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Medicare: Part B Premiums

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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 2006 monthly Part B premium is $88.50, a 13.2% increase over the 2005 premium of $78.20. The premium increase is attributable to increases in benefit costs as well as increases needed to assure adequate trust fund reserves. In May 2006, the Medicare Trustees announced that the estimated premium for 2007 will be $98.20, an 11% increase over the 2006 amount. The actual premium amount will not be announced until this fall. This report will be updated when the 2007 premium is announced.

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Medicare: Part B Premiums

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 2006 monthly Part B premium is $88.50, an increase of $10.30 (13.2%) over the 2005 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 9.2% in 2005).[1]

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.[2] Social Security payments are subject to an annual cost-of-living adjustment or COLA; the 2006 increase of 4.1% represents an average monthly increase of $39 per retired worker.[3]

Premium Calculations for 2006

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 2006.

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[1] Kaiser Family Foundation, *Survey Finds Steady Decline in Businesses Offering Health Benefits to Workers Since 2000*, press release, Sept. 14, 2005.

[2] 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.

[3] 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 2006 was calculated as follows. Total monthly benefit costs of $398.86 were reduced by $71.54 for required beneficiary cost-sharing. The resulting amount of $327.32 was increased by $5.34 for administrative expenses and reduced by $3.26 for interest earnings. This total of $329.40 was further *increased* by $24.40 for the contingency margin adjustment; this has the effect of increasing the reserves. Twenty-five percent of the resulting net per capita amount of $353.80 (rounded) yields a 2006 premium amount of $88.50.

The premium increase from 2005 to 2006 is attributable to a number of factors. The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare and Medicaid) stated that the most important single factor is the rapid growth in the volume and intensity of Part B services. Recent 2004 data shows these factors playing a larger role than previously estimated. Increases in volume and intensity for the two largest components of Part B were significant. The volume/intensity increase for services paid under the physicians fee schedule was 6.3% in 2004 and is estimated at 5.6% in 2005 and 6.4% in 2006. (These figures are substantially larger than the roughly 1% annual increases recorded from 1992-1999.) The volume/intensity increase for outpatient hospital services was 6.8% in 2004 and is estimated at 6.6% in 2005 and 3.8% in 2006. Growth in spending for these two services accounted for most of the increase in Part B benefit payments. By extension it also contributes to the increase in Medicare Advantage payments which are tied by law to payments in fee-for-service Medicare.

Another factor contributing to the premium increase is the adjustment for the contingency reserve. For several years, CMS reduced the otherwise applicable premium to draw down an anticipated surplus. However, this changed for 2005.[4] 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 2005 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 the end of 2002. However, at the end of 2004, the level was at 6%.

CMS attributes the change in direction of the contingency adjustment to faster than anticipated expenditure growth as well as enactment of two pieces of legislation which increased spending after the Part B premium was announced for the year. These laws were the Consolidated Appropriations Resolution (CAR, P.L. 108-7, enacted in February 2003) and the Medicare Prescription Drug, Improvement, and

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[4] The significant premium increase for 2005 was, in part, intended to partially replenish the trust fund assets. However, due to faster than expected growth in Part B expenditures, there will be only a minimal increase in assets in 2005.

[5] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, *2005 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*, Communication, Mar. 23, 2005.

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

Modernization Act of 2003 (MMA, P.L. 108-173). CAR increased physician payments for 2003 and MMA increased physician payments for 2004.[7]

Preliminary Calculations for 2007

The 2006 premium calculation was based on current law provisions in effect at the time the premium was announced. These provisions include a formula for calculating the annual update to the physician fee schedule. Use of this formula would have resulted in a *reduction* of 4.4% in 2006. However, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171, enacted February 8, 2006) overrode the scheduled reduction. This had the effect of increasing overall Part B costs, and by extension, the Part B premium. Since the 2006 premium amount had already been announced, the increase will first be reflected in the 2007 premium.

On May 1, 2006, the Medicare trustees issued their annual report,[8] which included a preliminary estimate of the 2007 Part B premium. The trustees estimated that the premium will be $98.20, an 11% increase over the 2006 amount. The increase is needed, in part, to increase the contingency reserve. The trust fund assets are expected to fall below an acceptable level by the end of the year. This reflects both the DRA physician payment provision and higher spending in 2005 than previously estimated.

It should be noted that the premium estimates for 2007 and subsequent years are based on current law provisions, including the formula for calculating the annual payment update for physicians services. Application of that formula is expected to result in a negative update for a number of years. If Congress overrides the update for any year, as it has done for 2003-2006, this will result in higher 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 increased much faster than inflation as measured by the Consumer Price Index on which the Social Security COLA is based.

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

[8] The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *2006 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 2006.

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) increased the Part B premium percentage for high income enrollees, beginning in 2007. MMA would have phased-in the increase over five years. However, DRA shortened the phase-in period to three years. (See discussion, below.)

Table 1. Monthly Part B Premiums, 1966-2006

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)
1975	$6.70		Technical error in law prevented updating
1976	$7.20	7/76	COLA limit; SSA of 1972

Year	Monthly premium	Effective date	Governing policy; Legislative authority
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
2006	$88.50	1/06	25% of costs; BBA 97

Source: Various Annual Reports. The 2005 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, Mar. 2005, and 70 *Federal Register* 55897, Sept. 23, 2005.

