Women and Medicare

Established in 1965, Medicare is a federal health insurance program that covers virtually all U.S. citizens age 65 or older, regardless of income. The program also covers younger people with permanent disabilities or certain diseases, who make up about 15 percent of all Medicare beneficiaries.[1] Medicare is primarily funded through a combination of payroll taxes and federal revenues, but most Medicare participants also pay premiums, deductibles, and additional out-of-pocket expenses for their medical care. From a beneficiary's point of view, Medicare may not seem any different than traditional private coverage, since private health insurers administer Medicare program benefits. But unlike traditional private coverage—and with the exception of Medicare Advantage plans (described below)—medical claims for Medicare beneficiaries are ultimately paid for by the federal government.

The Medicare program is divided into four parts:

- Part A ("Hospital Insurance") covers inpatient hospital, skilled nursing facility, and hospice services (funded through payroll taxes);
- Part B ("Supplementary Medical Insurance") covers physician, outpatient, preventive, and other medically-necessary services. All but the poorest Medicare enrollees contribute to their Part B coverage via monthly premiums—in 2007, premiums were roughly $94 per month[2];
- Part C ("Medicare Advantage") allows enrollees to receive their Medicare Part A and Part B benefits through private insurance carriers[3]; and,
- Part D covers outpatient prescription drugs.

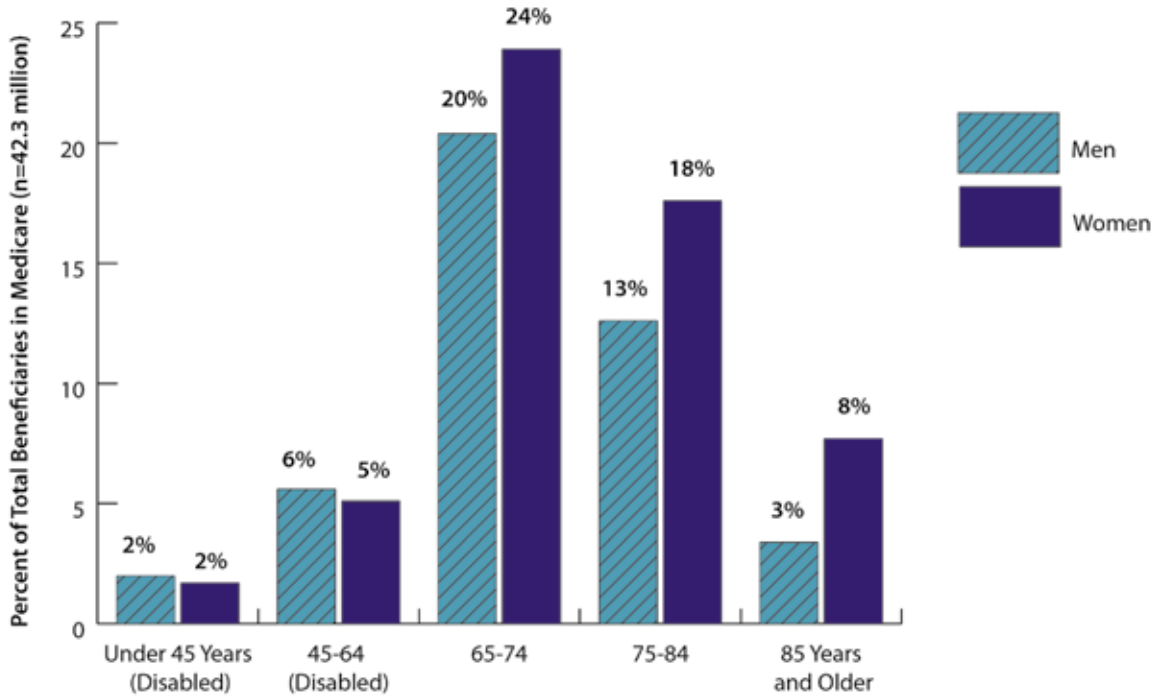
Basic Medicare does not cover certain services, such as long term care, dental care, or hearing aids. Many Medicare beneficiaries purchase additional health insurance to cover these services—typically through their employer or directly from the private insurance market. If Medicare beneficiaries have a low enough income, they may have "dual-eligibility," meaning that they also qualify for services available through the Medicaid program.

