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The Unique Needs of Medicare Beneficiaries

By Reginald D. Williams II

Introduction

Medicare beneficiaries have a distinctive combination of needs and circumstances that make providing appropriate health care services for them a greater challenge than for the working-age population.[1] Medicare beneficiaries generally have poorer health status, lower literacy levels, and suffer from more chronic conditions than the general population. More than half have arthritis and high blood pressure. Many Medicare beneficiaries are not totally independent, with forty-five percent needing help with at least one of the key activities of every day living, such as eating, bathing, shopping, using the telephone, or balancing a checkbook.[2] Medicare beneficiaries also have an increased likelihood of financial insecurity; nearly sixty percent have annual incomes below $20,000, compared to only fourteen percent of the working-age population.[3]

Given the complex needs and circumstances of many Medicare beneficiaries, managing their health and navigating the health care system can be challenging. Choosing physicians, understanding doctors' orders, deciding among complex treatment options, or choosing a drug discount card are more difficult for them than for the general population. Decreased mobility hampers their ability to travel to health care facilities. Others do not use the telephone easily because they cannot hear or see well. Many do not have computers or know how to use the internet to find valuable information. For all these reasons, many beneficiaries need appropriate services and supports to ensure that Medicare is meeting their needs.

Demographic Change and Health Status

Medicare was created in 1965 to provide health insurance for elderly people. It now covers more than forty-one million people: thirty-five million age sixty-five and older and six million disabled beneficiaries.[4] The aged population is growing in size and people are living longer. In 2000, thirty-five million people age sixty-five and older were counted in the United States census, a twelve percent increase since 1990.[5] The baby boom generation is expected to dou-

Reginald D. Williams II is Health Policy Research Assistant at the National Academy of Social Insurance.

1 People between the ages sixteen and sixty-four who are not eligible for Medicare.
2 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.
3 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS and United States Census Bureau. 2002. *Selected Characteristics of Families by Total Money Income in 2001 from Current Population Survey.* Washington, DC: Government Printing Office.
4 The Social Security Amendments of 1972 expanded Medicare eligibility to include disabled workers.
5 United States Census Bureau. 2001. *Statistical Abstract of the United States.* Washington, DC: Government Printing Office.
6 The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2003. *Annual Report of the Board of Trustees of the Federal Hospital and Federal Supplementary Medical Insurance Trust Funds, 2004*. Washington, DC.

ble the ranks of Medicare beneficiaries to seventy million by 2025.[6] Life expectancy at age sixty-five has risen from sixteen years in 1980 to eighteen years in 2000; women's life expectancy is one year longer than the average and men's is two years shorter.[7] People of color will also become a much more significant part of Medicare's population over the next generation.[8] By 2030, people of color will represent more than 25 percent of the population over the age of 65, or 18.6 million people. Today there are 6.5 million beneficiaries of color.[9] Beneficiaries of color have historically faced inequities in health status, treatment, and outcomes, which will pose greater challenges to Medicare in the future.

The number of elderly people living alone is also increasing. Being widowed puts many beneficiaries at a disadvantage because couples often provide support systems and help one another cope with health problems and functional limitations. In addition, a higher proportion of Medicare beneficiaries than ever before are divorced, separated, or never married. Of people age sixty-five and older in the community, forty-five percent live alone. Seventy-three percent of them are women.[10]

Medicare beneficiaries are less likely than the general population to rate their health positively. Table 1 compares self-reported health status between Medicare beneficiaries and adults under age sixty-five.

Table 1
Health Status of the and Medicare Beneficiaries in 2000 and the General Population, 2002

	All Medicare Beneficiaries	General Population Age 18–64
Health Status		
Excellent	13.5	33.6
Very good/good	56.1	57.0
Fair/poor	30.5	8.9

NOTE: Numbers do not equal one hundred percent due to rounding.

Source: Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS)*. Baltimore, MD: CMS. and National Center for Health Statistics (NCHS). 2004. *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2002.* Hyattsville, MD: NCHS.

