The Medicare Program: A Brief Overview

Megan Multack
AARP Public Policy Institute

✓ Medicare provides health security to older Americans and people with disabilities.
✓ Medicare provides its enrollees with essential coverage for hospital and medical care, prescription drugs, preventive screenings, and other health services.
✓ Health care costs are rising more slowly, extending the financial stability of Medicare’s Hospital Insurance Trust Fund, which is used to pay hospital expenses.

What Is Medicare?

Established in 1965, Medicare is a federal health insurance program that provides health care coverage for individuals age 65 and older. The program also covers certain people under age 65 with disabilities and those with end-stage renal disease (ESRD). In 2012, Medicare covered more than 50.7 million Americans.1

Medicare consists of Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part C refers to the Medicare Advantage (MA) program, under which private plans provide Medicare benefits to enrollees. Part D refers to the voluntary outpatient prescription drug benefit that began in 2006. Part D coverage is available through private plans, either through an MA plan or an independent prescription drug plan.

What Services Does Medicare Cover in 2013?2

Part A covers:

■ Inpatient hospital services, up to 90 days per “benefit period”3 and 60 “lifetime reserve days”4
■ Skilled nursing facility services for up to 100 days per benefit period,
following at least a three-day inpatient hospital stay
■ Home health care for homebound individuals5
■ Hospice care
■ Inpatient psychiatric care for up to 190 days during a beneficiary’s lifetime
■ Blood (after the beneficiary pays for the first three pints per year)

Part B covers:

■ Physicians’ services, including office visits, a one-time physical examination for new beneficiaries,6 a yearly wellness visit, and a yearly visit to help lower the risk for cardiovascular disease
■ Many preventive services (e.g., mammogram, prostate cancer screening, colorectal cancer screening, diabetes screening, tobacco use cessation counseling,7 flu and pneumonia shots)8
■ Durable medical equipment and supplies (e.g., wheelchairs, oxygen)
■ Outpatient hospital services
■ Outpatient mental health services
■ Clinical laboratory (e.g., blood tests, some screening tests) and diagnostic tests (X-rays, magnetic resonance
imaging, computerized tomography scan, etc.)

- Outpatient occupational, physical, and speech therapy
- Home health care not preceded by a hospital stay and visits over the 100-day Part A limit
- Blood (after the beneficiary pays for the first three pints per year)

**Part D** covers:

- Prescription drugs through private drug plans (the list of drugs covered by the plan formulary varies by plan)

### Whom Does Medicare Cover?

Medicare eligibility is available to individuals who fall into three specified categories, defined by age, disability, or ESRD. The majority of individuals are eligible for Medicare by virtue of attaining age 65.

In 2012, Medicare provided coverage to the following:

- **42.1 million people age 65 and older**—At age 65, individuals qualify for Medicare if they or their spouses paid Social Security taxes for at least 40 calendar quarters (10 years) or if they qualify for railroad retirement benefits.

- **8.5 million people under age 65 with disabilities**—Those under age 65 who have received Social Security Disability Insurance cash benefits for at least 24 months are eligible for Medicare.

Those under 65 with ESRD are eligible for Medicare if they or their spouses paid Social Security taxes for at least 40 quarters. There are 101,000 nondisabled ESRD beneficiarities and 155,000 disabled ESRD beneficiarities.

Medicare provides health coverage to a population that is generally low to moderate income and in relatively poor health (figure 1). In 2011, half of all Medicare beneficiaries had annual income below $22,502. Nearly one in four beneficiaries had a cognitive/mental impairment. More than one-quarter of beneficiaries reported being in fair or poor health. About one in six beneficiaries are under the age of 65 and disabled. Fifteen percent of all beneficiaries need assistance with two or more activities of daily living.

### How Are Medicare-Covered Services Delivered?

Medicare beneficiaries can obtain Medicare-covered services in one of two ways:

**Original Medicare**

The majority (73 percent) of beneficiaries receive Part A and B services through “fee-for-service” Medicare. The program pays a share of the Medicare-approved costs, and the beneficiary is responsible for any cost-sharing requirements, such as deductibles and coinsurance.

