

EBRI**EMPLOYEE****BENEFIT****RESEARCH****INSTITUTE®**

Notes

June 2005, Vol. 26, No. 6

The Impact of Immigration on Health Insurance Coverage in the United States, p. 2

Facts from EBRI: The Basics of Medicare, p. 9

New Publications and Internet Sites, p. 14

Executive Summary:

The Impact of Immigration on Health Insurance Coverage in the United States

- ***The Uninsured:*** During nearly every year between 1994 and 2003, the number and percentage of Americans without health insurance coverage increased, from 15.9 percent of the nonelderly population in 1994 up to 17.7 percent in 2003. Numerous reasons have been cited for this increase in the uninsured: The combination of the rising cost of providing health benefits and a weak economy; structural changes in the economy, such as the movement of workers out of the manufacturing sector and into the service sector; and the decline of unionization.
- ***The Immigration Factor:*** Previous studies have found that immigrants are disproportionately employed in low-wage jobs, in small firms, and in service or trade occupations, jobs that are less likely to offer health benefits. The relative lack of employment-based coverage is compounded by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which imposed a five-year ban on participation in health and other public programs by most newly arrived legal immigrants. Although these restrictions were subsequently loosened, the fact remains that fewer public benefits were available to recent immigrants during the latter part of the 1990s than earlier in the decade. And even after this five-year ban expired, immigrants may continue to be ineligible for public programs as a result of rules that attribute the income of an immigrant's sponsor to the immigrant.
- ***Immigrants and the Uninsured:*** More than 11 million immigrants in the United States were uninsured in 2003, accounting for 26.1 percent of the all uninsured individuals in the country. Immigrants accounted for about one-third of the increase in the uninsured between 1994 and 1998, but between 1998 and 2003 they accounted for 86 percent of the growth in the uninsured, presumably because PRWORA restricted their benefits under public assistance programs for five years after they entered the United States. To the degree that immigration continues to increase, it is likely that the uninsured will also continue to increase as a proportion of the population.

■ The Impact of Immigration on Health Insurance Coverage in the United States

by Paul Fronstin, EBRI

During nearly every year between 1994 and 2003, the number and percentage of Americans without health insurance coverage increased. In 2003, 44.7 million U.S. residents under age 65 (17.7 percent of the nonelderly population) were uninsured, up from 36.5 million in 1994 (15.9 percent of the nonelderly population).¹

During the 1990s, the decline in health insurance coverage in the United States was mainly due to an erosion of public sources of health insurance. The percentage of nonelderly Americans covered by Medicaid declined from 12.7 percent in 1994 to 10.5 percent in 1999. The erosion was in large part the result of former welfare recipients entering the work force. Similarly, the percentage of nonelderly Americans covered by Tricare or CHAMPVA² declined from 3.8 percent to 2.8 percent between 1994 and 2000, in large part due to downsizing in the military. In contrast to the decline in public coverage, the percentage of Americans covered by an employment-based health plan increased between 1994 and 1999.

The 2000–2003 period saw a reversal of the earlier trend and a growing rate of uninsured. Due to the weak economy and the rising cost of providing health benefits, there has been erosion in the percentage of Americans covered by employment-based health plans. The percentage of Americans with employment-based health benefits decreased from 66.8 percent in 2000 to 63 percent in 2003. Expansions in the percentage of the population covered by public programs, particularly Medicaid, and the relatively new State Children's Health Insurance Program (S-CHIP), to some degree offset the erosion in employment-based health benefits. Between 1999 and 2003, the percentage of nonelderly Americans with some form of public coverage increased; however, the expansion in public coverage was not large enough to fully offset the decline in employment-based health benefits. As a result, the percentage of nonelderly Americans without health insurance coverage increased.

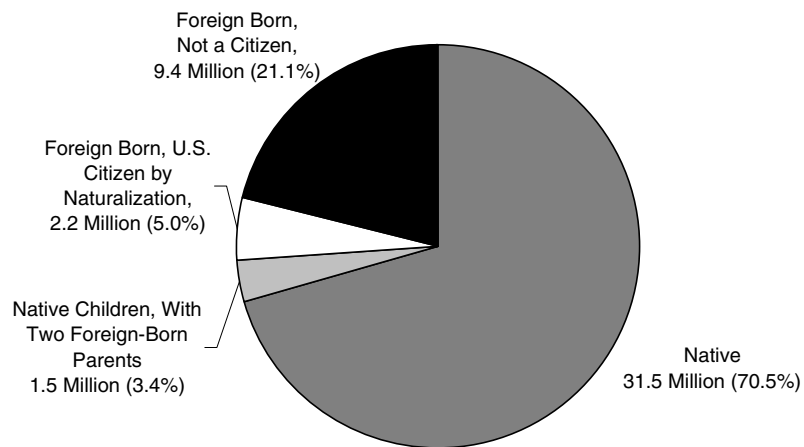
Numerous reasons have been cited for the increase in the uninsured population. The combination of the cost of providing health benefits, which has been rising about five times faster than overall worker wages,³ and the weak economy has caused fewer employers to offer health benefits and fewer workers to be covered.⁴ Between 2001 and 2004, the percentage of employers with 3–199 employees that offered health benefits declined from 68 percent to 63 percent.⁵ In addition, the percentage of workers taking health benefits when they were offered declined from 89 percent in 1988 to 82 percent in 2001.⁶

Structural changes in the economy have also contributed to the decline in employment-based health benefits. The movement of workers out of the manufacturing sector and the decline of unionization have both contributed to the decline in the percentage of Americans with employment-based health benefits.⁷

One factor that has contributed to the increase in the uninsured is immigration, and it has been receiving increasing attention recently. Previous studies have found that immigrants are disproportionately employed in low-wage jobs, in small firms, and in service or trade occupations, jobs that are less likely to offer health benefits.⁸ The relative lack of employment-based coverage is compounded by the fact that the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 imposed a five-year ban on participation in health and other public programs by most newly arrived legal immigrants. Although these restrictions were subsequently loosened a bit, the fact remains that fewer public benefits were available to recent immigrants during the latter part of the 1990s than earlier in the decade. And even after this five-year ban expired, immigrants may continue to be ineligible for public programs as a result of rules that attribute the income of an immigrant's sponsor to the immigrant.⁹