Chronic Conditions and Activities of Daily Living

Although some Medicare beneficiaries are relatively healthy, many have complex health needs manifested in chronic conditions. A chronic condition is defined as a condition, which lasts (or is expected to last) a year or longer, limits what a person can do and requires ongoing care.[11] Common chronic conditions include arthritis, hypertension, and diabetes. These conditions often limit an individual's functional ability by hampering their energy, strength, and mobility. Eighty-eight percent of all Medicare beneficiaries have at least one

7 National Center for Health Statistics (NCHS). 2003. *Health, United States.* Hyattsville, MD: National Center for Health Statistics.
8 In this paper, "(beneficiaries, communities, or people) of color" describes racial and ethnic groups that have traditionally been referred to as minorities. Communities of color include the following races: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and the ethnicity designation of Hispanic or Latino.
9 United States Census Bureau. 2000. Projections of the Total Resident Population by 5 year Age Groups, Race, and Hispanic Origin with Special Age Categories: Middle Series, 2025 to 2045. Washington, DC: United States Census Bureau".
10 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.
11 Partnership for Solutions. 2002. *Chronic Conditions: Making the Care for Ongoing Care.* Baltimore, MD: Partnership for Solutions.
12 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.
13 Eichner, June and David Blumenthal, eds. 2003. *Medicare in the 21st Century: Building a Better Chronic Care System.* Washington, DC: National Academy of Social Insurance.

chronic condition, as many as twenty percent have five or more chronic conditions.[12,13] Table 2 displays the percentage of beneficiaries with specified chronic conditions.

Serious chronic conditions can affect the quality of beneficiaries' lives. They frequently involve constant monitoring, require complex care from doctors, and can demand strict adherence to treatment regimens. Medicare beneficiaries with multiple chronic conditions face many obstacles to receiving optimal care. They sometimes receive conflicting medical advice from different physicians, with different diagnoses, and conflicting courses of treatment. The increased complexity of their conditions forces some to rely on others to help maintain their health and functional status.

Chronic conditions also drain resources. As the prevalence of chronic conditions increases among beneficiaries, so does the cost. Both the number of prescriptions filled and doctor visits increase as the number of chronic conditions increases. Beneficiaries with five or more chronic conditions comprise twenty percent of the Medicare population but account for sixty-six percent of its expenditures.[14]

Medicare beneficiaries are more likely than the working-age population to need assistance from others with daily living tasks. Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are measures of functional status. ADLs include basic tasks necessary for independence such as eating, bathing, dressing, and using the toilet. Those with IADLs need help with shopping, paying bills, and using the telephone. Forty-five

Alice Hansberry, age eighty-seven, has been a New Yorker all her life. Since her husband died, Alice lives alone and has no other family in the area. More and more her memory is failing her. She has been healthy, but recently debilitating pain from arthritis increasingly plagues her. The pain is so severe that it is beginning to affect her ability to live independently; at times eating and bathing are near impossible. Now she must pay others to clean her home and do her grocery shopping.*

Alice received a letter recently offering her arthritis treatments and pain management therapies if she joined one of Bluestar's Medicare Advantage Plans and paid an additional premium of $80 a month. She desperately wants access to these treatments, but thought the Medicare premium was already coming out of her social security check. She does not understand why she has to pay more. She is hesitant to call someone to ask for help, and she does not own a computer to use online services. However, she heard from friends at the community center that trained volunteers could help her with health insurance questions, so she signed up for a counseling session.

**Illustrative fictional accounts.*

Table 2
Percentage of Beneficiaries with Specified Chronic Conditions, by Beneficiary Category and Chronic Condition, 2000

	Disabled (<65)	Total beneficiaries
Arthritis	50%	57%
Hypertension	48%	56%
Heart Disease	33%	39%
Diabetes	20%	18%
Cancer (other than skin)	13%	17%
Osteoporosis/broken hip	15%	17%
Skin cancer	6%	16%
Pulmonary disease	22%	15%
Stroke	12%	11%
Alzheimer's disease	2%	5%
Parkinson's disease	1%	2%

Source: Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from them 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.

14 Eichner, June and David Blumenthal, eds. 2003. *Medicare in the 21st Century: Building a Better Chronic Care System.* Washington, DC: National Academy of Social Insurance.