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. Part B covers other home health services.

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 2006, the monthly level is $837 for an individual and $1,120 for a couple[9] 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 2006, the monthly income limits are $1,000 for an individual and $1,340 for a couple.[10] 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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[9] The annual HHS poverty guidelines for 2006 are $9,800 for an individual and $13,200 for a couple; the monthly figures are $817 for an individual and $1,100 for a couple. The qualifying levels are higher because, by law, $20 per month of unearned income is disregarded in the calculation. See [http://new.cms.hhs.gov/DualEligible/downloads/2006DERate.pdf].

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

2006 the monthly income limit for QI-1 for an individual is $1,123 and for a couple $1,505. Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium. The program is currently slated to expire September 30, 2007.[11]

MMA and DRA 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. The MMA provision increasing the premium for higher income enrollees was further modified by DRA.

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 were offered to increase the share of Part B costs borne by higher income individuals. Many observers suggested that it was inappropriate for taxpayers to pay (through general revenue financing) three-quarters of Part B costs for these persons. They pointed out that low income and middle income working persons might be subsidizing higher income elderly persons.

MMA increased the Part B premiums for higher income enrollees beginning in 2007. MMA would have phased-in the increase over five years. However, DRA shortened the phase-in period to three years. 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. 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.

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[11] 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 that 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 $400 million for both FY2006 and FY2007. The program was initially slated to terminate Dec. 31, 2002, but was extended several times and is now slated to expire Sept. 31, 2007.

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.

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

Modified AGI income category*		Year		
Single	**Couple**	**2007**	**2008**	**2009**
$80,001-$100,000	$160,001-$200,000	28.30	31.7	35
$100,001-$150,000	$200,001-$300,000	33.25	41.75	50
$150,001-$200,000	$300,001-$400,000	38.20	51.8	65
more than $200,000	more than $400,000	43.15	61.85	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.

At the time of enactment of the MMA provision, the Congressional Budget Office (CBO) estimated that 1.2 million persons (3% of beneficiaries) would pay higher premiums in 2007; and 2.8 million persons (6% of beneficiaries) would pay higher premiums in 2013. CBO further estimated that the MMA provision would reduce federal outlays by $13.3 billion over the 2007-2013 period. CBO estimated that the DRA provision accelerating the phase-in would increase premium collections by $1.6 billion over the 2007-2010 period.[12]

It should be noted that while some persons have labeled the premium change as means testing, the same Part B benefits will be available to all enrollees regardless of income.

Changes in 2010

MMA also required 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 fee-for-service (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 basic monthly Part B premium, as otherwise determined.

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[12] The MMA estimate and the DRA estimate were each made by CBO at the time of enactment of each law. Both estimates were based on the CBO budget baseline in effect at the time. As is the case for all CBO estimates, the earlier estimates are incorporated into subsequent CBO baselines. Therefore the two savings estimates cannot be added together.

Part B Deductible

The Part B deductible was set at $100 for 1991-2004. MMA raised it to $110 in 2005. Beginning in 2006, it is increased by the same percentage used to update the Part B premium. The 2006 deductible is $124.

Current Issues

Premium Amount

The size of recent premium increases 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 an increase in the Part B premium. However, some observers have suggested that beneficiaries should not face the prospect of losing a large portion of their cost-of-living (COLA) increase.[13] Further, since the hold harmless provision does not apply to the premiums for the new Part D drug program, some persons may see a reduction.

The 2006 premium calculation was based on current law provisions, which include a formula for calculating the annual update to the physician fee schedule. As noted earlier, use of this formula would have resulted in a reduction in the fee schedule rates for 2006. However, the DRA overrides the 2006 reduction. This has the effect of increasing overall Part B costs, and by extension the Part B premium. Since the 2006 premium amount had already been announced, the increase will first be reflected in the 2007 premium. The preliminary estimate for the 2007 premium is 11% over the 2006 amount.

The premium estimates for 2007 and subsequent years are based on current law provisions, including the formula for calculating the annual payment update for physicians services. Application of that formula is expected to result in a negative update for a number of years. If Congress overrides the update for any year, as it has done for 2003-2006, this will result in higher Part B premiums.

President's Budget

As noted above, higher-income individuals will pay a higher premium percentage beginning in 2007. The income threshold in 2007 is $80,000 for an individual and $160,000 for a couple. In subsequent years, the income levels are increased by the percentage increase in the consumer price index (CPI) for urban consumers.

The President's 2007 Budget would eliminate the annual CPI adjustments. This would mean that each year the number of beneficiaries subject to the higher premium

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[13] See CRS Report RL33364, *The Impact of Medicare Premiums on Social Security Beneficiaries*, by Kathleen Romig

would increase. The President's Budget estimated that this change would save $40 million over the FY2008 - FY2011 period. CBO estimated savings of $2 billion over the same period and $15.1 billion over the FY2008-FY2016 period. crsphpgw