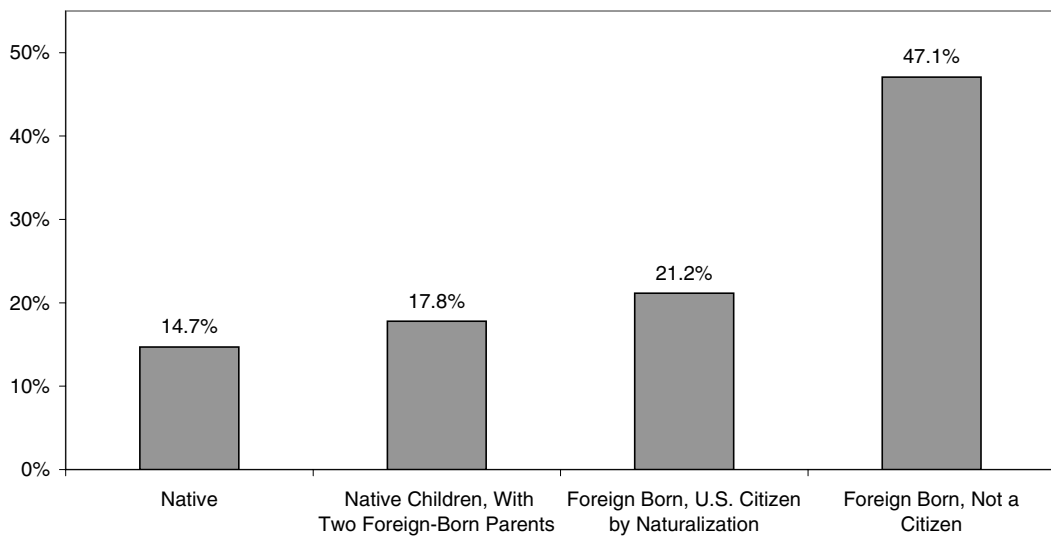
Previous research has examined the impact of increased immigration on the uninsured in the United States. One study concluded that immigrants who arrived between 1994 and 1998 accounted for the majority of the growth in the uninsured population since 1993.¹⁰ However, a similar study concluded that, although recent immigrants have high rates of being uninsured, they are not a significant reason for the growth in the number of uninsured.¹¹

Figure 1
Distribution of Uninsured Population, by Immigration Status,
U.S. Population Under Age 65, 2003



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2004 Supplement.

Figure 2
Likelihood of Being Uninsured, by Immigration Status,
U.S. Population Under Age 65, 2003



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2004 Supplement.

This article examines the issue of immigration and health insurance coverage in the United States. It first examines the status of health insurance coverage among immigrants as compared with nonimmigrants. It then examines the impact of immigration over the period 1994–2003, a much longer period than is covered by previous studies.

Immigrants and the Uninsured Population

Native-born Americans account for most of the uninsured population in the United States. In 2003, 33 million (or 73.9 percent of the 44.7 million U.S. residents without health insurance) were native-born Americans (Figure 1). Within the native-born population, 1.5 million were native children under age 18 of two foreign-born parents, accounting for 3.4 percent of the uninsured. Slightly more than 2 million (or 4.9 percent of the 44.7 million uninsured) were foreign-born individuals who have become citizens of the United States, while 9.4 million individuals (or 21.2 percent of the uninsured) were foreign-born persons who are not U.S. citizens.

Immigrants are much more likely to be uninsured than citizens. Nearly 50 percent of foreign-born noncitizens were uninsured in 2003 (Figure 2). This compares with 21.2 percent uninsured of foreign-born individuals who have become U.S. citizens, 17.8 percent of native-born children with two foreign-born parents, and 14.7 percent uninsured of native-born persons.

Whether an immigrant is uninsured is highly correlated with the length of time he or she has been in the United States. Slightly more than 21 percent of foreign-born noncitizens who entered the United States before 1970 were uninsured in 2003 (Figure 3). This compares with 43 percent of uninsured foreign-born noncitizens who entered the United States during the 1980s, and 53.4 percent uninsured of foreign-born noncitizens who entered the country during 2000–2004. Among foreign-born persons who have become U.S. citizens, the likelihood of being uninsured is also correlated with the length of time they have been in the United States, but they are about one-half as likely to be uninsured (when controlling for length of time in the country) as foreign-born noncitizens.

The majority of the uninsured foreign-born noncitizen population is comprised of recent immigrants. About one-third of uninsured noncitizens entered the United States during 2000–2004, while another 46 percent entered during the 1990s (Figure 4). In contrast, only 3 percent of uninsured foreign-born naturalized citizens entered the United States during 2000–2004. About one-quarter entered during 1990–1999, while the remainder entered prior to 1990.

The uninsured immigrant population is also highly concentrated in a few states. Slightly more than one-quarter of the 11.6 million uninsured immigrants in the United States reside in California (Figure 5). Fifteen percent of uninsured immigrants are in Texas, 10 percent are in New York, and 9 percent are in Florida. Overall, 60 percent of uninsured immigrants reside in these four states.

Immigrants and Sources of Health Insurance

Despite the fact that recent immigrants are banned under PRWORA from receiving benefits under public assistance programs for five years after entering the United States (except for native children with foreign-born parents), differences between immigrants and nonimmigrants in the likelihood of having employment-based health benefits affect the likelihood of being uninsured much more than differences in coverage from public programs.

