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An Overview of Medicare

Medicare is the federal health insurance program created in 1965 for people ages 65 and over, regardless of income, medical history, or health status. The program was expanded in 1972 to cover people under age 65 with permanent disabilities. Today, Medicare plays a key role in providing health and financial security to 59 million older people and younger people with disabilities. The program helps to pay for many medical care services, including hospitalizations, physician visits, and prescription drugs, along with post-acute care, skilled nursing facility care, home health care, hospice care, and preventive services. Medicare spending accounted for 15 percent of total federal spending in 2016 and 20 percent of total national health spending in 2015.

Most people ages 65 and over are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have paid payroll taxes for 10 or more years. People under age 65 who receive Social Security Disability Insurance (SSDI) payments generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.

Characteristics of People on Medicare

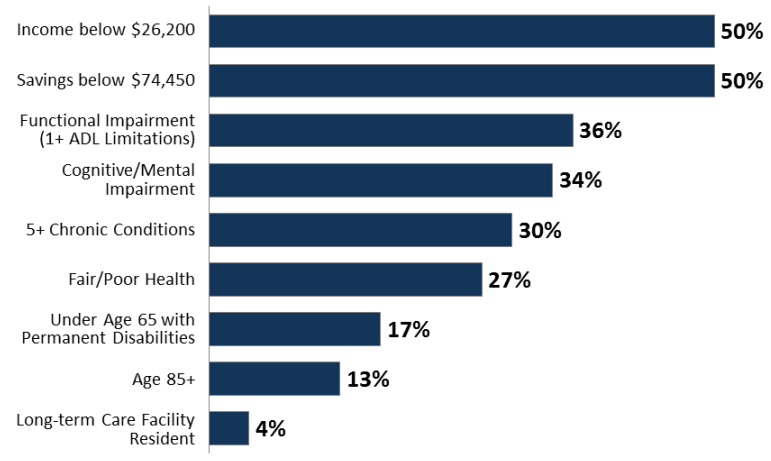
Many people on Medicare live with health problems, including multiple chronic conditions, cognitive impairments, and limitations in their activities of daily living, and many beneficiaries live on modest incomes **(Figure 1)**.

In 2013, over one-third of beneficiaries had a functional (36%) or a cognitive or mental impairment (34%), three in 10 (30%) had five or more chronic conditions, and more than one quarter of all beneficiaries (27%) reported being in fair or poor health.

Nearly one in six beneficiaries (17%) were under age 65 and living with permanent disabilities, and 13 percent were ages 85 and over. Nearly two million beneficiaries (4%) lived in a long-term care facility. In 2016, half of all people on Medicare had incomes below $26,200 per person and savings below $74,450.

Figure 1

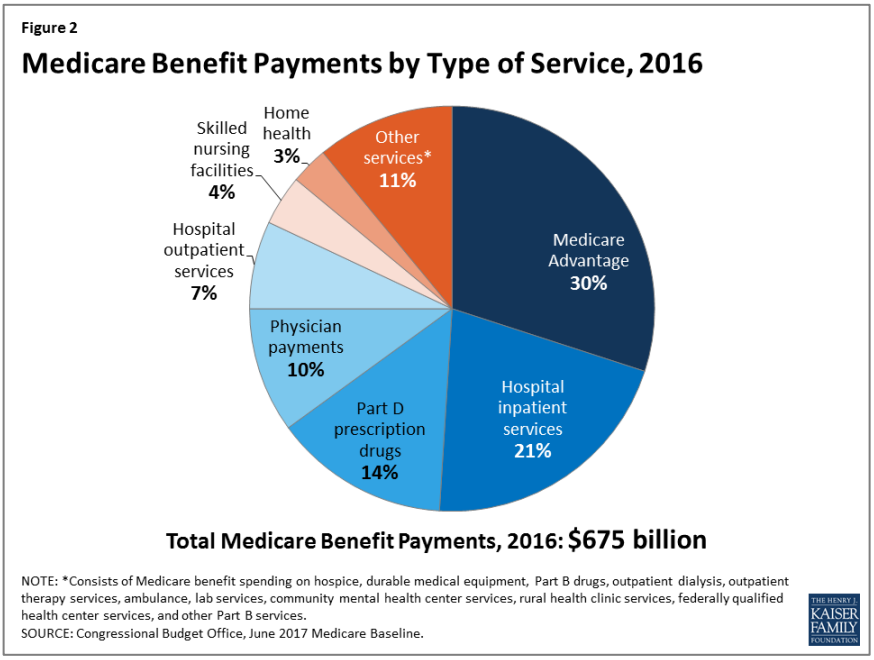
Characteristics of the Medicare Population