The following cost-sharing requirements apply to beneficiaries under original Medicare in 2013:

- **Part A:** For each benefit period, beneficiaries have a $1,184 deductible for an inpatient hospital stay of 1 to 60 days, and daily coinsurance starting the 61st day. If they use a skilled
nursing facility for more than 20 days in a benefit period, they must pay $148 per day for days 21 through 100. There is no cost-sharing for Medicare home health services under either Part A or Part B.

- **Part B:** Beneficiaries have an annual deductible of $147 in 2013. In addition, most Part B services require a coinsurance of 20 percent of the Medicare-approved amount.16

- **Part D:** The standard Medicare Part D benefit in 2013 consists of a $325 annual deductible; an initial coverage period, in which enrollees are responsible for 25 percent of their prescription drug costs; a coverage gap, in which enrollees are responsible for 100 percent of their prescription drug costs; and catastrophic coverage, in which enrollees are responsible for 5 percent of their prescription drug costs.17 In 2013, enrollees fall into the coverage gap after their total prescription drug spending reaches $2,970, and enter catastrophic coverage after their total out-of-pocket spending reaches $4,750.18 However, provisions in the Affordable Care Act (ACA) are slowly closing the coverage gap through a series of escalating discounts that will eliminate the coverage gap entirely by 2020.

- **Medicare Advantage:** In 2012, about 13.6 million beneficiaries (27 percent) were enrolled in private health plans (such as health maintenance organizations) that contract with Medicare to provide covered services.19 The number of beneficiaries enrolled in MA plans has more than doubled since 2004. Medicare pays the MA plan a fixed amount each month for each beneficiary. MA plans must cover, at a minimum, all Part A and Part B services, but may reduce cost-sharing requirements compared to original Medicare. Plans may also offer additional benefits that Medicare does not cover (e.g., dental care, vision care).20 Plans may charge a premium in addition to the monthly Part B premium.

Although original Medicare provides important coverage for hospital, physician, and other services, its cost-sharing requirements are sometimes substantial. In addition, its benefit package is lacking in key areas, including long-term care, dental, hearing, and vision. As a result, Medicare paid just under half (49 percent) of total personal health care expenditures for beneficiaries in 2009.21

Many Medicare beneficiaries obtain some type of supplemental insurance (e.g., employer-sponsored coverage, Medigap) that pays for some of the health care costs not covered by Medicare. For those who qualify, other public programs (e.g., Medicaid) may cover some, or all, of beneficiaries’ cost-sharing. In 2009, more than one in three beneficiaries relied on supplemental coverage provided through their employer (figure 2). Nearly one in

---

**Figure 2**

*Distribution of Medicare Beneficiaries by Type of Supplemental Coverage, 2009*

![Pie chart showing distribution of Medicare beneficiaries by type of supplemental coverage in 2009.](image)

Source: AARP Public Policy Institute analysis of 2009 Medicare Current Beneficiary Survey (MCBS), Cost and Use file. Excludes beneficiaries in long-term care facilities, those for whom Medicare is a secondary payer, and those lacking complete information on all types of supplemental coverage.
five purchased Medigap coverage. Thirteen percent enrolled in the Medicaid program. Nine percent of beneficiaries did not have any supplemental coverage. The cost of private supplemental coverage accounted for, on average, 30 percent of out-of-pocket health care spending in 2009 for beneficiaries age 65 or older with employer-sponsored, Medigap, or other private health insurance.

**How Is Medicare Financed?**

**Part A** income and expenditures are administered through the Medicare Hospital Insurance (HI) Trust Fund. HI Trust Fund income is generated primarily from payroll taxes from current workers; employees and employers each pay 1.45 percent of wage earnings (self-employed individuals pay 2.9 percent). Other sources of income include interest on trust fund assets and taxes on Social Security benefits. Starting in 2013, higher-income taxpayers (annual salary greater than $200,000 for individuals; greater than $250,000 for families) pay an additional 0.9 percentage point payroll tax on their wages.