The Medicare Program Plays a Vital Role for Women

Medicare is a critical source of health insurance for women over age 65 and for certain eligible women with disabilities. In 2003, the program covered over 23 million women, including roughly 21 million women ages 65 and older and nearly 3 million younger women with disabilities.[4] Because women generally have longer life expectancies than men, they are disproportionately represented among those enrolled in Medicare. Consider these facts:

- Women accounted for 56 percent of all Medicare beneficiaries in 2003.[5]
- They comprised nearly 70 percent of all Medicare enrollees aged 85 years and older (Figure 1).
- Over two-thirds of all Medicare beneficiaries living in long-term care facilities are women.[6]

Figure 1
Medicare Beneficiaries by Age and Sex, 2003



Source:
NWLC Calculations using Centers for Medicare and Medicaid Services, *Detailed Tables from the Medicare Current Beneficiaries Survey Data* (2002), http://www.cms.hhs.gov/mcbs/downloads/HHC2002section1.pdf.

- Women in Medicare who are age 75 or older are more than twice as likely as men to have incomes of $10,000 or less, which is below the federal poverty level (Figure 2).
- Because of their lower income, women are over-represented among those who are "dual-eligible" for Medicare and Medicaid: more than 60 percent of all dual-eligible beneficiaries are women.[7]

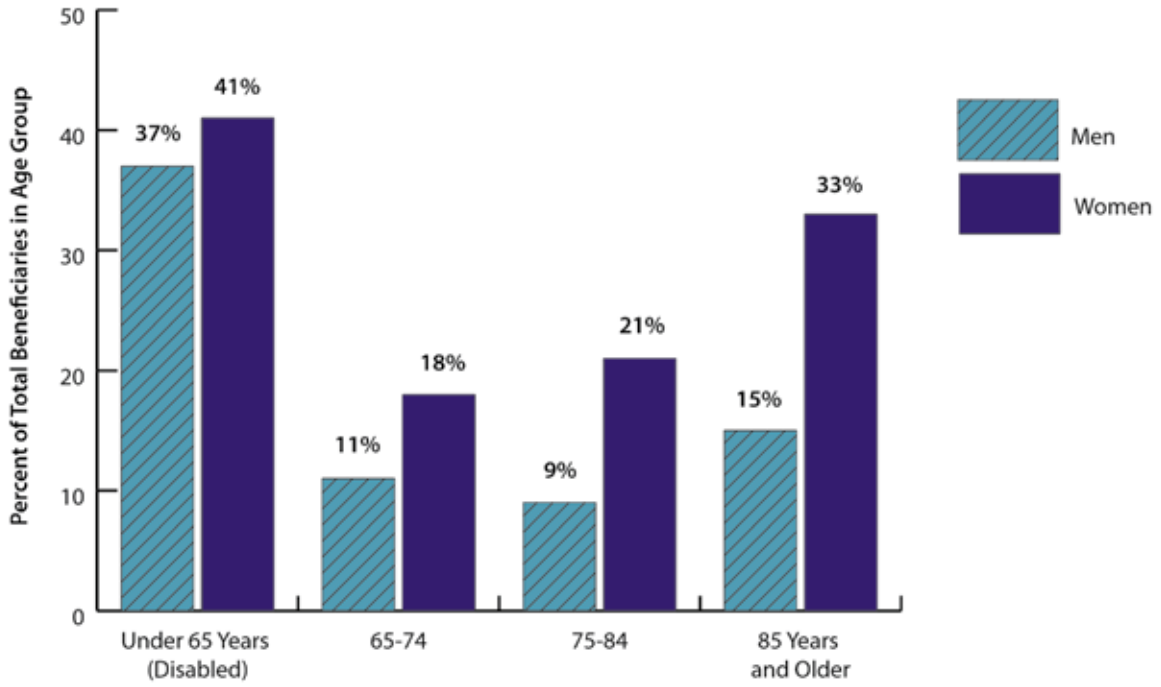
Cost-sharing in Medicare: A Barrier to Health Care for Many Women