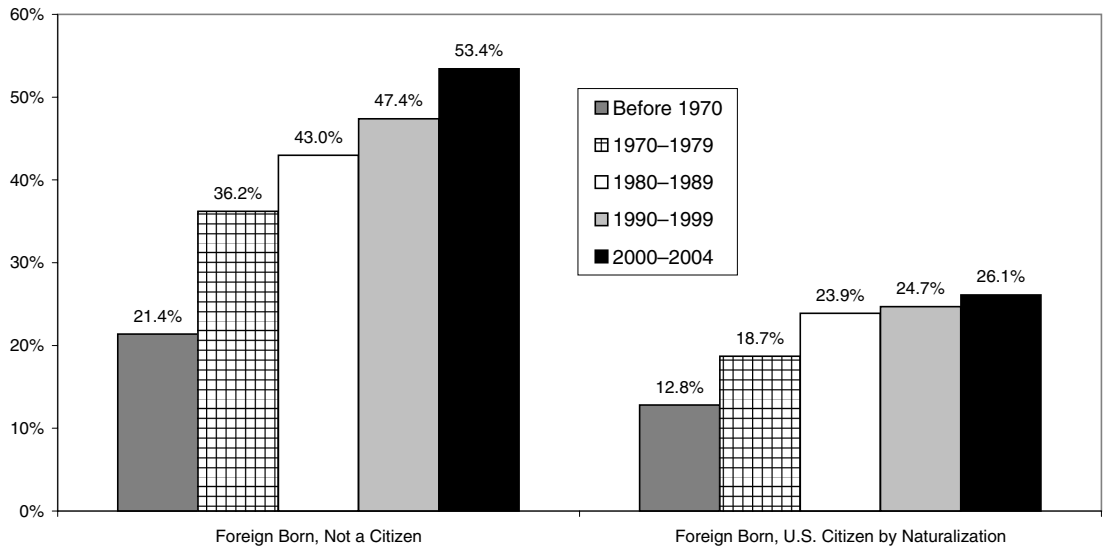
In 2003, 66 percent of natives and 64.7 percent of U.S. citizens who were foreign born were covered by employment-based health benefits, whereas 38.5 percent of foreign-born noncitizens, and 43.1 percent of native children with two foreign-born parents had employment-based coverage (Figure 6).

With respect to public coverage, however, 37.5 percent of native children with two foreign-born parents were covered by either Medicaid or S-CHIP, compared with 12.3 percent of natives, 10.9 percent of foreign-born noncitizens, and 6.9 percent of U.S. citizens who were foreign-born.

The Uninsured, 1994–2003

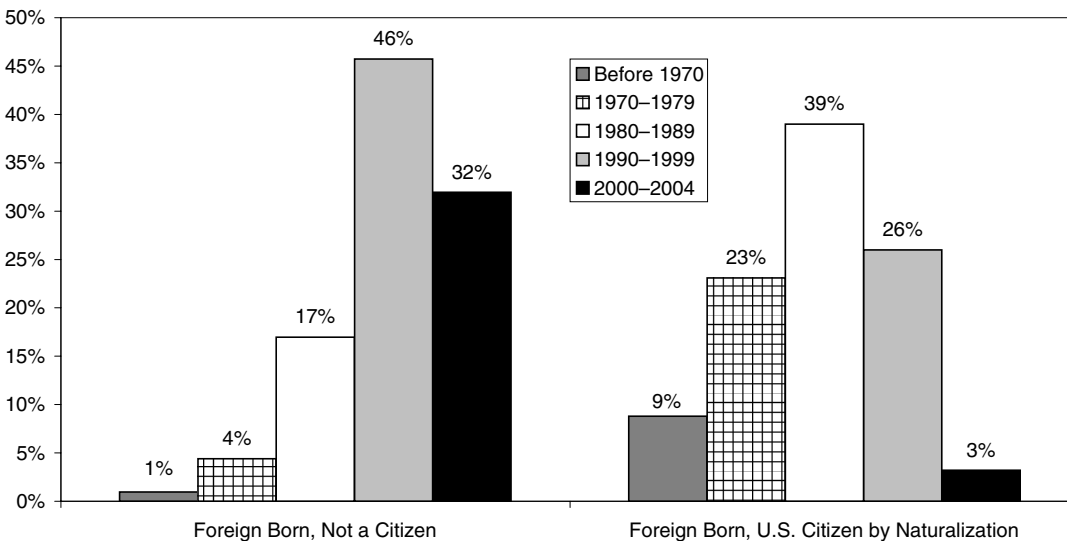
While the uninsured population is still dominated by native-born Americans, it is becoming increasingly comprised of immigrants. In 1994, immigrants accounted for 18.8 percent of the uninsured population, while native-born Americans accounted for 81.2 percent (Figure 7). In contrast, by 2003,

Figure 3
Likelihood of Being Uninsured, by Year Entered U.S. and
Immigration Status, U.S. Population Under Age 65, 2003



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2004 Supplement.

Figure 4
Distribution of Nonelderly Immigrant Uninsured Population,
by Year Entered United States and Immigration Status,
U.S. Population Under Age 65, 2003



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2004 supplement.

immigrants accounted for 26.1 percent of the uninsured population, while native-born Americans accounted for 73.9 percent.

The likelihood of being uninsured also increased for immigrants between 1994 and 2003, while it has barely changed for native-born Americans. In 1994, 34 percent of immigrants were uninsured, but by 2003, 38.2 percent were uninsured, a 12 percent increase in their likelihood of being uninsured (Figure 8). In contrast, the uninsured rate among native-born Americans increased from 14.1 percent in 1994 to 14.9 percent in 2003, a 5 percent increase in the chance of being uninsured.

The uninsured immigrant population increased from 6.9 million in 1994 to 11.6 million in 2003, a 70 percent increase. In comparison, the uninsured native-born population increased from 29.7 million to 33.0 million, a 12 percent increase over the period. As a result, immigrants accounted for about 59 percent of the increase in the uninsured population between 1994 and 2003. Clearly, while the uninsured rate among immigrants grew by 12 percent compared with an increase of only 5 percent among citizens between 1994 and 2003, the fact that there were only 6.9 million uninsured noncitizens in 1994 accounts for why immigrants comprised only 59 percent of the increase in the uninsured over this period.

The findings in this article help put earlier findings in context. Holahan et al. (2001) found that immigration had virtually no impact on the growth of the uninsured population between 1994 and 1998. In fact, this analysis confirms their findings, for that period. As part of the analysis, it was determined that native-born Americans accounted for 68 percent of the growth in the uninsured between 1994 and 1998, while immigrants accounted for only 32 percent.¹² But if this analysis is limited to the impact of immigration between 1998 and 2003, native-born Americans are found to have accounted for only 14 percent of the growth in the uninsured, while immigrants accounted for 86 percent, a major difference from the conclusion of Holahan et al., mainly because different periods of time were examined.

