

The Medicare Program: A Brief Overview

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- ✓ Medicare provides older Americans and people with disabilities with health security.
- ✓ Medicare provides its enrollees with essential coverage for hospital and medical care, and prescription drugs as well as preventive and other health services.
- ✓ Medicare spending growth is expected to slow over the next decade and extend the life of the Medicare Trust Fund.

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 (since 1972) those with end-stage renal disease (ESRD). In 2010, Medicare covered more than 47 million Americans.¹

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

What Services Does Medicare Cover in 2012?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 individuals
- 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)
- Inpatient care in a religious nonmedical health care institution

Part B covers:

- Physicians’ services, including office visits, a one-time physical examination for new beneficiaries,⁵ and a yearly wellness visit
- Durable medical equipment (e.g., wheelchairs, oxygen) and supplies
- Outpatient hospital services
- Outpatient mental health services
- Clinical laboratory (e.g., blood tests, some screening tests) and diagnostic tests (x-rays, magnetic resonance

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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
- Many preventive services (e.g., mammogram, prostate cancer screening, colorectal cancer screening, diabetes screening, flu and pneumonia shots)⁶
- 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 end-stage renal disease. The majority of individuals are eligible for Medicare by virtue of attaining age 65.

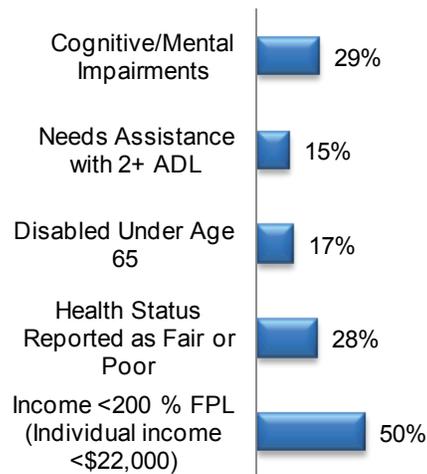
In 2010,⁷ Medicare provided coverage to the following:

- **39.6 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
- **7.9 million people under age 65 with disabilities**—Those under age 65 who have received Social Security Disability Insurance (SSDI) cash benefits for at least 24 months are eligible for Medicare.⁹
- **101,000 people under age 65 with ESRD**—Those with ESRD under age

65 are eligible for Medicare if they or their spouses paid Social Security taxes for at least 40 quarters.

Medicare provides health coverage to a population that is generally low to moderate income and in relatively poor health (figure 1). In 2010, half of all Medicare beneficiaries had annual income below \$22,000, or below 200 percent of the federal poverty level. Nearly one in three 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.

Figure 1
Characteristics of Medicare Beneficiaries



Source: Kaiser Family Foundation, "Medicare at a Glance," November 2011.

How Are Medicare-Covered Services Delivered?

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

Original Medicare: The majority (75%) of beneficiaries receive Part A and B services through "fee-for-service" Medicare. The program pays a share of the Medicare-approved costs, and

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the beneficiary is responsible for any cost-sharing requirements, such as deductibles and coinsurance.¹⁰

The following cost-sharing requirements apply to beneficiaries under original Medicare in 2012:¹¹

- **Part A:** For each benefit period, beneficiaries have a \$1,156 deductible for an inpatient hospital stay of 1 to 60 days and daily coinsurance starting the 61st day.¹² If they use a skilled nursing facility for more than 20 days in a benefit period, they must pay \$144.50 per day for days 21–100. 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 \$140 in 2012. In addition, most Part B services require coinsurance of 20 percent of the Medicare-approved amount.¹³
- **Part D:** The standard prescription drug plan in 2012 has a \$320 annual deductible. Most plans have a coverage gap, known as the “doughnut hole,” in which enrollees cover all of their prescription drug costs. The coverage gap begins once enrollees reach the plan’s initial coverage limit of \$2,930 and ends once they spend a total of \$4,700.¹⁴
- **Medicare Advantage (MA):** In 2010, 11.7 million beneficiaries (25 percent) were enrolled in private health plans (such as health maintenance organizations) that contract with Medicare to provide covered services.¹⁵ 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 and may offer additional benefits that Medicare does

not cover (e.g., dental care or vision care).¹⁶ Plans may charge a premium in addition to the monthly Part B premium.

