

FACTS from EBRI

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The Basics of Medicare, Updated With the 2008 Board of Trustees Report

History

- In 1965, Title 18, “Health Insurance for the Aged,” of the Social Security Act created the Medicare program. Medicare currently consists of three parts: Hospital Insurance (HI), Part A, covers hospital services and some home health care and skilled nursing facility services, and Supplemental Medical Insurance (SMI), Part B, covers physician care, outpatient hospital services, and independent laboratory services; and Part D, covers outpatient prescription drugs.
- 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 the section Medicare Advantage.
- 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 Part D, prescription drug coverage, means-tested Part B premiums and increased the Part B deductible.

Covered Beneficiaries

- Medicare serves elderly and disabled workers who qualify for DI benefits. Enrollment in HI (Part A) is automatic, while enrollment in SMI (Parts B and D) is voluntary. In 2007, 36.6 million elderly and 7.2 million disabled individuals were enrolled in Part A, and 34.6 million elderly and 6.4 million disabled individuals were enrolled in Part B, and 30.9 million individuals were enrolled in Part D.

Financing

- Expressing Medicare expenditures as a percentage of gross domestic product (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 2007, expenditures in the Medicare program equaled 3.18 percent of GDP. By 2080, that share is estimated to grow to 10.69 percent. However, after 2007, the projected Part B, SMI, and total Medicare expenditures are unrealistically low because of the current-law physician payment reductions. Should these payment rates, by new legislation, be prevented from declining, the overall Medicare costs shown in this section would be increased—possibly by 4 to 8 percent for 2030 and later, depending on the specific changes enacted.
- Medicare costs are projected to exceed those of the Social Security OASDI program in 2028 and to be 85 percent more than Social Security by 2082.

► *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.

▶ **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.
- In 2008, the fund is expected to begin using interest earnings to cover the excess of expenditures over tax income. Beginning in 2011, trust fund assets will begin to be used to cover the excess.
- The HI trust fund is expected to be exhausted by 2019.
- The difference between Medicare Part A's total outlays and its "dedicated financing sources" is estimated to reach 45 percent of outlays in fiscal year 2014, the seventh year of the projection. As a result, the Board of Trustees is required to issue a determination of projected "excess general revenue Medicare funding" in this report. This is the second consecutive such finding that triggers a statutory "Medicare funding warning," indicating that federal general revenues are becoming a substantial share of total financing for Medicare. As required by law, the president must again submit to Congress proposed legislation to respond to the warning, and Congress must consider the legislation on an expedited basis. (In February 2008, President Bush submitted legislation responding to the "Medicare funding warning" triggered by the 2007 Medicare Trustees Report.)
- HI payroll taxes are 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. In 2007, total income for the HI trust fund was \$223.7 billion: \$191.9 billion came from payroll taxes, \$10.6 billion from taxation of Social Security benefits, \$16.5 billion from interest, \$2.8 billion from premium payments, and \$1.9 billion from general revenue and other sources.¹
- In 2007, the average amount reimbursed per enrollee in Part A was \$4,573.
- In 2007, administrative costs for Part A were \$2.9 billion, or 1.4 percent of expenditures.
- The unfunded obligation of the HI trust fund, from program inception to 2082, is estimated to be \$12.4 trillion, while the unfunded obligation from program inception through the infinite horizon is \$34.4 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.
- In 2007, total income for Part B of the SMI trust fund was \$238.2 billion: \$178.4 billion from general revenues of the federal government; \$50.6 billion in premium payments, \$6.9 billion in transfers from states, and \$2.3 billion in interest.
- The average amount reimbursed per enrollee in Part B was \$4,312, in 2007.
- In 2007, administrative costs for Part B were \$3.4 billion, or 1.5 percent of expenditures.
 - The unfunded obligation of Part B, from program inception through 2082, is estimated to be \$21.2 trillion, while the unfunded obligation from program inception through the infinite horizon is \$45.9 trillion.

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

- Part D is 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.
- In 2007, total income for Part D of the SMI trust fund was \$49.5 billion: \$38.8 billion from general revenues of the federal government; \$3.9 billion in premium payments, and \$6.9 billion in transfers from states.
- The average amount reimbursed per enrollee in Part D was \$1,575, in 2007.
- The unfunded obligation of Part D, from program inception through 2082, is estimated to be \$10.0 trillion, while the unfunded obligation from the program inception through the infinite horizon is \$21.8 billion.
- Estimated operations of the Part D account are summarized below. Actual experience for 2006 came in significantly lower than the low-cost estimates from the 2006 Trustees Report.

Part D Estimated Operations

Calendar Year	Premiums From Enrollees	Other Income ¹	Total Revenue	Total Expenditures
(\$ in billions)				
Actual Experience				
2007	\$ 3.9	\$ 45.6	\$ 49.5	\$ 49.5
Estimated 2007 Operations from 2007 Trustees Report				
2007 ²	4.0	46.1	50.1	50.1
Intermediate Assumptions				
2008	4.7	46.8	50.5	50.5
2017	15.6	126.2	141.8	141.7
Low Cost Assumptions				
2008	4.6	44.9	49.6	49.6
2017	10.8	95.9	106.7	106.6
High Cost Assumptions				
2008	4.8	48.7	53.5	53.5
2017	21.8	165.8	187.6	187.4

¹ Contains federal and state government payments plus interest income.

² Intermediate assumptions.

Cost-Sharing Provisions

► *Hospital Insurance (HI): Part A*

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.

