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Medicare: Part B Premiums

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Jennifer O'Sullivan
Specialist in Social Legislation
Domestic Social Policy Division

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Summary

Medicare is the nation's health insurance program for individuals aged 65 and over and certain disabled persons. Medicare consists of four distinct parts: Part A (Hospital Insurance [HI]); Part B (Supplementary Medical Insurance [SMI]); Part C (Medicare Advantage [MA]); and Part D (the new prescription drug benefit added by the Medicare Prescription Drug and Modernization Act of 2003 [MMA]). The Part A program is financed primarily through payroll taxes levied on current workers and their employers; these are credited to the HI trust fund. The Part B program is financed through a combination of monthly premiums paid by current enrollees and general revenues. Income from these sources is credited to the SMI trust fund. Beneficiaries can choose to receive all their Medicare services through managed care plans under the MA program; payment is made on their behalf in appropriate parts from the HI and SMI trust funds. A separate account in the SMI trust fund will account for the new Part D drug benefit which will be implemented beginning in 2006; Part D will be financed through general revenues and beneficiary premiums.

When Medicare began in 1966, the Part B monthly premium paid by beneficiaries was set at a level to finance 50% of Part B costs; general revenues financed the remainder. Legislation enacted in 1972 limited annual premium increases. As a result, beneficiary contributions dropped to below 25% of program costs by the early 1980s. Since the early 1980s, Congress regularly voted to set Part B premiums at levels to cover 25% of program costs. The Balanced Budget Act of 1997 (BBA 97) permanently set the Part B premium at 25% of program costs. Certain low-income beneficiaries are entitled to assistance in paying their Part B premiums. Beginning in 2007, certain high income Medicare enrollees will pay a higher percentage of their Part B premiums.

The 2004 monthly Part B premium is $66.60; the 2005 premium will be $78.20, a 17.4% increase. The premium increase is attributable to increases in benefit costs as well as increases needed to assure adequate trust fund reserves. This report will be updated when the 2006 premium is announced.

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Financing Medicare Part B

Calculation

Medicare Part B is financed through a combination of beneficiary premiums and federal general revenues. Beneficiary premiums equal 25% of estimated program costs for the aged. (The disabled pay the same premium as the aged.) Federal general revenues account for the remaining 75%.

The 2004 premium is $66.60, an increase of $7.90 (13.5%) over the 2003 premium. The 2005 premium will be $78.20, an increase of $11.60 (17.4%) over the 2004 amount. The increases reflect the increase in the costs of health care services funded under Part B. Increases in premium costs are somewhat outpacing those in the private health insurance market (estimated at 11.2% in 2004).

Individuals receiving social security benefits have their Part B premium payments automatically deducted from their social security benefit checks; however, an individual's social security check cannot go down from one year to the next as a result of the annual Part B premium increase.[1] Social security payments are subject to an annual cost-of-living adjustment or COLA; the 2004 increase of 2.1% represents an average monthly increase of $19 per retired worker. (As of this writing, the 2005 COLA increase has not been announced.)[2]

Premium Calculations for 2004 and 2005

Each year, Medicare actuaries estimate total per capita incurred costs for the following year. These amounts are established prospectively. Actual spending for the year maybe different; and, as a result, income for the year may not equal program costs. Trust fund assets must be maintained at a level to cover a moderate degree of variation between actual and projected costs. This is achieved through a contingency margin adjustment. The following outlines the calculations for 2004 and 2005.

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[1] Specifically, the law provides that if the Part B premium increase is greater than the dollar increase in the annual social security cost-of living adjustment, the premium owed by the individual would be reduced to the amount needed to assure no reduction in the social security cash payment.

[2] The monthly social security check is rounded down to the next lowest multiple of $1 if it is not already a multiple of $1. The Part B premium is deducted before rounding down the monthly benefit payment.