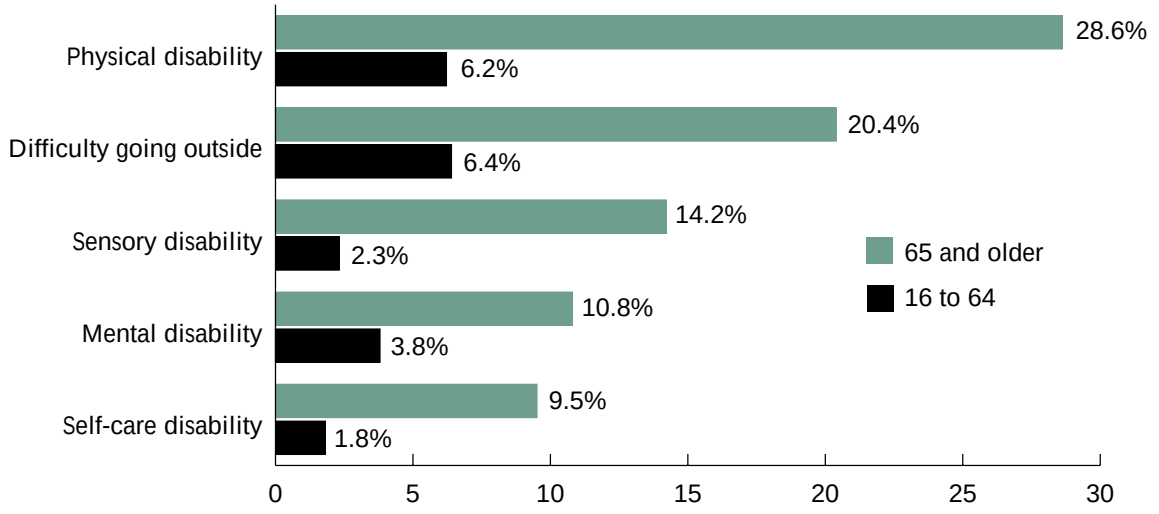
percent of all Medicare beneficiaries have at least one functional limitation; seventy-five percent of disabled beneficiaries have a functional limitation. The number of functional limitations also rises with age. Thirty percent of Medicare beneficiaries age eighty-five and older need help with three or more activities of daily living.[15]

Physical, Cognitive and Sensory Impairments

Impairments pose threats to the ability of Medicare beneficiaries to function independently and to make a wide range of decisions, including managing their financial resources, making real estate transactions, and making decisions about their health care. People age sixty-five and older are much more likely than younger adults (sixteen to sixty-four) to report a sensory, physical, mental or self-care disability, or a disability causing difficulty leaving the home. These disabilities make it more difficult for people to live independently and make a variety of decisions. Figure 1 illustrates the dramatic difference in disability between the working age population and the elderly.

Sensory impairments such as blindness and deafness (which are relatively rare) or severe vision or hearing impairments can have considerable effects. Twelve percent of beneficiaries are either blind or say their vision is poor, among beneficiaries eighty-five and older, over twenty percent are blind or have poor vision, even with glasses.[16] Written communication such as

Figure 1
Percentage of the Population with a Disability by Age and Type, 2000



NOTE: This population excludes people in the military and people who are in institutions.

Source: Waldrop, Judith and Sharon M. Stern. 2003. "Disability Status: 2000." *U.S. Census Brief* C2KBR-17. Washington, DC: Government Printing Office.

15 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.

16 Gold, Marsha, Michael Sinclair, Mia Cahill, Natalie Justh, and Jessica Mittler. 2001. *Medicare Beneficiaries and Health Plan Choice.* Washington, DC Mathematica Policy Research, Inc.

mailings and prescription drug instructions are difficult for people who cannot see properly. Deafness is reported by nine percent of beneficiaries, eight percent report poor hearing even with hearing aids, and an additional fifteen percent report fair hearing. These beneficiaries have considerable difficulty hearing a doctor's instructions and using a telephone to seek assistance.

