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Medicare Overview

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals aged 65 and older, and it was expanded in 1972 to include permanently disabled individuals under the age of 65. The program is administered by the Centers for Medicare & Medicaid Services (CMS), but individuals enroll in Medicare through the Social Security Administration. CMS also contracts with private entities to provide certain services, such as claims processing, auditing, and quality oversight.

Medicare serves approximately one in six Americans and virtually all of the population aged 65 and older. In 2018, the program will cover an estimated 60 million persons (51 million aged and 9 million disabled). All beneficiaries are entitled to the same coverage regardless of income or medical history. Funding for Medicare benefits is considered mandatory spending and is not subject to the annual Congressional appropriations process.

Medicare Structure

Medicare consists of four distinct parts. Medicare Parts A, B, and D each cover different services, and Part C provides a private plan alternative for Parts A and B. Together, Parts A and B of Medicare comprise "original" or "traditional" Medicare.

Part A (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, hospice care, and some home health services.

Part B (Supplementary Medical Insurance, or SMI) covers a range of medical services and supplies, including physician, laboratory, outpatient hospital and some home health services, physician-administered drugs, and durable medical equipment. Enrollment in Part B is optional, but most beneficiaries with Part A also enroll in Part B.

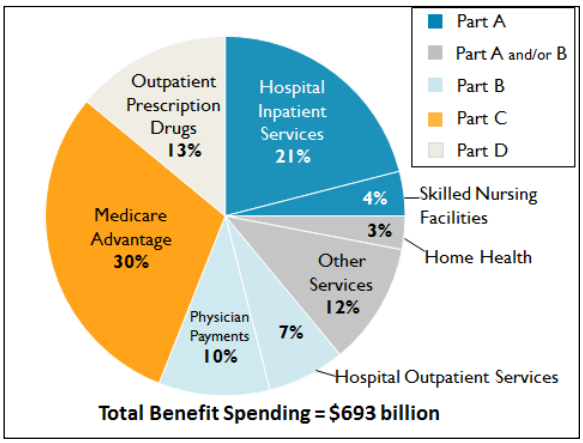
Part C (Medicare Advantage, or MA) is a private plan option that covers all Parts A and B services, except hospice. MA plans may offer additional benefits or require smaller co-payments or deductibles than original Medicare. Those who enroll in MA also must be enrolled in Parts A and B. About one-third of Medicare beneficiaries are enrolled in MA.

Part D is an optional outpatient prescription drug benefit. Part D is provided through private prescription drug plans (PDPs), which offer only drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs), which offer drug coverage that is integrated with the health care coverage they provide to beneficiaries under Part C. About 77% of eligible Medicare beneficiaries are enrolled in Part D.

Medicare Spending

Medicare spending is driven by a variety of factors, such as the level of enrollment, the complexity of medical services provided, health care inflation, and life expectancy. The Congressional Budget Office (CBO) estimates that total Medicare spending in 2018 will be about $714 billion; of this amount, close to $693 billion will be spent on benefits.

Figure 1. Projected Medicare Benefit Spending by Category, FY2018



Source: Figure by the Congressional Research Service (CRS) based on data from the Congressional Budget Office, "April 2018 Medicare Baseline," April 9, 2018.

CBO estimates that the federal portion of Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be close to $590 billion in 2018, accounting for about 14% of total federal spending and 3% of GDP. Over the next 10 years, Medicare spending is expected to almost double due mainly to growing enrollment and increasing health care costs.

Eligibility and Enrollment

Most persons aged 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 10 years. Persons under the age of 65 who receive cash disability benefits from Social Security for at least 24 months and individuals of any age with end-stage renal disease (ESRD) also are entitled to Medicare Part A. Eligible individuals who are not entitled to premium-free Part A may obtain coverage by paying a monthly premium.

All persons entitled to Part A may enroll in Part B by paying a monthly premium ($134 in 2018). Some Part B enrollees may pay less due to a "hold-harmless" provision in the Social Security Act. Beneficiaries with high incomes pay higher premiums, whereas those with low incomes may qualify for premium assistance through their state Medicaid programs.

When beneficiaries first become eligible for Medicare, they may enroll in either original Medicare or a private MA plan. Beneficiaries also may choose to enroll in a Part D plan at this time. There is an annual open enrollment period each fall during which Medicare beneficiaries may choose a different MA and/or Part D plan or may choose to leave or join the MA and/or Part D programs.

Beneficiaries generally pay monthly premiums for Part D, and there may be an additional premium for those who chose to enroll in MA (Part C). Premiums for Parts C and D vary by plan. Similar to Part B, some high-income enrollees pay higher premiums for Part D and the Part D program provides assistance to low-income enrollees. Individuals who do not enroll in Part B or Part D when they first become eligible for Medicare may pay a permanent penalty of increased monthly premiums if they choose to enroll at a later date.