The monthly premium for 2004 was calculated as follows. Total monthly benefit costs of $347.50 were reduced by $68.60 for required beneficiary cost-sharing. The resulting amount of $278.90 was increased by $6.52 for administrative expenses and reduced by $3.58 for interest earnings. This total of $281.84 was further *reduced* by $15.44 for the contingency margin adjustment; this adjustment had the effect of drawing down the reserves. Twenty-five percent of the resulting net per capita amount of $266.40 yielded a 2004 premium amount of $66.60. [3, 4]

The monthly premium for 2005 was calculated as follows. Total monthly benefit costs of $368.64 were reduced by $70.84 for required beneficiary cost-sharing. The resulting amount of $297.80 was increased by $6.68 for administrative expenses and reduced by $4.00 for interest earnings. This total of $300.48 was further *increased* by $12.30 for the contingency margin adjustment; this has the effect of increasing the reserves. Twenty-five percent of the resulting net per capita amount of $312.78 (rounded) yields a 2005 premium amount of $78.20.

The premium increase from 2004 to 2005 is attributable to a number of factors including projected changes in the costs of services. Increases in spending for physicians services and managed care are the major factors contributing to the increase in service costs. *Total* per capita monthly spending (including beneficiary cost-sharing) for physicians services increased from $148.94 to $153.56 (3.15%). *Total* per capita monthly spending for managed care increased from $45 to $52.82 (17.4%); this increase reflects increases in costs of covered services as well as higher payments for Medicare Advantage plans required by MMA. Overall, *total* incurred costs, including administrative costs increased from $285.42 to $304.50 (6.7%). This resulted in an increase in the base Part B premium amount (before adjustments for interest and the contingency reserve) of $4.77.

A key change in the calculation from 2004 to 2005 is that for the contingency reserve. For several years, CMS has been reducing the otherwise applicable premium to draw down an anticipated surplus. However, the actuaries now anticipate the reserves are insufficient to cover contingencies; therefore an amount needs to be added to the otherwise applicable premium amount. As was noted in the 2004 trustees report,[5] Medicare actuaries feel that a reserve ratio of 15% - 20% is sufficient to protect against unforseen contingencies.[6] The ratio was at 20% or above through

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[3] Note that the figures appearing in the *Federal Register* Notice are the per capita monthly actuarial rates; by law the monthly actuarial rate is equal to 50% of per capita program costs for the aged. The beneficiary premium equals one-half of the monthly actuarial rate or 25% of program costs.

[4] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2005*, 69 *Federal Register* Notice, Sept. 9, 2004.

[5] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, *2004 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*, Communication, Mar. 23, 2004.

[6] The reserve ratio is defined as the ratio of excess of assets over liabilities to the following year's total incurred expenditures.

the end of 2002. However, at the end of 2003, the level was at 12%. The actuaries estimated that it would drop to 10% in 2004.

CMS primarily attributes the change in direction of the contingency adjustment to two pieces of legislation: the Consolidated Appropriations Resolution (CAR, P.L. 108-7) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). CAR increased physician payments for 2003 and MMA increased physician payments for 2004.[7] Both bills were enacted after the premiums for those years were announced. In addition, actual spending for 2003 was slightly higher than had been projected; thus further reducing the reserves.

The contingency adjustment to the 2004 premium was a minus $3.90 ($3.86 rounded to the nearest $0.10). If this adjustment had not been made, the premium amount for 2004 would actually have been $3.90 higher or $70.50 (instead of $66.60). Because of the projected shortfall, the adjustment was made in the other direction for 2005. This adjustment represents $3.08 (26.6%) of the $11.60 increase in the 2005 premium amount.

Comparing the actual 2004 premium amount for 2004 and 2005 shows a difference of $11.60. This includes an increase of $4.77 in benefits, a decrease of $0.11 for interest adjustment and a shift of $6.94 (minus $3.86 for 2004 and plus $3.08 in 2005) in the contingency margin. It should be noted that the actuaries project that the 2005 contingency adjustment is only half of that needed to place the trust fund assets at a truly adequate level; a similar increase can be anticipated for 2006.