Women in Medicare, when compared to men, pay a larger share of their income in out-of-pocket medical costs.[8] Cost-sharing in Medicare presents a potential barrier to health service access, especially for beneficiaries with few cash resources who might avoid or delay cost-effective preventive care if they cannot afford the out-of-pocket cost of that care. A recent study of rates of biennial breast-cancer screenings in Medicare plans with different levels of cost-sharing for mammography demonstrated that even nominal copayments were associated with significantly lower screening rates compared to plans with full coverage. These negative effects of cost-sharing were magnified among women living in low-income areas.[9]

Medicare Advantage and the Debate on the Future of Medicare

Over 44 million Americans currently participate in Medicare, and program participation is expected to experience rapid growth over the next two decades.[10] The total number of people enrolled in Medicare will nearly double between the years 2000 and 2030, eventually

Figure 2
Medicare Beneficiaries with Annual Incomes Below $10,000, by Age and Sex, 2003



Source:
NWLC Calculations using Centers for Medicare and Medicaid Services, *Detailed Tables from the Medicare Current Beneficiaries Survey Data* (2002), http://www.cms.hhs.gov/mcbs/downloads/HHC2002section1.pdf.

reaching about 79 million beneficiaries.[11] This projected increase in program enrollment, in combination with the rapid growth of health care costs and the declining ratio of workers (i.e. those who fund Medicare through payroll taxes) to beneficiaries, has prompted some policymakers to debate whether and how Medicare can be sustained in the future.

A philosophical question that is central to this debate relates to Medicare Advantage (also known as Medicare's Part C): should private and for-profit insurance companies be allowed to sell Medicare plans, or should the program continue to function as it has for over 40 years, as a traditional federal insurance program? Proponents of Medicare Advantage (MA) have claimed that by using private health plans, the program can contain costs and provide better health care for Medicare beneficiaries. But there is little evidence that MA plans have made good on their promise to provide better quality care or enhanced benefits, and there is ample evidence that the plans are significantly overpaid.[12] In 2008, private MA plans are being paid 13 percent more, on average, than it would cost traditional Medicare to cover the same beneficiaries.[13] MA overpayments have contributed to a rapid growth in private plan contracts; participation in these plans has grown from 5.3 million beneficiaries in 2003 to 8.7 million (or, about 20 percent of all beneficiaries) in 2007, with growth concentrated in the areas of highest overpayment.[14, 15]

These overpayments raise a number of concerns. They have accelerated rapidly-growing Medicare program costs, and private insurers offering MA plans have recently been under

scrutiny for preying on Medicare beneficiaries through aggressive and abusive marketing practices, arguably due to the overpayments.[16] Paying Medicare Advantage plans at rates equal to traditional Medicare could save an estimated $54 billion over five years.[17]

Medicare and Health Reform

One type of health reform proposal would expand Medicare so that most, if not all, Americans would be eligible to participate in the program. These "Medicare for All" plans would open Medicare to any American who wanted to buy-in to the program, while still allowing those who did not want to participate in Medicare to purchase private insurance.

Another type of proposal, which is typically just one component of a larger reform package, would lower the age of eligibility for Medicare (to age 55, for example). This type of reform could be of particular benefit to women. Since they are more likely to be married to an older spouse, women are at greater risk of losing dependent coverage and becoming uninsured when that spouse becomes eligible for Medicare (and therefore transitions out of job-based health insurance).[18] Indeed, among adults aged 50-64, women are more likely than men to be uninsured; for all other adult age groups this pattern is reversed.[19]

Women and Medicare: What Can Women's Advocates Do?

Women's advocates can support reforms that protect and improve the Medicare program without sacrificing women's access to health care services.

Debate around the future of Medicare is certain to continue, especially in the context of health reform. Advocates should understand the important role that Medicare plays in providing health coverage for women as well as the access barriers that low-income women with Medicare face, and they must support health reforms that address these challenges.