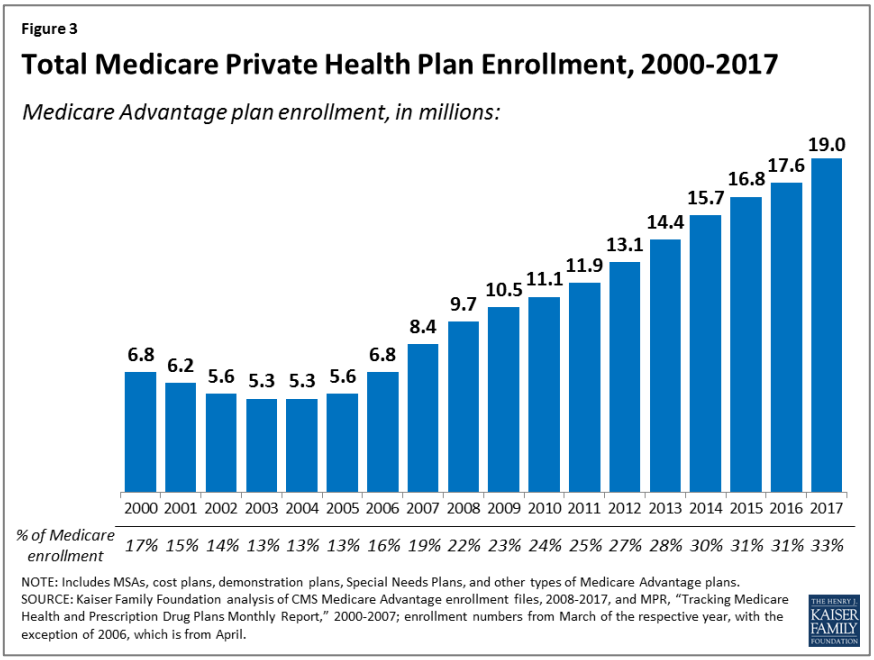
NOTE: ADL is activity of daily living.
SOURCE: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2013 Cost and Use file; Urban Institute/Kaiser Family Foundation analysis of DYNASIM data, 2017 (for income and savings).

What Medicare Covers

Medicare covers many basic health services, including hospital stays, physician services, and prescription drugs. Medicare benefits are organized and paid for in different ways **(Figure 2)**:



- **Part A** covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care. Part A benefits are subject to a deductible ($1,340 per benefit period in 2018). Beneficiaries are subject to coinsurance amounts for extended inpatient stays in a hospital or skilled nursing facility.
- **Part B** covers physician visits, outpatient services, preventive services, and some home health visits. Part B benefits are subject to a deductible ($183 in 2018), and most Part B benefits are subject to coinsurance of 20 percent. No coinsurance or deductible is charged for an annual "wellness visit" or for preventive services that are rated 'A' or 'B' by the U.S. Preventive Services Task Force.
- **Part C** refers to the Medicare Advantage program through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and receive all Medicare-covered Part A and Part B benefits and typically Part D benefits. Enrollment in Medicare Advantage plans has grown over time, with 19 million beneficiaries enrolled in Medicare Advantage plans in 2017, or 33 percent of all Medicare beneficiaries) **(Figure 3)**.