Beneficiary Costs

In addition to paying premiums for Medicare Parts B, C, and/or D, beneficiaries may pay other out-of-pocket costs, such as deductibles and coinsurance, for services provided under all parts of the Medicare program. For example, there is a $1,340 per episode deductible for inpatient services under Part A, and for Part B, there is an annual deductible ($183 in 2018) and a 20% coinsurance for most services. Under Part D, although costs can vary by plan, enrollees generally pay a deductible and cost sharing for prescriptions and 5% of costs after reaching a catastrophic threshold.

There is generally no limit on beneficiary out-of-pocket spending for Medicare services. (MA does have an annual limit of $6,700.) Medicare also does not cover some items and services, such as long-term care, hearing aids, eyeglasses, and most dental care. Most beneficiaries therefore have some form of supplemental coverage through MA, private supplemental (Medigap) plans, employer-sponsored retiree plans, or Medicaid. It is estimated that, on average, health expenses (including premiums) account for about 14% of Medicare household spending.

Provider and Plan Payments

Medicare pays health care providers and plans according to payment methodologies that vary by type of service. Most of these methodologies are established in statute, and Congress has changed these payment systems over time. Under traditional Medicare, Parts A and B, the government generally pays providers directly for services on a *fee-for-service* basis using different prospective (predetermined) payment systems or fee schedules. Under Parts C and D, Medicare pays private insurers a set monthly *capitated* amount per person to provide covered benefits to enrollees regardless of the amount of services used. The capitated payments are adjusted to reflect differences in the relative cost of sicker beneficiaries with different risk factors including age, disability, or ESRD.

Most plan and provider payments currently are being reduced by 2% due to sequestration of mandatory spending under the Budget Control Act of 2011 (P.L. 112-25). These reductions are scheduled to continue through FY2027.

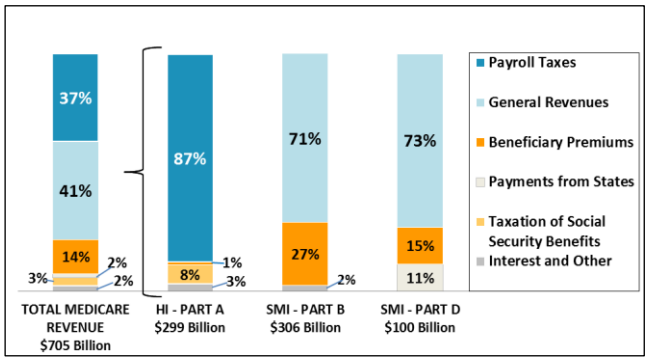
Financing

The Medicare program has two separate trust funds—the Hospital Insurance (HI) Trust Fund, which finances Part A, and the Supplementary Medical Insurance (SMI) Trust Fund, which finances Parts B and D. (Part C payments are made in appropriate parts from both the HI and SMI Trust Funds.) Both funds are maintained by the Department of the Treasury and overseen by a Board of Trustees, which reports annually to Congress.

Similar to Social Security, the HI portion of Medicare was designed to be self-supporting and is financed through dedicated sources of income. The primary source is *payroll taxes* paid by employees and employers; each pays a tax of 1.45% on earnings. An additional tax of 0.9% is imposed on high-income workers. There is no upper limit on earnings subject to the tax. Payroll taxes paid by current workers and their employers are used to pay Part A benefits for today's Medicare beneficiaries.

Unlike the HI portion of Medicare, SMI (Parts B and D) was not intended to be supported through dedicated sources of income. Instead, it relies primarily on general tax revenues and beneficiary premiums as revenue sources.

Figure 2. Sources of Medicare Revenue, 2017



Source: 2018 Report of the Medicare Trustees, Table II.B1.

Notes: Totals may not add to 100% due to rounding. HI is the Hospital Insurance Trust Fund, and SMI is the Supplementary Medical Insurance Trust Fund.

From its inception, the HI Trust Fund has faced a projected shortfall and eventual insolvency. The insolvency date has been postponed a number of times, primarily due to legislative changes that have had the effect of restraining growth in program spending. The 2018 Medicare Trustees Report projects that the HI Trust Fund will become insolvent in 2026. Because of the way it is financed, the SMI Trust Fund cannot become insolvent; however, the Medicare trustees continue to express concerns about the rapid growth in SMI costs.

For additional information, see CRS Report R40425, *Medicare Primer* and CRS Report R43122, *Medicare Financial Status: In Brief*.

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