- *2008 Cost-Sharing Provisions*
 - *In-patient Hospital Deductible*—For a hospital stay of 1–60 days, a patient is liable for a \$1,024 deductible. For a hospital stay of 61–90 days, the patient is liable for a \$256 co-pay per day. For a hospital stay of more than 90 days, a patient is liable for a \$512 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 \$128 co-pay per day.
 - *Part A Premium*—For an individual who is age 65 or older and not otherwise covered by the Medicare program, the monthly premium to be covered by Part A is \$423. For enrollees who have at least 30 quarters of credit may apply for a reduced premium. That reduced premium amount is \$233.
- *2017 Cost-Sharing Provisions Estimates* (based on intermediate assumptions)
 - *In-patient Hospital Deductible*—For a hospital stay of 1–60 days, a patient is estimated to be liable for an \$1,488 deductible. For a hospital stay of 61–90 days, the patient is estimated to be liable for a \$372 co-pay per day. For a hospital stay of more than 90 days, a patient is estimated to be liable for a \$744 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 estimated to be liable for a \$186 co-pay per day.
 - *Part A Premium*—For an individual who is age 65 or older and not otherwise covered by the Medicare program, the monthly premium to be covered by Part A is estimated to be \$610. Enrollees who have at least 30 quarters of credit may apply for a reduced premium. In 2017, that reduced premium amount is estimated to be \$336.
- 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, 2008, and is released on November 24, 2008, he or she is liable for \$1,024. If the beneficiary is re-admitted to the hospital on December 20, 2008, and released on December 26, 2008, he or she does not have to pay another \$1,024. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period on this example runs until January 24, 2009.
- 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.

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

- 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 Part B'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 2008, the monthly premium is \$96.40. By 2017, the monthly premium is estimated, under intermediate assumptions, to be \$126.40.
- *Annual Deductible*—This is applied to all Part B services except home health care services. In 2008, the annual deductible is \$135. By 2017, the annual deductible is estimated, under intermediate assumptions, to be \$178.
- *Coinsurance*—Coinsurance payment in 2008 is 20 percent.

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

- The Medicare Prescription Drug Improvement and Modernization Act of 2003 created Part D a prescription drug benefit. Under current law, no more than 25.5 percent of Part D's revenues can come from premium payments.
- *2008 Cost-Sharing Provisions*
 - *Premiums*—the base beneficiary premium is \$27.93.
 - *Annual Deductible*—the annual deductible is \$275.
 - *Initial Benefit Limit*—the initial benefit limit is \$2,510. The catastrophic threshold limit is \$4,050.
- *2017 Cost-Sharing Provisions estimates* (based on intermediate assumptions)
 - *Premiums*—the base beneficiary premium is \$51.08.
 - *Annual Deductible*—the annual deductible is \$535.
 - *Initial Benefit Limit*—the initial benefit limit is \$4,830. The catastrophic threshold limit is \$7,850.

▶ **Supplementary Medical Insurance Costs Compared With Social Security Benefits**

- The average Part B plus Part D premium in 2010 is estimated to equal 11 percent of the average Social Security benefit but would increase to an estimated 29 percent in 2080. Similarly, an average cost-sharing amount in 2010 would be equivalent to 14 percent of the Social Security benefit, increasing to 37 percent in 2080.

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.
- As of January 1, 2006, Medigap policies providing coverage for prescription drugs (Plans H, I, and J) cannot be sold or issued, though they can be renewed if an individual does not enroll in Medicare Part D.
- 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

▶ **Hospital Insurance (HI): Part A**

- *Hospitalization*—Covered services include semiprivate room and board, general nursing, miscellaneous hospital services and supplies, inpatient psychiatric hospital care.
- *Post-hospital 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.

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

- *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.

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

- Provides subsidized access to drug insurance coverage on a voluntary basis for all beneficiaries and premium and cost-sharing subsidies for low-income beneficiaries.

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. In 2005, 5.8 million Medicare beneficiaries (13.0 percent of Medicare beneficiaries) were enrolled in a Medicare Managed Care. This number is estimated to increase to 16.0 million (31.7 percent of Medicare beneficiaries). Since 1998, most managed care contracts with the Centers for Medicare & Medicaid Services have operated under the Medicare Advantage program.

Trustees in 2008

- Treasury Secretary Henry M. Paulson, Jr. acts as the Managing Trustee. The other trustees include: Elaine Chao, Secretary of Labor; Michael O. Leavitt, Secretary of Health and Human Services; Michael J. Astrue, Commissioner of Social Security; Leslie V. Norwalk, Administrator of the Centers for Medicare and Medicaid Statistics and Secretary, Board of Trustees; the two public trustee positions are currently vacant.
- A copy of the 2008 Trustees report is online at www.cms.hhs.gov/ReportsTrustFunds/

Recent EBRI Research on Medicare and Retiree Health

- “Savings Needed to Cover Health Insurance and Health Care Expenses in Retirement,” [EBRI Issue Brief no. 295 \(July 2006\)](#)
- “The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees,” [EBRI Issue Brief no. 279 \(March 2005\)](#):
- “Controlling Health Costs and Improving Health Care Quality for Retirees,” [EBRI Issue Brief no. 278 \(February 2005\)](#):
- “Health Care Expenses in Retirement and the Use of Health Savings Accounts,” [EBRI Issue Brief no. 271 \(July 2004\)](#):
- “Medicare Program Takes on More Income-Related Features,” [EBRI Notes, no. 5 \(May 2004\)](#):

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, *2008 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, 2008).

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.