It should also be noted that current projections are based on the requirements of current law. It is estimated that application of the current physician payment formula will result, beginning in 2006, in a year-to-year reduction in the conversion factor (i.e., the dollar amount that converts the relative value for a physician's service under the fee schedule to a payment amount). It is expected that the Congress will address this issue. If payment reductions are not allowed to go into effect, this will have the effect of further increasing Part B costs, and, by extension, Part B premiums.

History of Part B Premium Calculation

Annual Update

When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance 50% of Part B program costs. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which Social Security benefits were adjusted for changes in cost-of-living (i.e., COLAs). Under this formula, revenues from premiums soon dropped from 50% to below 25% of program costs. This was because Part B program costs

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[7] For a discussion of these payment increases, see CRS Report RL31199, *Medicare Payments to Physicians*, by Jennifer O'Sullivan.

increased much faster than inflation as measured by the Consumer Price Index on which the Social Security COLA is based.

From the early 1980s, Congress regularly voted to set Part B premiums at a level to cover 25% of program costs, in effect, overriding the COLA limitation. The 25% provisions first became effective January 1, 1984. General revenues covered the remaining 75% of Part B program costs. Congress took this general approach again in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). However, OBRA 90 set specific dollar figures, rather than a percentage, in law for 1991-1995. These dollar figures reflected Congressional Budget Office (CBO) estimates of what 25% of program costs would be over the five-year period. Program costs grew more slowly than anticipated, in part due to subsequent legislative changes. As a result, the 1995 premium of $46.10 actually represented 31.5% of program costs.

Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended the policy of setting the Part B premium at a level to cover 25% of program costs for 1996-1998. As was the case prior to 1991, a percentage rather than a fixed dollar figure was used. This meant that the 1996 premium ($42.50) and the 1997 premium ($43.80) were lower than the 1995 premium ($46.10).

BBA 97 permanently set the premium at 25% of program costs. *If Part B costs increase or decrease, the premium rises or falls accordingly*. (See **Table 1** for a history of Part B premiums.)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) increases the Part B premium percentage for high income enrollees, beginning in 2007. (See discussion, below.)

Table 1. Monthly Part B Premiums, 1966-2005

Year	Monthly premium	Effective date	Governing policy; Legislative authority
1966	$3.00	7/66	Fixed dollar amount; Social Security Amendments (SSA) of 1965
1967	$3.00		Fixed dollar amount; SSA of 1965
1968	$4.00	4/68	Fixed dollar amount through March; Medicare Enrollment Act of 1967. Beginning April: 50% of costs; SSA of 1965
1969	$4.00		50% of costs; SSA of 1967
1970	$5.30	7/70	50% of costs; SSA of 1967
1971	$5.60	7/71	50% of costs; SSA of 1967
1972	$5.80	7/72	50% of costs; SSA of 1967
1973	$6.30	9/73	50% of costs; SSA of 1967 (COLA limit, added by SSA of 1972, could have applied, but was not needed). Limitations imposed by Economic Stabilization program set 7/73 amount at $5.80 and 8/73 amount at $6.10.
1974	$6.70	7/74	50% of costs; SSA of 1967 (COLA limit, added by SSA of 1972, could have applied, but was not needed)

