
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<td>2</td>
<td>18</td>
<td>$2,543</td>
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<td>3</td>
<td>24</td>
<td>$3,426</td>
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<tr>
<td>4</td>
<td>30</td>
<td>$4,046</td>
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<td>5 or more</td>
<td>40</td>
<td>$5,673</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>$3,320</strong></td>
<td><strong>51%</strong></td>
</tr>
</tbody>
</table>


Out-of-Pocket Spending on Prescription Drugs as a Share of Income Among Beneficiaries Under Age 65 with Disabilities, by Drug Coverage Status

Percent of <65 beneficiaries with disabilities spending 5 percent or more of their income on Rx

Percent of Seniors in Eight States Who Spend $100+ Per Month on Drugs, by Source of Drug Coverage

Percent of Seniors in Eight States Who Spend $100+ Per Month on Drugs, by Chronic Condition and Prescription Drug Coverage

Percent of Seniors in Eight States Who Did Not Fill a Prescription One or More Times Due to Cost or Skipped Doses to Make a Prescription Last Longer in the Last 12 Months, by Drug Coverage

Did not fill a prescription one or more times because it was too expensive

- Total: 14%
- Without Prescription Drug Coverage: 11%
- With Prescription Drug Coverage: 25%

Skipped doses of medicines to make the prescription last longer

- Total: 16%
- Without Prescription Drug Coverage: 13%
- With Prescription Drug Coverage: 27%

Either did not fill a prescription one or more times or skipped doses of medicines

- Total: 22%
- Without Prescription Drug Coverage: 18%
- With Prescription Drug Coverage: 35%

Percent of Seniors in Eight States Who Reported Forgoing Needed Medicines, by Chronic Condition and Prescription Drug Coverage

- **CHF**: Seniors with Coverage (25%) vs. Seniors without Coverage (31%)
- **Diabetes**: Seniors with Coverage (14%) vs. Seniors without Coverage (33%)
- **Hypertension**: Seniors with Coverage (12%) vs. Seniors without Coverage (30%)

Percent of seniors who did not fill prescriptions one or more times due to cost:
- CHF: 14%
- Diabetes: 14%
- Hypertension: 12%

Percent of seniors who skipped doses of medicine to make it last longer:
- CHF: 16%
- Diabetes: 17%
- Hypertension: 14%

Projected Annual Medicaid Prescription Drug Expenditures Per Dual Eligible with Full Medicaid Benefits, 2002 (in Dollars)

States spend $6.8 billion on prescription drugs for dual-eligible beneficiaries

Percent of Seniors in Eight States with Incomes at or Below 100% of Poverty Who Have Heard of Medicaid and QMB/SLMB Programs

Medicare Prescription Drug Improvement & Modernization Act of 2003
Medicare Prescription Drug Improvement & Modernization Act of 2003

- Prescription drug coverage—largest benefit expansion in program history
- Structural changes—increased “privatization”
- Health Savings Accounts
Key Features of Medicare Prescription Drug Benefit

- Voluntary benefit effective January 1, 2006
- Rx benefit through regional stand-alone private Rx plans or HMOS or PPOs
- $410 billion in federal government spending, 2004–2013
- Annual premium in 2006 about $420—can vary by plan
- Annual $250 deductible indexed to drug spending
- Coverage gap (“donut hole”)—no coverage for spending between $2,250 and $5,100
- Subsidies for low-income beneficiaries
- Subsidies to employers to maintain retiree coverage
Medicare-Approved Drug Discount Card Program

• Effective June 2004, all beneficiaries (except those with Medicaid drug coverage) can enroll in a Medicare-approved discount card program; program ends when new benefit is implemented

• Choice of at least discount 2 cards; discounts of about 10%–15% of total drug costs; enrollment fee up to $30 annually

• Beneficiaries with incomes below 135% of poverty pay no fee and receive $600 annual subsidy toward the purchase of drugs; no asset test

• Bush administration assumes only 4.7 million out of 7.2 eligible low-income beneficiaries will sign up for the program

• Increasing participation rates to 90% would provide valuable assistance to 6.5 million of the most vulnerable elderly and disabled beneficiaries
## Standard Drug Benefit

<table>
<thead>
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<th>2006</th>
<th>2013</th>
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<tr>
<td><strong>Annual Deductible:</strong></td>
<td>$250</td>
<td>$445</td>
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<td><strong>Coinsurance to Initial Limit:</strong></td>
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<td>25%</td>
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<td><strong>Initial Limit:</strong></td>
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<td>$4,000</td>
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<td><strong>Out-of-Pocket Threshold:</strong></td>
<td>$3,600</td>
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<td><strong>Coverage Gap:</strong></td>
<td>$2,850</td>
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<td><strong>Coinsurance Above OOP:</strong></td>
<td>$2/$5</td>
<td>$3/$8</td>
</tr>
<tr>
<td>(greater of)</td>
<td>or 5%</td>
<td>or 5%</td>
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</tbody>
</table>
Prescription Drug Benefit 2006: Beneficiary Cost-Sharing

- $420 estimated annual premium
- Medigap and Medicaid cannot fill in gap
- Employer contributions do not count as out-of-pocket spending
Estimated Impact of the Medicare Law on State Medicaid Spending (FY 2004–2013)

In Billions

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Medicaid Savings Retained by States</td>
<td>$17.2</td>
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<tr>
<td>Mandatory State Payments to Federal Government</td>
<td>$88.5</td>
</tr>
<tr>
<td>(“Clawback”)</td>
<td></td>
</tr>
<tr>
<td>New State Costs</td>
<td>$8.9</td>
</tr>
<tr>
<td>(New Enrollment of Beneficiaries and Administration of Low-income Subsidy Program)</td>
<td></td>
</tr>
</tbody>
</table>

Beneficiary and Plan Share of Spending in 2006, at Individual Expenditure Levels, Under the New Medicare Drug Benefit

Source: Marilyn Moon, American Institutes for Research.
Structural Change: Increased “Privatization”

• Stand-alone private drug plans

• Establishes Medicare Advantage—HMOs and new regional PPO options

• Subsidies to encourage private plan participation—extra payments to HMOs begin 2004; average payments exceed those in traditional Medicare

• Moves toward defined contribution plan—demonstration of competition between traditional Medicare and private plans starts in 2010
Selected Commonwealth Fund Medicare Reports


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