Conclusion

More than 11 million immigrants in the United States were uninsured in 2003, accounting for 26.1 percent of the 44.7 million uninsured individuals in the country. Immigrants accounted for about one-third of the increase in the uninsured between 1994 and 1998, but between 1998 and 2003 they accounted for 86 percent of the growth in the uninsured, presumably because PRWORA restricted their benefits under public assistance programs for five years after they entered the United States. To the degree that immigration continues to increase, it is likely that the uninsured will also continue to increase as a proportion of the population.

Endnotes

¹ Paul Fronstin, "Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey," *EBRI Issue Brief* no. 276 (Employee Benefit Research Institute, December 2004).

² Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

³ Jon Gabel et al., "Health Benefits In 2004: Four Years of Double-Digit Premium Increases Take Their Toll On Coverage," *Health Affairs*, Vol. 23, no. 5 (September/October 2004): 200–209.

⁴ Fronstin (op. cit., 2004).

⁵ Jon Gabel, et al. (op. cit., 2004).

⁶ Paul Fronstin, "Trends in Health Insurance Coverage: A Look at Early 2001 Data," *Health Affairs*, Vol. 21, no. 1 (January/February 2002): 188–193.

⁷ See Paul Fronstin, "The Impact on Employment-Based Health Benefits of the Shift From a Manufacturing Economy to a Service Economy," *EBRI Notes*, no. 6 (Employee Benefit Research Institute, June 2004):1–3; and Paul Fronstin, "Union Status and Employment-Based Health Benefits," *EBRI Notes*, no. 5 (Employee Benefit Research Institute, May 2005): 2–6.

⁸ Joan C. Alker, and Marcela Urrutia, “Immigrants and Health Coverage: A Primer,” The Kaiser Commission on Medicaid and the Uninsured, Publication no. 7088 (June 2004).

⁹ Alker and Urrutia (ibid., 2004).

¹⁰ S. Camarota and J.R. Edwards, “Without Coverage: Immigration’s Impact on the Size and Growth of the Population Lacking Health Insurance.” (Center for Immigration Studies, July 2000), www.cis.org/articles/2000/coverage/index.html.

¹¹ See John Holahan, Leighton Ku, and Mary Pohl, “Is Immigration Responsible for the Growth in the Number of Uninsured?” The Kaiser Commission on Medicaid and the Uninsured, Publication no. 2221 (February 2001).

¹² These estimates are available upon request from the author. They are slightly different from those published in Holahan et al. because of methodological changes to the way in which the uninsured population is identified in the CPS.

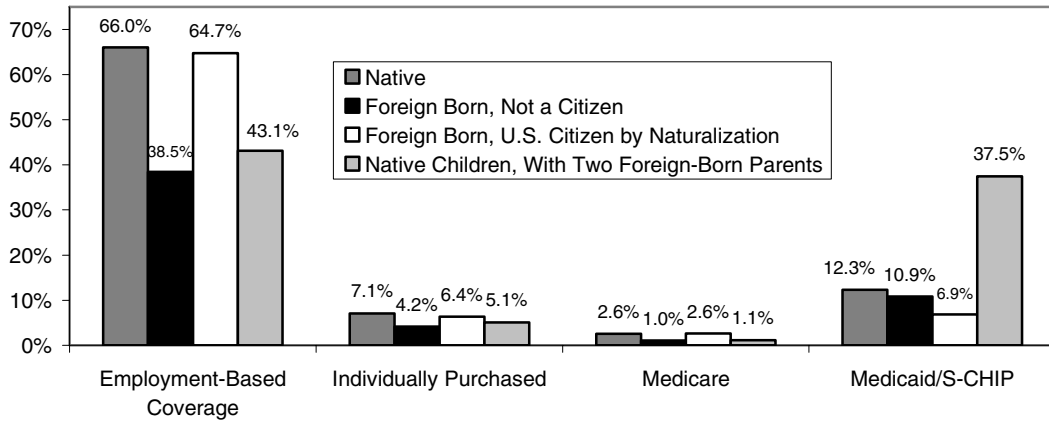
Figure 5

Distribution of Nonelderly Immigrant Uninsured Population, by State, U.S. Population Under Age 65, 2003

	Percentage of Uninsured Immigrants	Number of Uninsured Immigrants (millions)
Total	100%	11.6
California	27	3.2
Texas	15	1.7
New York	10	1.1
Florida	9	1.0
Illinois	4	0.4
New Jersey	4	0.4
Arizona	3	0.4
North Carolina	3	0.3
Maryland	2	0.3
Georgia	2	0.2
Washington	2	0.2
Virginia	2	0.2
Colorado	2	0.2
Massachusetts	2	0.2
Oregon	1	0.2
Ohio	1	0.1
Nevada	1	0.1
Pennsylvania	1	0.1
States not listed	10	1.2

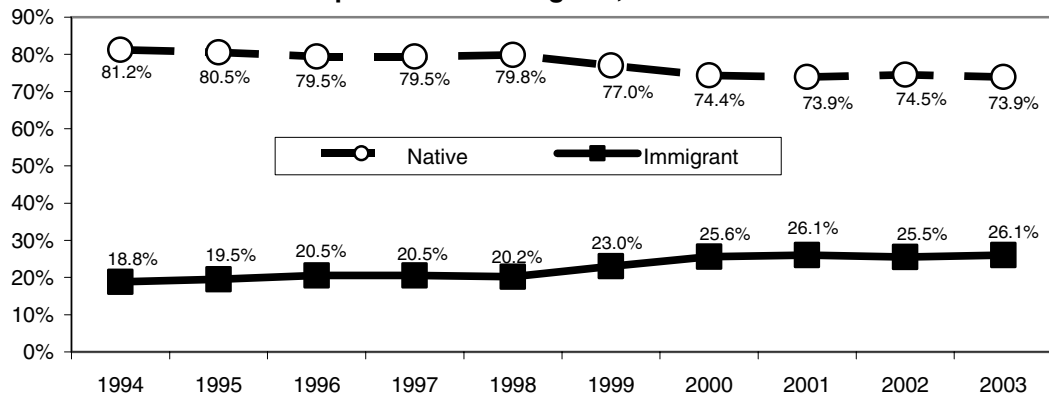
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2004 supplement.