- **Part D** covers outpatient prescription drugs through private plans that contract with Medicare, including both stand-alone prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PD plans); enrollment in Part D plans is voluntary. The benefit helps pay for enrollees' drug costs after a deductible is met (where applicable), and offers catastrophic coverage for very high drug costs. Additional financial assistance is available for beneficiaries with low incomes and modest assets. Enrollees pay monthly premiums and cost sharing for prescriptions, with costs varying by plan, and those who do not receive low-income subsidies pay 5 percent of total drug costs after reaching the catastrophic coverage threshold. In 2017, more than 42 million people on Medicare were enrolled in a PDP or MA-PD plan.

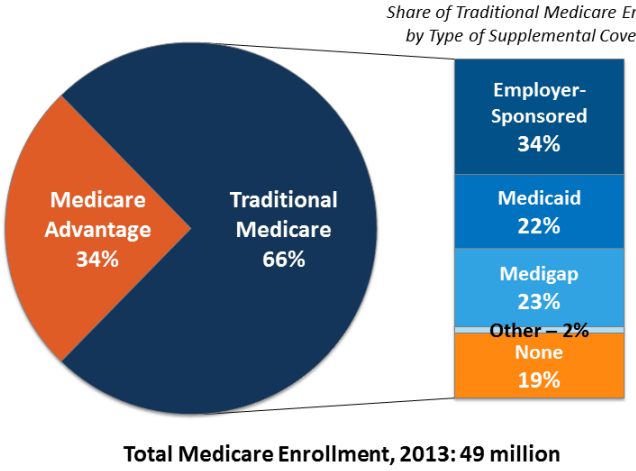
Benefit Gaps and Supplemental Coverage

Medicare provides protection against the costs of many health care services, but traditional Medicare has relatively high deductibles and cost-sharing requirements and places no limit on beneficiaries' out-of-pocket spending for services covered under Parts A and B. Moreover, Medicare does not pay for some services that are important for older people and people with disabilities, including long-term services and supports, dental services, eyeglasses, and hearing aids. Medicare Part D has a coverage gap (also called the "doughnut hole") that will gradually close by 2020, when beneficiaries will pay 25 percent of the cost of their drugs in the gap, and a 5 percent coinsurance requirement in the catastrophic coverage phase of the benefit that can expose beneficiaries to high out-of-pocket costs.

In light of Medicare's benefit gaps, cost-sharing requirements, and lack of an annual out-of-pocket spending limit, most beneficiaries covered under traditional Medicare have some type of supplemental coverage that helps to cover beneficiaries' costs and fill the benefit gaps **(Figure 4)**.

Figure 4

Distribution of Medicare Advantage and Traditional Medicare Enrollment and Types of Supplemental Coverage, 2013



NOTE: Analysis excludes beneficiaries enrolled in Part A or Part B only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2013 Cost & Use file.

- Employer-sponsored retiree health plans are a primary source of supplemental coverage for people on Medicare, providing coverage to one-third of traditional Medicare beneficiaries in 2013. Over time, however, fewer beneficiaries are expected to have this type of coverage, since the share of large firm employers offering it to their employees has dropped from 66 percent in 1988 to 25 percent in 2017.
- Medigap policies, also called Medicare Supplement Insurance, provide supplemental coverage for roughly one-fourth of beneficiaries in traditional Medicare, as of 2013. These policies, typically sold by private insurance companies, fully or partially cover Medicare Part A and Part B cost-sharing requirements, including deductibles, copayments, and coinsurance.
- Medicaid, the federal-state program that provides health and long-term care coverage to low-income people, is a source of supplemental coverage for nearly 11 million Medicare beneficiaries with low incomes and modest assets in 2014, including 6.5 million people ages 65 and over and 4.6 million people under age 65 with disabilities. These beneficiaries are known as dually eligible beneficiaries because they are eligible for both Medicare and Medicaid. Medicaid helps pay for Medicare's premiums and cost sharing for dually eligible beneficiaries, most of whom also qualify for full Medicaid benefits, which include long-term care.
- Roughly 1 in 5 (19%) Medicare beneficiaries with traditional Medicare had no supplemental coverage in 2013, including a disproportionate share of beneficiaries under age 65 with disabilities.