Making decisions is difficult for some Medicare beneficiaries. The normal aging process diminishes aged beneficiaries' capacity to make decisions. The field of cognitive psychology suggests that as the brain ages, the ability to focus and the speed of mental processing decreases, as well as the capacity to draw inferences and alter judgments when given complex information.[17]

In addition to the normal aging process, cognitive and mental impairments also hamper Medicare beneficiaries' decision-making ability. Fifty-two percent of disabled and eighteen percent of aged beneficiaries have some type of cognitive or mental impairment.[18] According to the Medicare Current Beneficiary Survey, a person is classified as having a cognitive difficulty if they report problems using the telephone, paying bills, or has ever been diagnosed with Alzheimer's disease, mental retardation, or various other mental disorders.[19]

Education and Health Literacy

Compared to younger people, Medicare beneficiaries have lower levels of educational attainment. Sixty-six percent of Medicare beneficiaries are high school graduates compared with eighty-three percent of the general population ages twenty-four to sixty four.[20] The skills learned through formal education are important in helping beneficiaries understand Medicare and the health care system. For example, twenty-three percent of beneficiaries with less than nine years of schooling report that they know all or most of the Medicare program information they need to know, compared to forty-six percent of beneficiaries with some college education. In addition, beneficiaries with some college education are more likely to report seeking and receiving Medicare information from their doctor's office, health plan, or hospital than less educated beneficiaries.[21]

Recent studies by the Institute of Medicine and Agency for Health Care Research and Quality illustrate how low health literacy negatively affects health care understanding and decision-making across the entire population. Nearly half of all adults in America have difficulty understanding and using health information. Many do not understand what their doctors and pharmacists are saying when they are talking to them. Medicare beneficiaries score even lower than the general population. Combined with their increased need for health services, Medicare beneficiaries with limited literacy skills are less likely to access and benefit from proper care.[22] The internet brings volumes of useful information to peoples' fingertips, but

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17 Stevens, Beth. 2003. "How Seniors Learn." *Center for Medicare Education Issue Brief* 4(9): 1–8. Washington, DC: Center for Medicare Education.
18 Urban Institute, unpublished data, 2002, in Eichner, June and David Blumenthal, eds. 2003. *Medicare in the 21st Century: Building a Better Chronic Care System.* Washington, DC: National Academy of Social Insurance. The percentage of beneficiaries may be underreported because they are based on self-reports by beneficiaries.
19 If someone has one of these conditions, a caregiver answers the survey questions.
20 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS and Bauman, Kurt J. and Nikki L. Graf. 2003. "Educational Attainment: 2000." *U.S. Census Brief* C2KBR-24. Washington, DC: Government Printing Office.
21 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.
22 Agency for Healthcare Research and Quality. 2004. *Literacy and Health Outcomes.* Rockville, MD: Agency for Healthcare Research and Quality. and Institute of Medicine. 2004. *Health Literacy: A Prescription to End Confusion.* Washington, DC: National Academy Press.
23 Gold, Marsha, Michael Sinclair, Mia Cahill, Natalie Justh, and Jessica Mittler. 2001. *Monitoring Medicare+Choice: Medicare Beneficiaries and Health Plan Choice.* Washington, DC Mathematica Policy Research, Inc.

James Weldon, age sixty-eight, was born in Selma, Alabama and has lived in the rural South all of his life. He has managed to live a successful life despite not graduating from high school and having limited reading ability. Currently, he works part-time at the local hardware store to supplement his Social Security income. He has a history of hypertension and diabetes, but his health is generally good when his chronic conditions are managed properly. Sometimes he forgets to take his "pressure" pills, and there were a few times in the past when he could not afford his insulin, although he did not realize the health consequences of these actions. James' son tries to be helpful in managing his father's health care. He helps with insurance questions, schedules doctor visits, and reads prescription drug instructions to his father.*

Recently during a routine preventive exam, the doctor told James that he found polyps in his colon. The doctor told him this was a cancer warning sign and that he would have to return for further tests. Without asking any questions, James left the doctor's office and went home. James tried to read the materials the doctor gave him, but he did not understand the complicated materials. They were full of terms he had never heard of before. Frustrated, James asked his son for help. His son then spent the rest of the evening researching cancer on the internet and explaining to his father the information the doctor gave him.

only about nineteen percent of Medicare beneficiaries have ever used the internet.[23]