Figure 6
**Selected Sources of Health Insurance, by Immigration Status,
 U.S. Population Under Age 65, 2003**



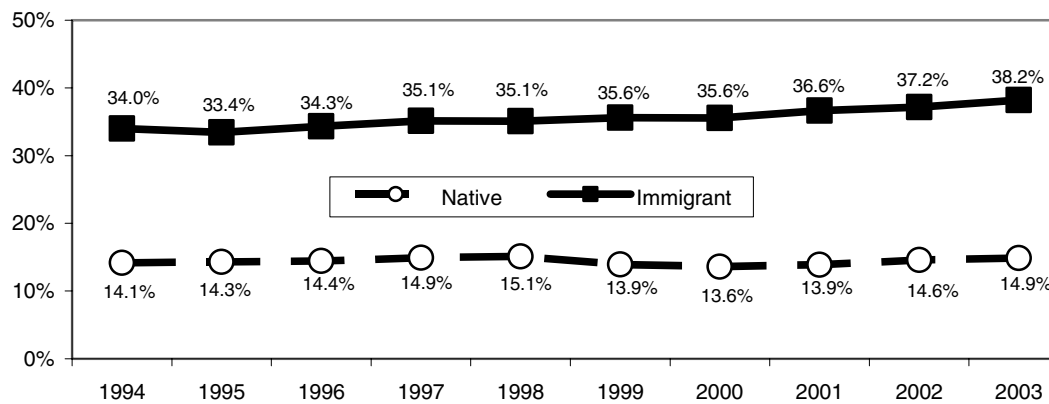
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2004 Supplement.

Figure 7
**Distribution of Uninsured Population, by Immigration Status,
 Population Under Age 65, 1994–2003**



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2004 Supplement.

Figure 8
**Likelihood of Being Uninsured, by Immigration Status,
 Population Under Age 65, 1994–2003**



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2004 Supplement.

■ Facts from EBRI: The Basics of Medicare, Updated With the 2005 Board of Trustees Report

by Ken McDonnell, EBRI

History

- In 1965, Title 18, “Health Insurance for the Aged,” of the Social Security Act created the Medicare program. Medicare consists of two parts: Part A, Hospital Insurance (HI), covers hospital services and some home health care and skilled nursing facility services, and Part B, Supplemental Medical Insurance (SMI), covers physician care, outpatient hospital services, and independent laboratory services.
- In 1972, the Medicare program was expanded to include disabled persons who qualified for benefits under the Disability Insurance (DI) program and certain individuals with end-stage renal (kidney) disease.
- In 1986, all state and local government employees hired after Mar. 31, 1986, and not covered under Social Security, were required to be covered by Medicare.
- In 1997, the Balanced Budget Act of 1997 expanded the delivery of health care under Medicare with the Medicare+Choice program. See below for more details.
- In 1997, under the Balanced Budget Act of 1997, home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI were transferred from the HI program to the SMI program, effective January 1998.
- In 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare+Choice program.
- In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act, which created an outpatient prescription drug benefit under Part D, means tested Part B premiums, and increased the Part B deductible.

Covered Beneficiaries

- Medicare serves elderly. Enrollment in Part A (HI) is automatic, while enrollment in Part B (SMI) is voluntary. It also serves disabled workers who qualify for DI benefits. In 2004, 34.9 million elderly and 6.3 million disabled individuals were enrolled in Part A, and 33.3 million elderly and 5.5 million disabled individuals were enrolled in Part B.

Financing

- Expressing Medicare expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The projection of this measure affords the public an idea of the relative financial resources that will be necessary to pay for Medicare services. In 2004, expenditures in the Medicare program equaled 2.6 percent of GDP. In 2006, when Part D starts to pay benefits, Medicare’s expenditures as a percentage of GDP are projected to jump to 3.3 percent. By 2079, that percentage is estimated to be 13.6 percent.
- In 2024, Medicare costs are projected to exceed those of the Social Security OASDI program and to be almost twice as much by 2078.

▸ Part A: Hospital Insurance (HI)

- The Balanced Budget Act of 1997 contained numerous provisions affecting the Medicare program. These provisions were designed in part to postpone the imminent depletion of the HI trust fund, which, according to the 1997 Board of Trustees’ report, had been projected for 2001. Under this legislation, fund exhaustion is postponed until 2030, based on the

intermediate assumptions used in the 2002 Board of Trustees' report. The projected date for exhaustion of the HI Trust Fund is 2020 according to the 2005 Trustees' Report.

- HI payroll taxes for 2003 were based on a combined employer/employee rate of 2.9 percent. The Omnibus Budget Reconciliation Act of 1993 completely removed any wage base limit for the HI payroll tax, effective Jan. 1, 1994. For years 2005 and afterward, the payroll tax is scheduled to be 2.9 percent. In 2004, total income for the HI trust fund was \$183.9 billion: \$156.7 billion came from payroll taxes, \$8.6 billion from taxation of Social Security benefits, \$15.0 billion from interest and other income,¹ \$1.9 billion from premium payments, and \$1.8 billion from miscellaneous revenue.
- In 2004, the average amount reimbursed per enrollee in Part A was \$4,064.
- In 2004, administrative costs for Part A were \$3.0 billion, or 1.8 percent of expenditures.
- By the end of 2079, the unfunded obligation of the HI trust fund is estimated to be \$8.6 trillion, while the unfunded obligation through the infinite horizon is \$24.1 trillion.

► **Part B: Supplementary Medical Insurance (SMI)**

- The SMI trust fund is financed on a year-by-year basis. The SMI program derives its revenues from premium payments by beneficiaries and general revenues from the federal budget. Under current law, no more than 25 percent of SMI's revenues can come from premium payments.
- The average amount reimbursed per enrollee in Part B was \$3,489, in 2004.
- In 2004, administrative costs for Part B were \$2.9 billion, or 2.1 percent of expenditures.
- By the end of 2079, the unfunded obligation of Part B is estimated to be \$16.6 trillion, while the unfunded obligation through the infinite horizon is \$34.5 trillion.