In 2017, one-third of all beneficiaries are enrolled in Medicare Advantage plans rather than traditional Medicare, some of whom also have coverage from an employer plan or Medicaid. Medicare Advantage plans are required to limit beneficiaries' out-of-pocket spending for services covered under Medicare Parts A and B to no more than $6,700, and may also cover supplemental benefits not covered by Medicare, such as eyeglasses, dental services, and hearing aids.

Medicare Beneficiaries' Out-of-Pocket Health Care Spending

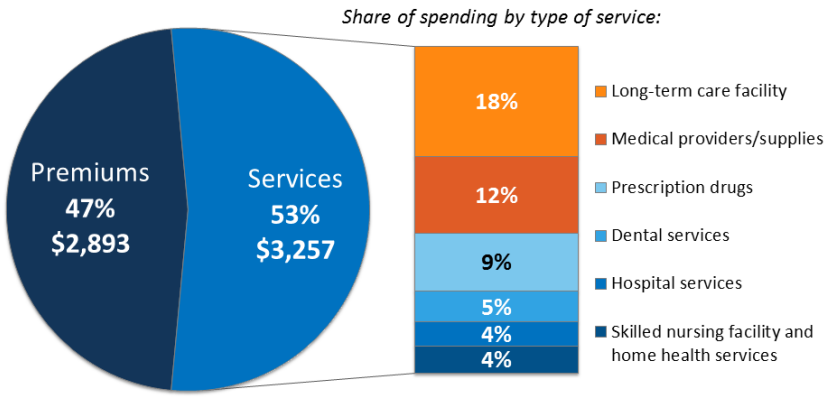
In 2013, beneficiaries in traditional Medicare and enrolled in both Part A and Part B spent $6,150 out of their own pockets for health care spending, on average **(Figure 5)**.

Nearly half (47%) of beneficiaries' average total spending was for premiums for Medicare and other types of supplemental insurance, and 53 percent was for medical and long-term care services.

Among different types of services, average per capita spending was highest for long-term care facility services, followed by medical providers and supplies, prescription drugs, and dental services. Out-of-pocket spending rises with age among beneficiaries ages 65 and over and is higher for women than men. Not surprisingly, Medicare beneficiaries with poorer self-reported health status spend more than those who rate themselves in better health.

Figure 5

Average Out-of-Pocket Spending on Services and Premiums by Medicare Beneficiaries, 2013



Average Total Out-of-Pocket Spending on Services and Premiums, 2013: $6,150

NOTE: Analysis excludes beneficiaries enrolled in Medicare Advantage plans and those enrolled in Part A or Part B only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2013 Cost & Use file.

Medicare Spending Now and In the Future

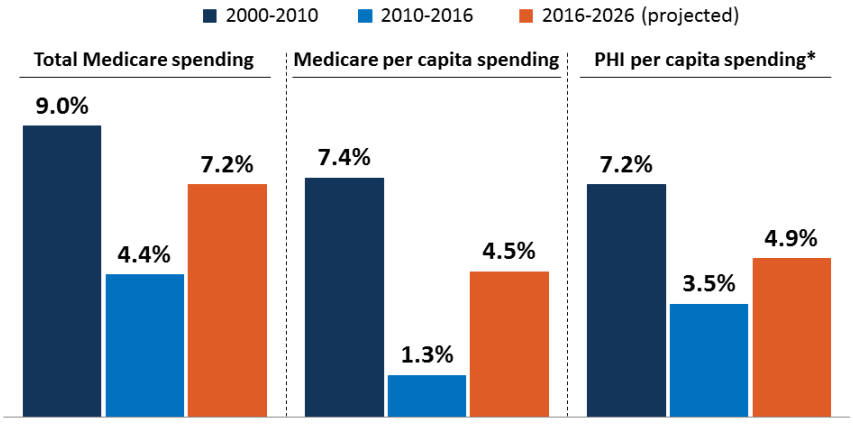
In 2016, Medicare benefit payments totaled $675 billion; 21 percent was for hospital inpatient services, 14 percent for outpatient prescription drugs, and 10 percent for physician services; 30 percent was for payments to Medicare Advantage plans *(see Figure 2)*.