Year	Monthly premium	Effective date	Governing policy; Legislative authority
1975	$6.70		Technical error in law prevented updating
1976	$7.20	7/76	COLA limit; SSA of 1972
1977	$7.70	7/77	COLA limit; SSA of 1972
1978	$8.20	7/78	COLA limit; SSA of 1972
1979	$8.70	7/79	COLA limit; SSA of 1972
1980	$9.60	7/80	COLA limit; SSA of 1972
1981	$11.00	7/81	COLA limit; SSA of 1972
1982	$12.20	7/82	COLA limit; SSA of 1972
1983	$12.20		Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) had set 25% rule for updates in 7/83 and 7/84. However, SSA of 1983 froze premiums 7/83-12/83 and changed future updates to January.
1984	$14.60	1/84	25% of costs; TEFRA, as amended by SSA of 1983
1985	$15.50	1/85	25% of costs; TEFRA, as amended by SSA of 1983
1986	$15.50	1/86	25% of costs; Deficit Reduction Act (DEFRA) of 1984
1987	$17.90	1/87	25% of costs; DEFRA of 1984
1988	$24.80	1/88	25% of costs, Consolidated Omnibus Budget Reconciliation Act of 1985
1989	$31.90	1/89	25% of costs, OBRA 87, *plus* $4 catastrophic coverage premium added by Medicare Catastrophic Coverage Act of 1988
1990	$28.60	1/90	25% of costs; OBRA 89. Medicare Catastrophic Coverage Repeal Act of 1989 repealed additional catastrophic coverage premium, effective 1/90
1991	$29.90	1/91	Fixed dollar amount; OBRA 90
1992	$31.80	1/92	Fixed dollar amount; OBRA 90
1993	$36.60	1/93	Fixed dollar amount; OBRA 90
1994	$41.10	1/94	Fixed dollar amount; OBRA 90
1995	$46.10	1/95	Fixed dollar amount; OBRA 90
1996	$42.50	1/96	25% of costs; OBRA 93
1997	$43.80	1/97	25% of costs; OBRA 93
1998	$43.80	1/98	25% of costs; OBRA 93 and BBA 97
1999	$45.50	1/99	25% of costs; BBA 97
2000	$45.50	1/00	25% of costs; BBA 97
2001	$50.00	1/01	25% of costs; BBA 97
2002	$54.00	1/02	25% of costs; BBA 97
2003	$58.70	1/03	25% of costs; BBA 97
2004	$66.60	1/04	25% of costs; BBA 97
2005	$78.20	1/05	25% of costs; BBA 97

Source: Various Annual Reports. The 2003 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, 108th Cong., 1st sess., Mar. 2003, 69 *Federal Register* 54674, Sept. 9, 2004.

Home Health Benefit Transfer

BBA 97 made a change which had the effect of increasing the Part B premium over time. Prior to BBA 97, both Parts A and B of Medicare covered home health services. Payments were made under Part A, except for those few persons who had no Part A coverage. In order to extend the solvency of the Part A (hospital insurance) trust fund, BBA 97 gradually transferred coverage of some home health visits from Part A to Part B. Beginning January 1, 2003, Part A covers only post-institutional home health services for up to 100 visits, except for those persons with Part A coverage only, who are covered without regard to the post-institutional limitation.

Assistance for Low Income

Certain low-income beneficiaries are entitled to assistance in paying their Part B premiums. Eligible persons fall into one of the following three coverage groups:

- **Qualified Medicare Beneficiaries (QMBs)**. QMBs are aged or disabled persons with incomes at or below the federal poverty level. In 2004, the monthly level is $796 for an individual and $1,061 for a couple[8] and assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the federal-state Medicaid program. Medicaid protection is limited to payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.

- **Specified Low-Income Medicare Beneficiaries (SLIMBs).** These are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLIMB limit is 120% of the federal poverty level. In 2004, the monthly income limits are $951 for an individual and $1,269 for a couple.[9] Medicaid protection is limited to payment of the Medicare Part B premium (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.

- **Qualifying Individuals (QI-1)**. These are persons who meet the QMB criteria, except that their income is between 120% and 135% of poverty. Further, they are *not* otherwise eligible for Medicaid. In

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[8] The annual HHS poverty guidelines for 2004 are $9,310 for an individual and $ 12,490 for a couple; the monthly figures are $776 for an individual and $1,041 for a couple. The qualifying levels are higher because, by law, $20 per month of unearned income is disregarded in the calculation. The 2005 poverty guidelines will not be issued until Feb. or Mar. 2005.

[9] This is calculated the same way as the QMB level. See preceding footnote.

2004 the monthly income limit for QI-1 for an individual is $1,068 and for a couple $1,426. Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium. The program is slated to expire September 30, 2004, though extensions are possible.[10]

MMA Changes

MMA added a new drug benefit to Medicare Part D. It should be emphasized that the cost of this drug benefit is accounted for separately and has no effect on the Part B premium. MMA did, however, include two provisions directly affecting the Part B premium calculation; an additional provision affects the calculation of the Part B deductible.