► **Part D: Medicare Prescription Drug Account**

- Beginning in 2004 and continuing through 2005, the Medicare Modernization Act created the Transitional Assistance Account, which is used to provide assistance to certain low-income beneficiaries prior to the start of the Medicare Prescription Drug Account.
- Part D will be financed by beneficiary premium payments, transfers from the general fund of the Treasury, and transfers from state governments. Premiums are to account for 25.5 percent of the total costs of Part D.
- Expenditures for the Transitional Account in 2004 were \$216 million.
- Estimated operations of the Part D Account are summarized below. Actual experience is likely to fall within the range of the assumptions but no assurance of this can be given because Part D is a new voluntary program for which there is no actual experience.

Estimated Costs of Medicare Prescription Drug (Part D) Program, 2006–2014

Calendar Year	Premiums From Enrollees	Other Income ¹	Total Revenue	Total Expenditures
(\$ billions)				
Intermediate Assumptions				
2006	\$ 8.5	\$ 73.4	\$ 81.9	\$ 81.9
2014	21.3	153.6	174.9	174.9
Low-Cost Assumptions				
2006	6.4	54.4	60.7	60.7
2014	13.2	95.4	108.7	108.7
High-Cost Assumptions				
2006	11.1	92.5	103.5	103.5
2014	33.1	236.7	269.8	269.8

¹ Contains federal and state government payments plus interest income.

- By the end of 2079, the unfunded obligation of Part D is estimated to be \$11.2 trillion, while the unfunded obligation through the infinite horizon is \$23.5 trillion.

► Federal Budgetary Processes

- Currently, the U.S. Department of the Treasury credits the Medicare and Social Security trust funds with any annual excess of Medicare and Social Security tax revenues over the amount spent for current benefits. By law, these assets must be invested in special securities issued by the Treasury. The government then spends these “assets” to ease fiscal pressures on other programs. The trust fund surpluses are not reserved for future Medicare and Social Security benefits but are bookkeeping entries showing how much the Medicare and Social Security programs have lent to the Treasury (or alternatively, what is owed to Medicare and Social Security, including interest, by the Treasury). When the trust funds go into negative cash flow, the Treasury must start repaying the money.
- For budgetary purposes, the date on which the trust funds go into negative cash flow (i.e., the benefit payments exceed the income from payroll taxes and the taxation of benefits) is significant because it marks the point at which the government must provide cash from general revenues to the programs rather than receive surplus cash from them to fund other current spending.

Cost-Sharing Provisions

► Part A Hospital Insurance (HI)

- Part A requires an enrolled individual to pay various deductibles and co-pays, depending on the facility where the service is provided and the length of stay.
- *In-patient Hospital Deductible*—For a hospital stay of 1–60 days in 2005, a patient is liable for an \$912 deductible. For a hospital stay of 61–90 days in 2005, the patient is liable for a \$228 co-pay per day. For a hospital stay of more than 90 days in 2005, a patient is liable for a \$456 co-pay per day.
- *Skilled Nursing Facility*—There is no deductible or co-pay for the first 20 days of a skilled nursing facility stay. If the stay lasts for 21 days or longer, the patient is liable for a \$114 co-pay per day in 2005.
- *Part A Premium*—For an individual who is age 65 or older and not otherwise covered by the Medicare program, the monthly premium in 2005 to be covered by Part A is \$375.
- The use of Medicare benefits is calculated based on benefit periods and reserve days. The benefit period is the block of time used to determine how much of a deductible and/or co-pay the beneficiary owes. A benefit period begins and ends when he or she has been out of the hospital for 60 consecutive days. For example, if a beneficiary enters the hospital on November 10, 2005, and is released on November 24, 2005, he or she is liable for \$912. If the beneficiary is re-admitted to the hospital on December 20, 2005, and released on December 26, 2005, he or she does not have to pay another \$912. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period on this example runs until January 24, 2006.
- There is no limit on the number of benefit periods a beneficiary may use in a lifetime, except for hospice care, which entitles a beneficiary to two 90-day periods and one 30-day period.
- Reserve days are used for hospital stays beyond 90 days. A beneficiary is entitled to only 60 reserve days.

► Part B: Supplementary Medical Insurance (SMI)

- Since Part B of Medicare is voluntary, participants are required to make a monthly contribution to the premium. Part B premiums are automatically deducted from the enrollee’s Social Security benefit, provided the enrollee receives Social Security benefits. Under current law, no more than 25 percent of SMI’s revenues can come from premium payments.
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Medicare Part B premium to be related to income starting in 2007. By 2011, premiums will increase with income. Medicare beneficiaries with income under \$80,000 (\$160,000 for a married couple) will continue to be required to pay 25 percent of the cost of Part B. However, beneficiaries with income between \$80,000 and \$100,000 will be required to pay

35 percent of the premium, and beneficiaries with income of at least \$200,000 will be responsible for 80 percent of the premium to enroll in Part B. These income levels will also be indexed to general inflation.

- *Premiums*—In 2005, the monthly premium is \$78.20.
- *Annual Deductible*—This is applied to all Part B services except home health care services. In 2005, the annual deductible is \$110.
- *Coinsurance*—Coinsurance payment in 2005 is 20 percent.

▶ **Part D: Prescription Drugs**

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created Part D, a prescription drug benefit.
- Starting in May 2004, a prescription drug discount card program will be available and will continue through December 31, 2005. For individuals with income of \$12,569 or less and for married couple with income of \$16,862 or less a \$600 credit is added to the discount card.
- Starting in January 1, 2006, the comprehensive prescription drug benefit will be available. General guidelines of cost-sharing arrangements are as follows:
 - The Congressional Budget Office estimated in July 2004 that the monthly premium for Part D in 2006 would be \$35, increasing to \$58 by 2013.
 - A deductible of the first \$250.
 - On drug purchases of \$251 through \$2,250, Medicare pays 75 percent of the costs, and beneficiaries pay the remaining 25 percent.
 - On drug purchases of \$2,251 through \$5,100, Medicare does not pay anything, meaning beneficiaries pay 100 percent of the cost of prescription drugs.
 - On drug purchases above \$5,100, Medicare pays 95 percent of the costs, and beneficiaries are responsible for only 5 percent.
- Assistance for low-income individuals will be available. Income limits are to be set in 2005.