**Part B** income and expenditures are administered through the Supplementary Medical Insurance (SMI) Trust Fund. Part B income comes from beneficiary premiums and federal general revenues. Beneficiary premiums ($104.90 per month in 2013) cover about 25 percent of total annual costs for Part B services, while federal general revenues cover the remaining 75 percent. Higher-income beneficiaries (annual salary equal to or greater than $85,000 for individuals; equal to or greater than $170,000 for families) pay higher monthly Part B premium ($146.90 to $335.70 in 2013) based on their income (table 1).

Benefits for enrollees in private health plans under **Part C** (MA) are paid out of the HI and SMI Trust Funds. In 2013, the average premium for MA with a prescription drug plan is $35 per month. Ninety-five percent of MA enrollees in individual plans are enrolled in a plan with a prescription drug benefit.

**Part D** (outpatient prescription drug benefit) is administered through a separate account within the SMI Trust Fund. Part D is financed with beneficiary premiums (13 percent), general revenues (74 percent), and state payments (13 percent). As of 2011, higher-income beneficiaries pay a higher premium based on the same income thresholds used for Part B (table 1). The average premium in 2013 among independent prescription drug plans is $32 a month.

### Table 1

<table>
<thead>
<tr>
<th>Annual Income in 2011</th>
<th>Monthly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Individual Tax Return</td>
<td>File Joint Tax Return</td>
</tr>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
</tr>
<tr>
<td>Above $85,000 up to $107,000</td>
<td>Above $170,000 up to $214,000</td>
</tr>
<tr>
<td>Above $107,000 up to $160,000</td>
<td>Above $214,000 up to $320,000</td>
</tr>
<tr>
<td>Above $160,000 up to $214,000</td>
<td>Above $320,000 up to $428,000</td>
</tr>
<tr>
<td>Above $214,000</td>
<td>Above $428,000</td>
</tr>
</tbody>
</table>

How Much Does Medicare Spend?

In 2012, Medicare spent $574.2 billion on benefits and administration. Thirty-one percent of Medicare expenses in 2012 were for payments for inpatient or outpatient hospital services (figure 3). Another 12 percent was for physician services. Payments to private Medicare plans accounted for 24 percent, post-acute care (home health and skilled nursing facility care) accounted for 8 percent, and Part D accounted for 12 percent of Medicare expenses. Other benefits and administrative expenses made up 12 percent and 1 percent, respectively.29

Medicare per capita spending is expected to grow much more slowly over the next decade than it has in the past. Between 2005 and 2012, Medicare per capita spending growth rate averaged 6.5 percent annually.30 The 2013 Medicare Trustees Report projects that between 2013 and 2022, Medicare per capita spending growth rate will slow to an average annual rate of 3.67 percent.31 However, total Medicare spending is projected to grow more rapidly over the next decade—around 6.49 percent annually—because enrollment is increasing and will continue to increase as the baby boomers age.32

The ACA added many benefits to Medicare, such as an annual wellness visit, closing the doughnut hole, and eliminating deductibles and coinsurance for certain preventive services. The ACA also included payment and delivery system reforms designed to improve quality and affordability of care that, according to the 2013 Medicare Trustees Report, are expected to extend the estimated life of Medicare’s HI Trust Fund until 2026—2 years later than projected in last year’s report and 9 years longer than prior to the enactment of the ACA.33

Endnotes

1 Enrollment figures are from the 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (May 31, 2013).


3 A “benefit period” begins on the first day a beneficiary receives inpatient hospital services and ends 60 consecutive days after discharge if the person is not readmitted to the hospital.

4 “Lifetime reserve days” are a lifetime limit of 60 days beyond the 90th day of benefit periods.

5 Medicare covers medically necessary part-time or intermittent skilled nursing care/health aide, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy.
Medicare covers a one-time “Welcome to Medicare” physical examination within the first 12 months of enrollment in Part B.

Tobacco use cessation counseling is covered for beneficiaries who use tobacco and are diagnosed with an illness caused or complicated by tobacco use, or who take medicine affected by tobacco.