One study that focuses on health literacy skills among Medicare beneficiaries found that fifty-four percent of beneficiaries surveyed could not follow prescription drug directions, compared to sixteen percent with adequate health literacy. Even those who tested positively in health literacy skills faced tremendous difficulty. Only seventeen percent of enrollees with adequate health literacy understood their rights and responsibilities when submitting a Medicaid application.[24]

Medicare beneficiaries and those who help them make decisions need reliable and understandable information to ensure that they are properly receiving assistance in making health care decisions. Beneficiaries need to understand letters that discuss Medicare coverage, evaluate health plan benefit choices, interpret courses of treatment, and follow prescription drug regimens. Medicare's current education program includes: *Medicare & You,* the Medicare handbook, toll-free telephone services, interactive internet activities, and community-based outreach and counseling.

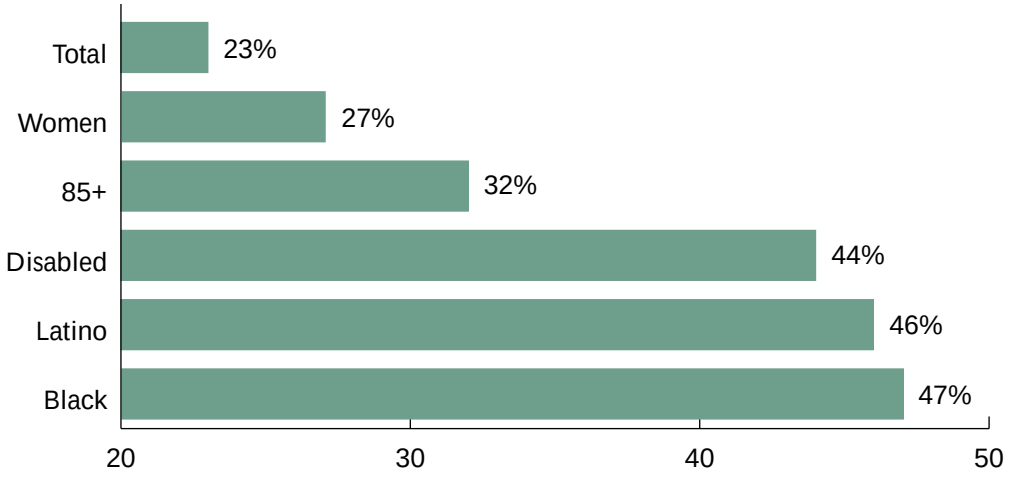
Low Income Medicare Beneficiaries

Eighteen percent of Medicare beneficiaries had incomes below the poverty line, which was $8,860 for an individual in 2002.[25] Nearly sixty percent of Medicare beneficiaries have incomes below $20,000.[26] Medicare's low-income beneficiaries are disproportionately disabled, women, Blacks, Latinos, and oldest-old (eighty-five and older).[27] Figure 2 details these selected groups.

Poorer beneficiaries report lower health status and have more health problems. Beneficiaries with the lowest incomes were twice as likely as those with incomes above two hundred percent of poverty to rate their health as fair or poor. Medicare's poor were four times as likely as those with incomes above two hundred percent of poverty to report needing help with at

24 Gazmararian, Julie, David Baker, Mark Williams, Ruth Parker, Tracey Scott, Diana Green, Nicole Fehrenback, Junling Ren, and Jeffrey Koplan. 1999. "Health Literacy among Medicare Beneficiaries in a Managed Care Organization." Journal of the American Medical Association 281(6):545-551.
25 Non-institutionalized beneficiaries, Kaiser Family Foundation. 2004. *Medicare at a Glance, Fact Sheet.* Menlo Park, CA: Kaiser Family Foundation.
26 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.
27 Kaiser Family Foundation. 1999. *Faces of Medicare: Medicare and Low Income Beneficiaries.* Menlo Park, CA: Kaiser Family Foundation.
28 Schoen, Cathy, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland. 1998. *Medicare Beneficiaries: A Population at Risk.* New York, NY and Menlo Park, CA: The Commonwealth Fund and Kaiser Family Foundation.