Premiums for High-Income Enrollees

Since the inception of Medicare, all Part B enrollees have paid the same Part B premium, regardless of their income level. For a number of years, proposals have been offered to increase the share of Part B costs borne by higher income individuals. Many observers suggested that it is inappropriate for taxpayers to pay (through general revenue financing) three-quarters of Part B costs for these persons. They point out that low income and middle income working persons may be subsidizing higher income elderly persons.

MMA increases the Part B premiums for higher income enrollees beginning in 2007. In 2007, individuals whose modified adjusted gross income (AGI) exceeds $80,000 and couples whose modified AGI exceeds $160,000 will be subject to higher premium amounts. The increase will be phased-in over five years. When fully phased-in, higher income individuals will pay total premiums ranging from 35% to 80% of the value of Part B (See **Table 2**). The term modified AGI means adjusted gross income as defined under the Internal Revenue Code (determined without regard to specified exclusions), increased by tax-exempt interest. In general, the taxable year to be used is that beginning in the second calendar year preceding the year involved. Under certain circumstances, an individual may request to have the determination made for a more recent year.

The current law provision which specifies that a beneficiary's check can not go down from one year to the next as a result of the Part B premium increase will not apply to persons subject to an income-related increase in their Part B premiums.

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[10] In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 program are paid for 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. Any expenditures beyond that level are paid by the state. Total allocations are $300 million for Jan. 2004-Sept. 2004. The program was initially slated to terminate Dec. 31, 2002, but was extended through Sept. 31, 2004.

Table 2. Percentage of Part B Costs Paid by High-Income Beneficiaries
(in percent)

Income Category*		Year				
Single	**Couple**	**2007**	**2008**	**2009**	**2010**	**2011**
$80,001- $100,000	$160,001-$200,000	27	29	31	33	35
$100,001- $150,000	$200,001- $300,000	30	35	40	45	50
$150,001- $200,000	$300,001- $400,000	33	41	49	57	65
more than $200,000	more than $400,000	36	47	58	69	80

* Beginning in 2008, the income levels are increased by the increase in the consumer price index for urban consumers, rounded to the nearest $1,000.

The Congressional Budget Office (CBO) estimates that 1.2 million persons (3% of beneficiaries) will pay higher premiums in 2007; and 2.8 million persons (6% of beneficiaries) will pay higher premiums in 2013. CBO further estimates that the new provision will reduce federal outlays by $13.3 billion over the 2007-2013 period. It should be noted that while some persons have labeled this premium change as means testing, the same Part B benefits will be available to all enrollees regardless of income.

Changes in 2010

MMA also requires the Secretary to establish a six-year program, beginning in 2010, for the application of comparative cost adjustment (CCA) in CCA areas. The CCA program will introduce competition between traditional FFS Medicare and local private plans. As a result, an individual residing in a CCA area who is enrolled in Part B of Medicare, but not enrolled in a managed care plan, can have an adjustment to his or her Part B premium, either as an increase or a decrease. No premium adjustment will be made for certain low-income persons. The annual adjustment for a year, can not exceed 5% of the amount of the monthly Part B premium, as otherwise determined.

Part B Deductible

The Part B deductible has been set at $100 since 1991. MMA raises it to $110 in 2005. In subsequent years, it will be increased by the same percentage used to update the Part B premium.

Legislation

The size of the 2005 increase in the Part B premium has received considerable attention. As noted, an individual's social security check cannot go down from one year to the next as a result of the increase. However, some observers have suggested that beneficiaries should not face the prospect of losing a large portion of their cost-of-living (COLA) increase. For example, the Social Security COLA Protection Act of 2004 (S. 2754, Daschle, et al. and HR. 4910, Herseth et al.) would specify that the premium increases for *both* Part B and the new Part D could not exceed 25% of a beneficiary's COLA increase in a year. It should be noted that any premium costs not paid by beneficiaries would be paid from federal general revenues, thereby increasing overall federal Medicare costs.

As of this writing, it is not clear if any attempt will be made this year to roll back any portion of the premium increase or to otherwise adjust the calculation.