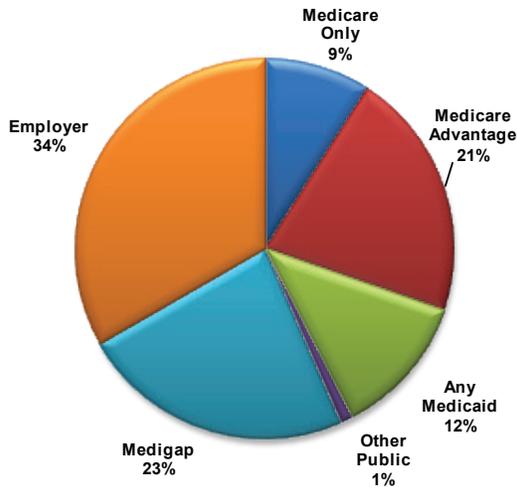
Although Medicare provides important coverage for hospital, physician, and other services, its cost-sharing requirements are sometimes substantial. In addition, its benefit package is lacking in key areas, including long-term care, dental, hearing, and vision. As a result, Medicare paid just under half (49 percent) of total personal health care expenditures for beneficiaries in 2007.¹⁷

Many Medicare beneficiaries obtain some type of supplemental insurance (e.g., employer-sponsored coverage, Medigap, Medicaid) that pays for some of the health care costs not covered by Medicare. In 2007, more than one in three beneficiaries relied on supplemental coverage provided through their employer (figure 2). About one in four purchased Medigap coverage, one in five enrolled in MA plans, and nearly 10 percent did not have any supplemental coverage.¹⁸ The cost of private supplemental coverage accounted for, on average, 28 percent of out-of-pocket health care spending in 2007 for beneficiaries age 65 or older with employer-sponsored, Medigap, or other private health insurance.¹⁹

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.²⁰ Starting in 2013, higher-income taxpayers (annual salary greater than \$200,000 for individuals;

Figure 2
Distribution of Medicare Beneficiaries Age 65+ by Type of Supplemental Coverage



Source: Medicare Payment Advisory Commission Report to the Congress: Medicare and the Healthcare Delivery System, June 2011. Based on 2007 Medicare Current Beneficiary Survey (MCBS), Cost and Use file.

greater than \$250,000 for families) will pay an additional 0.9 percentage point payroll tax on their wages.

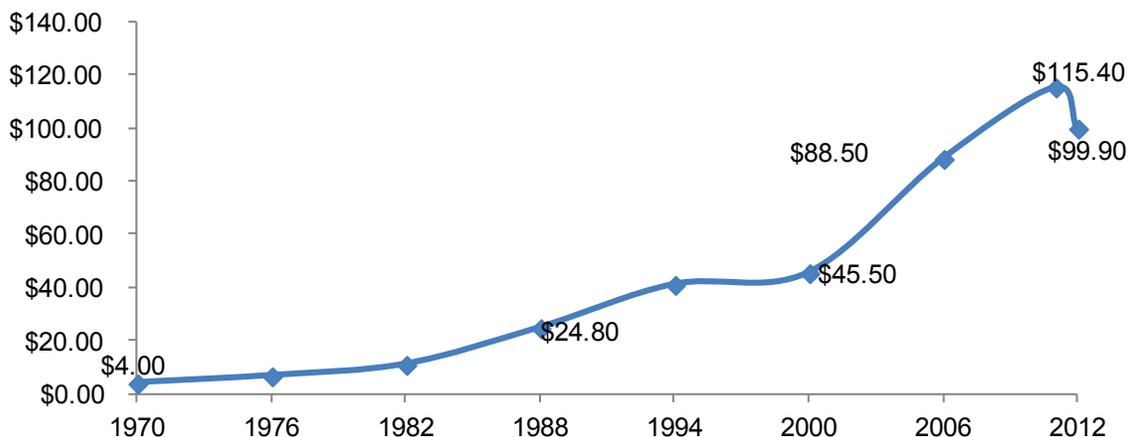
Part B income and expenditures are administered through the Supplementary Medical Insurance (SMI) Trust Fund. Part B income comes from (1) beneficiary premiums

and (2) federal general revenues. Beneficiary premiums (\$99.90 per month in 2012) cover about 25 percent of total annual costs for Part B services, while federal general revenues cover the remaining 75 percent.²¹ 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 (\$139.90 to \$319.70 in 2012) based on their income (table 1).

Benefits for enrollees in private health plans under **Part C** (Medicare Advantage) are paid out of the HI and SMI Trust Funds. In 2011, the average premium for MA with a prescription drug plan was \$43 per month.

Part D (outpatient prescription drug benefit) is administered through a separate account within the SMI Trust Fund. Part D is financed with beneficiary premiums (11 percent), general revenues, and state payments (89 percent).²² As of 2011, higher-income beneficiaries pay a higher premium based on the same income thresholds used for Part B (table 1). The average premiums for independent prescription drug plans are projected to be \$39.36 per month, and

Figure 3
Part B Medicare Premiums, 1970–2012



Source: 2011 Medicare Trustees Report and Medicare.gov.