Medigap

- Although Medicare eases many financial worries for the elderly, it does not cover 100 percent of all medical services. Medicare's deductibles and co-payments can be high, particularly for long hospital stays.
- Medicare does not cover all medical services. Most notable are eye exams and glasses, hearing aids, and dental services.
- To help meet these additional expenses, Medicare beneficiaries frequently purchase what is known as Medigap policies. A Medigap policy is purchased in the individual market.
- In the 1970s and 1980s, Medicare enrollees encountered problems with purchasing health insurance to supplement Medicare. In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress charged the National Association of Insurance Commissioners (NAIC) with developing a variety of Medigap policies. NAIC developed 10 policies ranging from a basic coverage plan, Plan A, to comprehensive coverage, Plan J. Insurance carriers are not required to offer all 10 policies, but if a carrier offers Medigap policies, they must be from the 10 policies designed by NAIC. Exceptions to this rule are for carriers in Massachusetts, Minnesota, and Wisconsin, states that had Medigap laws in place before OBRA '90.
- The Centers for Medicare & Medicaid Services maintains an interactive Web page designed to assist an enrollee in obtaining Medigap coverage. The Web site is at the following link: www.medicare.gov/MGCompare/Home.asp

Covered Services

▶ **Part A: Hospital Insurance (HI)**

- *Hospitalization*—Covered services include semiprivate room and board, general nursing, miscellaneous hospital services and supplies, inpatient psychiatric hospital care.
- *Posthospital Skilled Nursing Facility Care*—To receive this service, the individual must have been in the hospital for at least three days and enter facility within 30 days after hospital discharge.

- *Home Health Care*—Covered services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs), and medical supplies.
- *Hospice Care*—Covered services include medical and support services from a Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief, and other services not otherwise covered by Medicare. Hospice care is usually given in the home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed.
- *Blood*—Covered services include pints of blood received at a hospital or skilled nursing facility during a covered stay.

▶ **Part B: Supplementary Medical Insurance (SMI)**

- *Medical and Other Services*—Covered services include doctors' services (not routine medical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs). Part B covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.
- *Clinical Laboratory Services*—Services include blood tests, urinalysis, and more.
- *Home Health Care*—Services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies, and other services.
- *Outpatient Hospital Services*—Services include hospital services and supplies received as an outpatient as part of a doctor's care.
- *Blood*—Covered services include pints of blood received as an outpatient or as part of a Part B covered service.

Medicare Advantage

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 changed the name of the Medicare+Choice program to Medicare Advantage.
- The Medicare Advantage program was created by Congress in the Balanced Budget Act of 1997 to allow more types of health insurance plans, including managed care plans, to serve Medicare beneficiaries. As of March 2003, 5.3 million Medicare beneficiaries (approximately 14 percent of Medicare beneficiaries) were enrolled in a Medicare HMO. Since 1998, most HMO contracts with the Centers for Medicare & Medicaid Services have operated under the Medicare Advantage program.
- In 1999, 97 plans either withdrew or reduced their service areas, directly affecting 407,000 enrollees. In 2000, 99 plans withdrew, affecting 327,000 enrollees. In 2001, withdrawals and service area reductions affected an estimated 934,000 enrollees. In 2002, 536,000 enrollees were affected by withdrawals and service area reductions.
- In late 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare Advantage program. Under BIPA, as of March 1, 2001, the floor or minimum payment for Medicare Advantage plans in counties in large urban areas is \$525 while for all other counties it is \$475. Early data suggest that the BIPA minimum payments are having a greater impact in the large urban areas than in the counties with the lower minimum payment.

Trustees in 2004

- Treasury Secretary John W. Snow acts as the Managing Trustee. The other trustees include: Elaine Chao, Secretary of Labor; Michael O. Leavitt, Secretary of Health and Human Services; Jo Anne B. Barnhart, Commissioner of Social Security; Mark B. McClellan, M.D, PhD., Administrator of the Centers for Medicare & Medicaid Statistics and Secretary, Board of Trustees; John L. Palmer, and Thomas R. Saving.
- For a copy of the 2004 trustees report, please click on the following link.
www.cms.hhs.gov/publications/trusteesreport/

Recent EBRI Research on Medicare and Retiree Health

- “The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees,” *EBRI Issue Brief* no. 279 (March 2005). www.ebri.org/ibs/279ib.htm
- “Controlling Health Costs and Improving Health Care Quality for Retirees,” *EBRI Issue Brief* no. 278 (February 2005). www.ebri.org/ibs/278ib.htm
- “Health Care Expenses in Retirement and the Use of Health Savings Accounts,” *EBRI Issue Brief* no. 271 (July 2004). www.ebri.org/ibs/271ib.htm
- “Medicare Program Takes on More Income-Related Features,” *EBRI Notes* vol. 25, no. 5 (May 2004). www.ebri.org/notes/0504note.htm

For additional detailed information on the Medicare program, go to www.medicare.gov/ which is maintained by the Centers for Medicare & Medicaid Services, part of the U.S. Department of Health and Human Services.

Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *2005 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund* (Washington, DC: U.S. Government Printing Office, 2005); and *Medlearn Matters: Information For Medicare Providers*, “Update to Medicare Deductible, Coinsurance, and Premium Rates for Calendar Year (CY) 2005” (September 10, 2004). www.cms.hhs.gov/medlearn/matters/

¹Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income.

■ New Publications and Internet Sites

Employee Benefits

Hay Group, Inc. *2004 Hay Benefits Report: Prevalence of Benefits Practices*. \$2,190. Hay Group, Inc., Attn: HBR Unit, The Wanamaker Building, 100 Penn Square East, Philadelphia, PA 19107-3388, (215) 861-2438, fax: (215) 861-2128.

Workplace Economics, Inc. *2005 State Employee Benefits Survey*. \$145. Workplace Economics, Inc., P.O. Box 33367, Washington, DC 20033-0367, (202) 223-9191, fax: (301) 774-7485, www.workplace-economics.com.