As of 2011, cost-sharing is eliminated for Medicare-covered preventive services that receive an A or B rating by the U.S. Preventive Task Force, and the deductible for colorectal cancer screening tests is waived. Medicare also now covers screening and counseling for alcohol abuse, depression, and obesity. Other preventive services covered under Medicare Part B include Pap smears, glaucoma testing, prostate cancer screening, cardiovascular screening blood tests, and vaccinations. Some may require cost-sharing, and certain restrictions may apply. For more details on covered preventive services, see CMS, *Medicare and You 2012*.

Most individuals in Part A do not pay a premium because they or their spouse had 40 or more quarters of Medicare-covered employment. People who are not eligible for premium-free Part A will pay a monthly premium of up to $451 in 2012. See [http://www.medicare.gov](http://www.medicare.gov).

Individuals disabled with amyotrophic lateral sclerosis are not subject to the Medicare waiting period. To receive Social Security Disability Insurance benefits, an applicant’s medical condition must be evaluated and determined to meet Social Security’s strict definition of disability.

Table IV. B5 from the *2013 Medicare Trustees Report*.

Beneficiaries may also have to pay “balance billing” charges (i.e., physicians who are not participating providers in Medicare may charge Medicare beneficiaries up to 15 percent above the Medicare-approved amount for the service).

Cost-sharing requirements under Part A, Part B, and Part D are subject to change annually.

For 2013, the copayment is $296 per day for days 61 through 90 of a hospital stay, and $592 per day for additional hospital days, up to a lifetime limit of 60 days.

Medicare pays 50 percent of the Medicare-approved amount for outpatient mental health therapy after the annual Part B deductible has been paid. For some outpatient hospital services, beneficiaries pay a coinsurance amount that is greater than 20 percent of the Medicare-approved amount. Also, some preventive services are not subject to Part B cost-sharing. See [http://www.medicare.gov](http://www.medicare.gov) for more information.


*2013 Medicare Trustees Report*.

Medicare Advantage plans that offer drug coverage must offer at least one option with the standard Part D benefit.

AARP Public Policy Institute analysis of 2009 Medicare Current Beneficiary Survey (MCBS). Personal health care expenditures include the costs of health care goods and services purchased directly by beneficiaries or paid by a third party on behalf of beneficiaries. These include spending on inpatient and outpatient hospital, physician, vision, hearing, dental, nursing home, and home health services (medical home health care only), as well as on outpatient prescription drugs and medical supplies and equipment.

AARP Public Policy Institute analysis of 2009 Medicare Current Beneficiary Survey (MCBS), Cost and Use file.

This figure pertains to all noninstitutionalized Medicare beneficiaries age 65 or older who have supplemental coverage (employer sponsored, Medigap, or other private insurance). AARP Public Policy Institute analysis of 2009 MCBS.
24 Up to 85 percent of Social Security income is taxed if total income exceeds certain thresholds; a portion of these taxes goes to the HI Trust Fund.

25 Although enrollment in Part B is voluntary, almost 95 percent of Part A enrollees were also enrolled in Part B in July 2010. See https://www.cms.gov/MedicareEnRpts/Downloads/10All.pdf. Beneficiaries age 65 and older who do not enroll in Part B when they first become eligible for Medicare can do so later with a financial penalty. For each 12-month period that a beneficiary could have enrolled in Part B after turning age 65 but did not, an additional 10 percent penalty (i.e., additional monthly premium) is assessed. This penalty does not apply to a beneficiary with group health insurance through an employer (or spouse’s employer) so long as the beneficiary follows Medicare’s application rules once such employment-sponsored coverage ends.


29 Percentages are based on AARP Public Policy Institute calculations using 2012 Medicare Trustees Report data.

30 Author’s calculation using nominal Medicare beneficiary spending growth rates from Table V. D1 from the 2013 Medicare Trustees Report.

31 Ibid.

32 Author’s calculation using nominal Medicare outlays less dedicated revenues from Table V.B6 from the 2013 Medicare Trustees Report.