Figure 2
Percentage of Selected Medicare Beneficiaries with Incomes at or below $10,000 in 2000



Source: Centers for Medicare & Medicaid Services (CMS). 2004. Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS.

least one of the basic activities of daily living. Low-income Medicare beneficiaries were twice as likely to have mental impairments or diabetes.[28]

The financial burden is greater on beneficiaries with poor health status and low incomes. They generally require more health care services because they are sicker and spend a greater proportion of their income on these services. Those in poor health spent approximately fifty percent more out-of-pocket than those in very good or excellent health ($2,697 to $1,373).[29] Beneficiaries with incomes below $20,000 spend over twenty percent of their incomes on health care, compared to only nine percent for beneficiaries with incomes between $40,000 and $69,000.[30]

The poorest Medicare beneficiaries are dually eligible for Medicare and Medicaid. The poorest and those who have impoverished themselves by paying for health care, are usually entitled to comprehensive Medicaid benefits. Other low-income Medicare beneficiaries receive some Medicaid assistance through the Medicare Savings Program. There are about seven million dual eligibles, but only approximately sixty percent of those eligible are enrolled in Medicaid or the Medicare Savings Program.[31] Despite outreach efforts, many beneficiaries who are eligible but not enrolled are unaware of these programs, or believe they are not eligible.[32]

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29 Goldman, Dana and Julie Zissimopoulos. 2003. "High Out-of-pocket Health Care Spending by the Elderly." Health Affairs 22(3): 194–202.
30 Centers for Medicare & Medicaid Services (CMS). 2004. *Medicare Program Information from the 2000 Medicare Current Beneficiary Survey (MCBS).* Baltimore, MD: CMS.
31 Information about the number of Medicare beneficiaries who are also enrolled in Medicaid is from the Kaiser Commission on Medicaid and the Uninsured, Medicaid Facts: *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,* January 2004, and the 40 percent estimate of Medicare beneficiaries who are eligible but not enrolled is unpublished data from the Actuarial Research Corporation.
32 The National Academy of Social Insurance has a study panel, *Medicare/Medicaid Dual Eligibles: Reaching All Who Qualify,* that is exploring new federal initiatives that could increase the enrollment of dually eligible beneficiaries.

The new Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provides additional federal assistance to low income beneficiaries for prescription drugs. In 2004 and 2005, beneficiaries with incomes below 135 percent of poverty will receive assistance of up to $600 per year for drugs. In 2006, they will receive subsidies for comprehensive drug coverage, while beneficiaries with incomes between 135 and 150 percent of poverty will receive some subsidies for drug coverage. While the drug program provides new benefits to poor and low-income beneficiaries, they will still face substantial out-of-pocket costs for other health care services.

The Increasing Complexity of Medicare

Now more than ever, using information at higher and more frequent levels is a requirement in the health care system, and Medicare is no exception. Medicare beneficiaries make many choices and decisions regarding their health care insurance coverage, including whether to remain in Medicare fee-for-service or to choose a Medicare Advantage plan, whether to purchase supplemental Medigap insurance, determining whether they are dually eligible for Medicaid or the Medicare Savings Program, deciding whether to choose a prescription drug discount card, and if so which one, and beginning in 2006, whether to enroll in a Medicare prescription drug program. While clearly these options present beneficiaries with valuable choices and opportunities for better coverage, the beneficiaries who choose to take advantage of them will likely face multiple options and complex choices that may be daunting for some. For example, implementation of the new drug discount card has generated widespread confusion and frustration among beneficiaries and those assisting them because of the sheer volume and intricacy of the information.[33]

Many beneficiaries are capable of managing their own affairs, however a substantial number of beneficiaries suffer from serious chronic conditions, have complex health care needs, low literacy levels, or cognitive or physical impairments. Many of these beneficiaries need assistance in many aspects of their lives, including managing their health care. This suggests that policymakers should give careful consideration to structuring the choices in ways that most beneficiaries can understand, and to designing educational programs that will help beneficiaries and those who assist them in making informed choices about Medicare options.

33 Health Policy Alternatives, Inc. for the Kaiser Family Foundation (KFF). 2004. *Medicare Drug Discount Cards: A Work in Progress.* Menlo Park, CA: KFF.

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