For further reading, see:

Henry J. Kaiser Family Foundation, *Medicare: A Primer* (Mar. 2007), http://www.kff.org/medicare/upload/7615.pdf.

Edwin Park, Center on Budget and Policy Priorities, *Informing the Debate about Curbing Medicare Advantage Payments* (May 13, 2008), http://www.cbpp.org/5-13-08health.htm#6.

Centers for Medicare and Medicaid Services, *Women with Medicare* (Oct. 16, 2007), http://www.medicare.gov/Publications/Pubs/pdf/02248.pdf.

References

1 Henry J. Kaiser Family Foundation: State Health Facts, *Distribution of Medicare Beneficiaries by Eligibility Category* (2004), http://www.statehealthfacts.org/comparetable.jsp?ind=293&cat=6.

2 Henry J. Kaiser Family Foundation, *Medicare: A Primer* (Mar. 2007), http://www.kff.org/medicare/upload/7615.pdf.

3 Private insurers participating in Medicare Advantage receive payments from the Medicare program, but the plans themselves assume the medical risk for enrollees and ultimately pay beneficiaries' medical claims. For more information about Medicare Advantage, see: Henry J. Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (Jun. 2007), http://www.kff.org/medicare/upload/2052-10.pdf.

4 NWLC Calculations using Center for Medicare and Medicaid Services, *Detailed Tables from the Medicare Current Beneficiaries Survey Data* (2002), http://www.cms.hhs.gov/mcbs/downloads/HHC2002section1.pdf.

5 *Id.*

6 *Id.*

7 MedPac (Medicare Payment Advisory Commission), *A Data Book: Health Care Spending and the Medicare Program* (Jun. 2007), www.medpac.gov/documents/Jun07DataBook_Entire_report.pdf.

8 Henry J. Kaiser Family Foundation, *Women and Medicare Fact Sheet* (Jul. 2001), http://www.kff.org/medicare/upload/Women-and-Medicare-Fact-Sheet-2.pdf.

9 Ann N. Trivedi et al., *Effect of Cost Sharing on Screening Mammography in Medicare Health Plans*, New England Journal of Medicine 358(4):375-83 (Jan. 24, 2008), http://content.nejm.org/cgi/content/abstract/358/4/375.

10 Henry J. Kaiser Family Foundation: State Health Facts, *Total Number of Medicare Beneficiaries* (Jan. 2008), http://www.statehealthfacts.org/comparetable.jsp?ind=290&cat=6&sub=74&yr=63&typ=1&sort=n&o=a.

11 A Data Book, *supra* note 7.

12 Center on Budget and Policy Priorities, *Curbing Medicare Overpayments Would Strengthen Medicare* (Dec. 5, 2007), http://www.cbpp.org/12-5-07health.pdf.

13 MedPac (Medicare Payment Advisory Commission), *Report to the Congress: Medicare Payment Policy* (March 2008), http://www.medpac.gov/documents/Mar08_EntireReport.pdf.

14 Henry J. Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (Jun. 2007), http://www.kff.org/medicare/upload/2052-10.pdf.

15 Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, *Private Plan Overpayments Weaken Medicare's Financing and Hasten the Program's Insolvency* (Apr. 20, 2007), http://www.cbpp.org/4-20-07health.htm.

16 Edwin Park, Center on Budget and Policy Priorities, *Informing the Debate about Curbing Medicare Advantage* Payments (May 13, 2008), http://www.cbpp.org/5-13-08health.htm#6.

17 Congressional Budget Office, *Preliminary CBO Estimates of Policies Capping the Medicare Advantage Benchmarks* (April 15, 2008).

18 Jeanne M. Lambrew, The Commonwealth Fund, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (Aug. 2001), http://www.commonwealthfund.org/usr_doc/lambrew_disparities_493.pdf?section=4039.

19 Elizabeth M. Patchias and Judy Waxman, National Women's Law Center and The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* (Apr. 2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf

2008