Medicare spending is affected by a number of factors, including the number of beneficiaries, how care is delivered, the use of services, and health care prices. Both in the aggregate and on a per capita basis, Medicare spending growth has slowed in recent years and is expected to grow at a slower rate in the future than in the past.

Looking ahead, Medicare spending (net of income from premiums and other offsetting receipts) is projected to grow from $590 billion in 2017 to $11,159 billion in 2027. On a per capita basis, Medicare spending is projected to grow at a faster rate between 2016 and 2026 (4.5%) than it did between 2010 and 2016 (1.3%) but slower than between 2000 and 2010 (7.4%) **(Figure 6)**.

Figure 6

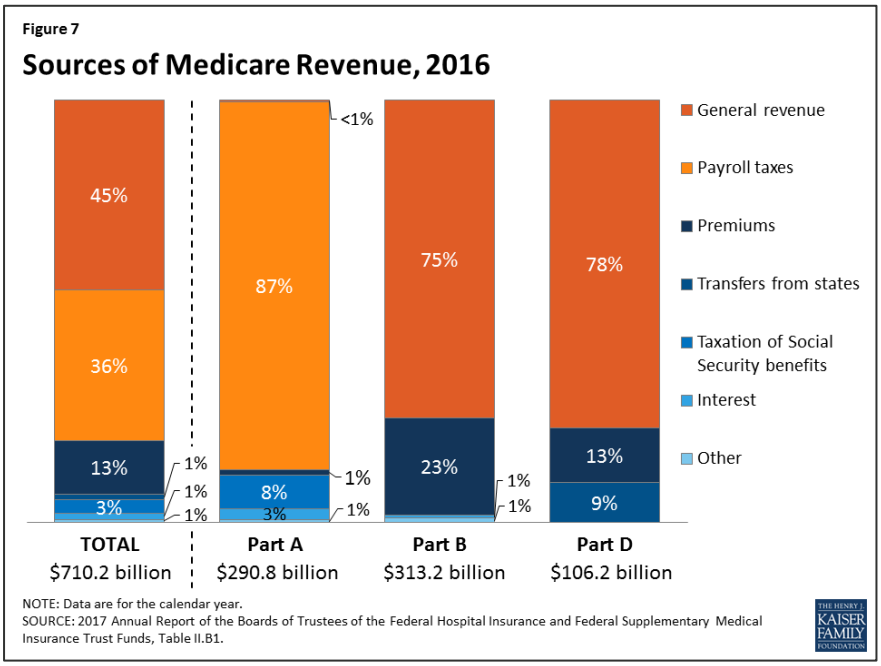
Actual and Projected Average Annual Growth Rate in Medicare and Private Health Insurance Spending



NOTE: PHI is private health insurance. *Reflects growth between 2016 and 2025 for projected spending; 2026 data not available.
SOURCE: Kaiser Family Foundation analysis of Medicare spending data from Boards of Trustees and private health insurance spending data from the CMS National Health Expenditure data.

How Medicare is Financed

Medicare is financed by general revenues (45% in 2016), payroll tax contributions (36%), beneficiary premiums (13%), and other sources **(Figure 7)**.