Health Care

Atlantic Information Services, Inc. *AIS's Directory of Health Plans: 2005*. Print edition, \$492; CD-ROM version, \$1,495. AIS, 1100 17th St., NW, Suite 300, Washington, DC 20036, (800) 521-4323, fax: (202) 331-9542, customerserv@aispub.com.

Mercer Human Resource Consulting. *National Survey of Employer-Sponsored Health Plans, 2004*. Report, \$500, Report and tables, \$1,000 (tables not sold separately). Mercer Human Resource Consulting, 1166 Avenue of the Americas, 29th floor, New York, NY 10036, (212) 345-2451, e-mail: tara.lewis@mercer.com.

United Health Foundation. *America's Health: State Health Rankings, 2004 Edition*. Free. United Health Foundation, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Susan Hayes, Associate Director, info@unitedhealthfoundation.org.

Pension Plans/Retirement

Great-West Retirement Services. *401(k) Answer Book, 2005 Edition*. \$199. Aspen Publishers, 7201 McKinney Circle, Frederick, MD 21704-8356, (800) 234-1660, www.aspenpublishers.com.

HR Investment Consultants. *401k Provider Directory Averages Book, 7th Edition*. \$95 + S&H. 401K Averages Book, 305 West Chesapeake Ave., Suite 205, Towson, MD 21204, (888) 401-3089, ext. 10, www.401ksource.com.

Social Security

Fullerton, Don, and Brent Mast. *Income Redistribution from Social Security*. \$20. The AEI Press, Order Department, 193 Edwards Dr., Jackson, TN 38301, (800) 343-4499, fax: (800) 351-5073, www.aei.org/book804.

National Academy of Social Insurance. *Uncharted Waters: Paying Benefits from Individual Accounts in Federal Retirement Policy, Study Panel Final Report*. \$29.95. National Academy of Social Insurance, 1776 Massachusetts Ave., NW, Suite 615, Washington, DC 20036, (202) 452-8097, fax: (202) 452-8111, www.nasi.org.

Disability Benefits Sites

About Disability Insurance
www.about-disability-insurance.com/

Disability Income Guide
www.ahia.net/consumers/guide_di_2.html

Disability Management Employer Coalition
www.dmec.org/

Disability Research Institute
www.dri.uiuc.edu/default.htm

Social Security Online—Disability Programs
www.ssa.gov/disability/

U.S. Department of Labor Office of Disability Employment Policy
www.dol.gov/odep/pubs/adabro/employ.htm

U.S. Equal Employment Opportunity Commission
www.eeoc.gov/

Web Documents

2004 Survey of Cash Balance Plans: Report Highlights
www.mellon.com/hris/pdf/cash_balance_report_highlights.pdf

2004 United States @Work: Redefining the Employer/Employee Relationship
www.aon.com/about/publications/pdf/issues/2004_forum_dec_jan_lead.pdf

Building Futures V: A Report on Corporate Defined Contribution Plans
buildingfutures.fidelity.com/president.html

The Bush Administration's Plan for Strengthening Retirement Security [Fact Sheet]
www.dol.gov/opa/media/press/opa/retirementsecurityfactsheet.htm

Current Trends and Future Outlook for Retiree Health Benefits: Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits
www.kff.org/medicare/med121404pkg.cfm

Health Insurance Mandates in the States, 2005
www.cahi.org/cahi_contents/resources/pdf/MandatePubDec2004.pdf

The MetLife Study of Employee Benefits Trends: Findings from the 2004 National Survey of Employers and Employees
www.metlife.com/WPSAssets/12675819101115057436V1FEBTS_FINAL_4.29.pdf

National Compensation Survey: Employee Benefits in Private Industry in the United States, 2002-2003
stats.bls.gov/ncs/ebs/sp/ebb10020.pdf

EBRI Notes

EBRI Employee Benefit Research Institute Notes (ISSN 1085-4452) is published monthly by the Employee Benefit Research Institute, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896, at \$300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Notes*, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896. Copyright 2005 by Employee Benefit Research Institute. All rights reserved, Vol. 26, no. 6.

Who we are

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

What we do

EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund** (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

Our publications

EBRI Issue Briefs are periodicals providing expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. **EBRI Notes** is a monthly periodical providing current information on a variety of employee benefit topics. **EBRI's Pension Investment Report** provides detailed financial information on the universe of defined benefit, defined contribution, and 401(k) plans. **EBRI Fundamentals of Employee Benefit Programs** offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. **EBRI Databook on Employee Benefits** is a statistical reference volume on employee benefit programs and work force related issues.

Orders/ subscriptions

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to *EBRI Issue Briefs* are included as part of EBRI membership, or as part of a \$199 annual subscription to *EBRI Notes* and *EBRI Issue Briefs*. Individual copies are available with prepayment for \$25 each (for printed copies) or for \$7.50 (as an e-mailed electronic file) by calling EBRI or from www.ebri.org. **Change of Address:** EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037, (202) 659-0670; fax number, (202) 775-6312; e-mail: Publications_Subscriptions@ebri.org. **Membership Information:** Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President/ASEC Chairman Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org

Editorial Board: Dallas L. Salisbury, publisher; Steve Blakely, editor. Any views expressed in this publication and those of the authors should not be ascribed to the officers, trustees, members, or other sponsors of the Employee Benefit Research Institute, the EBRI Education and Research Fund, or their staffs. Nothing herein is to be construed as an attempt to aid or hinder the adoption of any pending legislation, regulation, or interpretative rule, or as legal, accounting, actuarial, or other such professional advice.

EBRI Notes is registered in the U.S. Patent and Trademark Office. ISSN: 1085-4452 1085-4452/90 \$.50+.50

Did you read this as a pass-along? Stay ahead of employee benefit issues with your own subscription to *EBRI Notes* for only \$49/year electronically e-mailed to you or \$199/year printed and mailed. For more information about subscriptions, visit our Web site at www.ebri.org or complete the form below and return it to EBRI.

Name _____
Organization _____
Address _____
City/State/ZIP _____

Mail to: EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037 or Fax to: (202) 775-6312