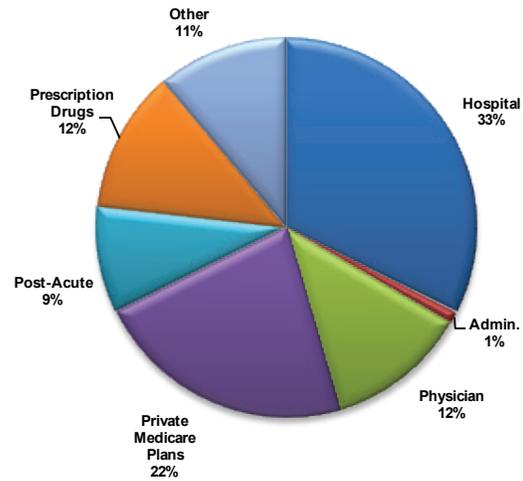
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range from \$42 to \$96 for higher-income beneficiaries in 2012.²³

How Much Does Medicare Spend?

In 2010, Medicare spent nearly \$523 billion on benefits and administration. Thirty-three percent of Medicare expenses in 2010 were for payments for inpatient or outpatient hospital services (figure 4). Another 12 percent was for physician services. Payments to private Medicare plans accounted for 22 percent, post-acute care (home health and skilled nursing facility care) accounted for 9 percent, and Part D accounted for 12 percent of Medicare expenses. Other benefits and administrative expenses made up 11 percent and 1 percent, respectively.²⁴

Figure 4
Medicare Expenditures, 2010



Source: 2011 Medicare Trustees Report.

Table 1
Medicare Part B and Part D Premiums for 2012

Annual Income in 2010		Monthly Premiums	
File Individual Tax Return	File Joint Tax Return	Part B	Part D
\$85,000 or less	\$170,000 or less	\$99.90	Varies by plan
Above \$85,000 up to \$107,000	Above \$170,000 up to \$214,000	\$139.90	\$11.60 + plan premium
Above \$107,000 up to \$160,000	Above \$214,000 up to \$320,000	\$199.80	\$29.90 + plan premium
Above \$160,000 up to \$214,000	Above \$320,000 up to \$428,000	\$259.70	\$48.10 + plan premium
Above \$214,000	Above \$428,000	\$319.70	\$66.40 + plan premium

Source: U.S. Social Security Administration, "Medicare Premiums: Rules for Higher Income Beneficiaries" December, 2011. See: www.socialsecurity.gov/pubs/10536.pdf

Medicare per capita spending is expected grow much more slowly over the next decade than it has in the past. Between 1985 and 2007, Medicare per capita spending growth averaged 3.4 percent above inflation annually. In comparison, the Congressional Budget Office projects that between 2012 and 2022, Medicare per capita spending growth will slow to an average of 1 percent more than inflation. However, total Medicare spending will grow more rapidly—around 3.9 percent of gross domestic product—because enrollment is increasing and will continue to increase as the baby boomers age.²⁵

The Affordable Care Act (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 other changes to the program that, according to the Medicare Trustees' report, are expected slow Medicare spending growth over the next 10 years (2010–2019) and extend the solvency of the Medicare Trust Fund.

Endnotes

¹ Enrollment figures are from the *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (May 13, 2011).

² Centers for Medicare and Medicaid Services (CMS), *Medicare and You 2012*, www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

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 a one-time “Welcome to Medicare” physical examination within the first 12 months of enrollment in Part B.

⁶ 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*.

⁷ *2011 Medicare Trustees Report*.

⁸ 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 www.medicare.gov.

⁹ Individuals disabled with amyotrophic lateral sclerosis are not subject to the Medicare waiting period. To receive SSDI benefits, an applicant’s medical condition must be evaluated and determined to meet Social Security’s strict definition of disability.

¹⁰ 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).

¹¹ Cost-sharing requirements under Part A, Part B, and Part D are subject to change annually.

¹² For 2012, the copayment is \$289 per day for days 61–90 of a hospital stay, and \$578 per day for additional hospital days, up to a lifetime limit of 60 days.

¹³ 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 www.medicare.gov for more information.

¹⁴ L. Purvis and L. Rucker, *Medicare Part D Open Enrollment for 2012: Increasing Plan Complexity Highlights Need for Careful Evaluation*, AARP Public Policy Institute Insight on the Issues, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2011/fs241.pdf

¹⁵ *2011 Medicare Trustees Report*.

¹⁶ Medicare Advantage plans that offer drug coverage must offer at least one option with the standard Part D benefit.

¹⁷ AARP Public Policy Institute analysis of 2007 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.

¹⁸ *Medicare Payment Advisory Commission Report to the Congress: Medicare and the Healthcare Delivery System* (June 2011).

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¹⁹ 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 2007 MCBS.

²⁰ 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.

²¹ 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 aged 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.

²² The Henry J. Kaiser Family Foundation, *Medicare Spending and Financing* (September 2011), <http://kff.org/medicare/upload/7305-06.pdf>.

²³ The Henry J. Kaiser Family Foundation, *Medicare At A Glance* (November 2011), <http://www.kff.org/medicare/1066.cfm>.

²⁴ Percentages based on AARP Public Policy Institute calculations using 2011 Medicare Trustees Report data.

²⁵ Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012–2013* (January 2012).

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