- **Part A** is funded mainly by a 2.9 percent payroll tax on earnings paid by employers and employees (1.45% each) deposited into the Hospital Insurance Trust Fund. Higher-income taxpayers (income greater than $200,000/individual and $250,000/married couple) pay a higher Medicare payroll tax on earnings (2.35%). The Part A Trust Fund is projected to be solvent through 2029.
- **Part B** is funded by general revenues and beneficiary premiums; the standard premium is $134 per month in 2018, the same as in 2017. Medicaid pays Part B premiums on behalf of beneficiaries who qualify for Medicaid based on having low incomes and assets. Beneficiaries with incomes greater than $85,000 for individuals or $170,000 for married couples filing jointly pay a higher, income-related monthly Part B premium, ranging from $187.50 to $428.60 per month in 2018. Although the standard Part B monthly premium is unchanged for 2018, most beneficiaries paid a lower monthly premium in 2017 due to the hold-harmless provision (about $109, on average), and will therefore face an increase in their Part B premium for 2018.
- **Part C**, the Medicare Advantage program, is not separately financed; Medicare Advantage plans provide benefits covered under Part A, Part B, and (typically) Part D, and these benefits are financed primarily by payroll taxes, general revenues, and premiums, as described. Medicare Advantage plan enrollees generally pay the monthly Part B premium and many also pay an additional premium directly to their plan. The average premium for Medicare Advantage drug plans in 2017 is $36 per month.
- **Part D** is funded by general revenues, beneficiary premiums, and state payments. The average PDP premium for 2018 is $43.48 per month (weighted by 2017 enrollment). Part D enrollees with higher incomes pay an income-related premium surcharge, with the same income thresholds used for Part B. In 2018, premium surcharges range from $13 to $74.80 per month for higher-income beneficiaries.

Medicare Payment and Delivery System Reform

Policymakers, health care providers, insurers, and researchers continue to debate how best to introduce payment and delivery system reforms into the health care system to tackle rising costs, quality of care, and inefficient spending. Medicare has taken a lead in testing a variety of new models that include financial incentives for providers, such as doctors and hospitals, to work together to lower spending and improve care for patients in traditional Medicare. The goals of these financial incentives generally link a portion of Medicare's payments for services to "value" as determined by providers' performance on spending and quality targets.

Accountable Care Organizations (ACOs) are one example of a delivery system reform model currently being tested within Medicare. With over 10 million attributed beneficiaries in 2017, ACO models allow groups of providers to accept responsibility for the overall care of Medicare beneficiaries and share in financial savings if spending and care quality targets are met. Other new models include medical homes, bundled payments (models

that combine Medicare payments to multiple providers across a single episode rather than pay for each service separately), and initiatives aimed to reduce hospital readmissions.

Many of the new Medicare payment models are managed through the Center for Medicare and Medicaid Innovation (CMMI), which was created by the Affordable Care Act (ACA). These models are being evaluated to determine their effect on Medicare spending and the quality of care provided to beneficiaries. The Secretary of Health and Human Services (HHS) is authorized to expand or extend models that demonstrate quality improvement without an increase in spending, or spending reduction without a decline in quality.

In 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA), which changed the Medicare payment system for physician services. In this law, physicians and other professionals who are affiliated with certain alternative payment models (APMs) are eligible for automatic 5-percent bonuses on their Medicare payments starting in 2019. The Centers for Medicare & Medicaid Services estimated that for 2017, between 70,000 and 120,000 providers are affiliated with qualifying APMs.

Looking to the Future

Medicare faces a number of critical issues and challenges, perhaps none greater than providing affordable, quality care to an aging population while keeping the program financially secure for future generations. The ACA included numerous changes designed to improve Medicare benefits, slow the growth in Medicare spending, and improve the quality and delivery of care. While Medicare spending is on a slower upward trajectory now than in past decades, total and per capita annual growth rates appear to be edging away from their historically low levels of the past few years. Medicare prescription drug spending is also a growing concern, with the Medicare Trustees projecting a comparatively higher per capita growth rate for Part D in the coming years than in the program's earlier years due to higher costs associated with expensive specialty drugs.

To address the health care financing challenges posed by the aging of the population, a number of changes to Medicare have been proposed, including: restructuring Medicare benefits and cost sharing; further increasing Medicare premiums for beneficiaries with relatively high incomes; raising the Medicare eligibility age; shifting Medicare from a defined benefit structure to a "premium support" system; allowing people under age 65 to buy in to Medicare; and accelerating (or otherwise modifying) the ACA's payment and delivery system reforms. As policymakers consider possible changes to Medicare, it will be important to evaluate the potential effect of these changes on total health care spending and Medicare spending, as well as on beneficiaries' access to quality care, coverage, and out-of-pocket spending.