Medicare: A Basic Overview

Center Forward Basics
July 2019

Overview

Medicare provides critical health care to about 60 million Americans today, including seniors and people with disabilities. Established in 1965 under the Social Security Act, it was set up to provide health insurance to individuals aged 65 and older, but was expanded in 1972 to include permanently disabled people under the age of 65. Medicare recipients can choose to opt into additional programs, but all beneficiaries are entitled to the same baseline coverage regardless of income or medical history.

In this basic, we break down the key components of Medicare, including its beneficiaries, structure, and financing.

Who are Medicare beneficiaries?

Medicare provides health insurance for approximately one in six Americans and basically all of the population aged 65 and older. In addition to seniors, Medicare is available to individuals under 65 who receive cash disability benefits from Social Security and people with end-stage renal disease (ESRD). In 2018, Medicare covered about 60 million people, including 51 million seniors and 9 million disabled.

Medicare recipients often have complex, sometimes chronic, healthcare needs. Of Medicare beneficiaries in 2016, 32 percent had a functional impairment, 25 percent reported being in fair or poor health, 22 percent had five or more chronic conditions, 15 percent were under age 65 and living with a disability, and 12 percent were over age 85. Additionally, half of all Medicare beneficiaries in 2016 had incomes below $26,200 per person and savings below $74,450.

How is Medicare structured?

Medicare covers many different services and people have options for how they get their Medicare coverage. Medicare has four parts.

Medicare Part A

Medicare Part A is often referred to as Hospital Insurance, or HI, and covers inpatient hospital services, skilled nursing facility (SNF) stays, hospice care, and some home health visits.

Most people aged 65 or older are automatically entitled to Part A benefits and do not have to pay a premium because they or their spouse paid Medicare payroll taxes for at least 10 years. However, Part A is still subject to a deductible of $1,364 per benefit period in 2019 and beneficiaries may be required to pay coinsurance for extended hospital or SNF stays.

Medicare Part B

Medicare Part B, or Supplementary Medical Insurance (SMI), covers medical services and supplies, including physician visits, laboratory services, outpatient hospital care, preventive services, some home health care, physician-administered medicine, and durable medical equipment. Enrollment in Part B is optional, but most beneficiaries enrolled in Part A also opt into Part B by paying a monthly premium ($135.50 in 2019). Beneficiaries with high incomes pay higher premiums and those with low incomes can qualify for premium assistance through state Medicaid programs.

Center Forward Basics

Center Forward brings together members of Congress, not-for profits, academic experts, trade associations, corporations and unions to find common ground. Our mission: to give centrist allies the information they need to craft common sense solutions, and provide those allies the support they need to turn those ideas into results.

In order to meet our challenges we need to put aside the partisan bickering that has gridlocked Washington and come together to find common sense solutions.

For more information, please visit www.center-forward.org

Key Definitions

- **Accountable Care Organization (ACO):** Group of health care providers who coordinate care to improve a patient's overall health. ACOs get paid based on how well they are able to achieve health care goals while driving down costs.
- **Benefit period**: For Medicare purposes, a benefit period begins the day a beneficiary is admitted to a hospital or SNF and ends when they have not received any hospital or SNF care for 60 consecutive days. If a beneficiary goes into the hospital or SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods a beneficiary can have in a year.
- **Capitation**: Under this payment model, providers are paid a predetermined amount on a

Many benefits in Part B are subject to a deductible ($185 in 2019) and coinsurance of 20 percent. Part A and Part B benefits together are typically referred to as "Original Medicare" and are paid for on a fee-for-service basis.

Medicare Part C (Medicare Advantage)

Medicare Part C refers to Medicare Advantage, or MA, the private plan option available to Medicare beneficiaries. MA covers all Part A and Part B services with the exception of hospice care and may offer additional benefits that address social determinants of health, such as nutrition and transportation services, as well as benefits important to this population, such as vision, dental care, and hearing. Unlike Original Medicare, MA plans are required to cap out-of-pocket expenses.

Private plans were offered in Medicare as early as the 1970s but became known officially as Medicare + Choice under the *Balanced Budget Act of 1997*. The program was renamed Medicare Advantage in 2003 when Congress created the prescription drug program (Part D). More than one third of all Medicare beneficiaries are enrolled in this type of plan with enrollment reaching an all-time high in 2019 with 22.4 million Medicare beneficiaries. In 2019, one in five MA enrollees, or 4.4 million people, are in group plans offered by employers or unions to their retirees. Another 13 percent, or 2.9 million MA beneficiaries, are enrolled in Special Needs Plans (SNPs), which can tailor care for participants with specific healthcare needs.

MA enrollees typically pay the monthly Part B premium and may also pay an additional premium directly to their plan. More information on MA can be found HERE.

Medicare Part D

Medicare Part D was created by Congress in 2003 to provide an optional outpatient prescription drug benefit to Medicare recipients. Part D plans are provided through private prescription drug plans (PDPs), which offer drug coverage exclusively, or through Medicare Advantage prescription drug plans (MA-PDs), which offer drug coverage in addition to health care provided through MA.

Part D provides coverage for very high cost drugs and makes available financial assistance for low income beneficiaries. Enrollment in Part D is voluntary, but in 2019 a total of 45 million people on Medicare are enrolled in plans with a prescription drug benefit, representing 70 percent of all Medicare beneficiaries. Roughly 30 percent of this group receive low-income subsidies.

Medicare Advantage and Medicare prescription drug plans are paid for on a capitated payment system, or one where Medicare pays private insurers a monthly rate to provide covered benefits to enrollees regardless of the amount of services used. By contrast, Original Medicare is typically paid for on a fee-for-service basis, or one where care is paid for based on each service performed.

Supplemental Coverage

Given Original Medicare's coverage gaps, lack of an annual out-of-pocket maximum on spending, and cost-sharing requirements, many traditional Medicare beneficiaries utilize some sort of supplemental coverage to fill the benefit gaps and offset costs. For instance, roughly 30 percent of traditional Medicare beneficiaries in 2016 also had employer-sponsored insurance, another 29 percent were enrolled in a Medigap policy, and about 22 percent were dually eligible for Medicaid and traditional Medicare. About 6 million beneficiaries, or 19 percent, had no supplement coverage in 2016.

Many beneficiaries receive supplemental coverage from Medigap, also known as Medicare supplemental insurance, which is sold by private insurance companies to help cover Part A and Part B cost-sharing requirements such as copays, coinsurance, and deductibles. Only beneficiaries enrolled in Original Medicare may purchase a Medigap policy.

periodic basis (e.g. per month) to care for a patient rather than paid for each healthcare service rendered.

- **Coinsurance**: Percentage of costs of a covered health service a beneficiary pays after the deductible has been reached.
- **Copayment**: Fixed amount paid by a beneficiary once the deductible has been paid.
- **Deductible**: Amount a beneficiary pays for health care services before their insurance plan begins to pay. Once this amount has been paid, beneficiaries usually only pay a copayment or coinsurance while the insurance company pays the rest.
- **Fee-for-service**: Method of payment for medical services where the provider is paid for each service performed, e.g., office visit, blood work taken, tests administered.
- **Medicaid**: Federal and state health coverage program that covers low-income families, qualified pregnant women and children and the elderly, as well as people with disabilities. In FY2016, 76 million Americans received health care coverage through Medicaid.
- **Medigap**: Also known as Medicare supplemental insurance, Medigap is sold by private insurance companies to fully or partially cover Part A and Part B cost-sharing requirements such as copays, coinsurance, and deductibles.
- **Premium**: Amount one pays for health insurance every month.

A full glossary of common health care terms can be found HERE.

Additional Resources

AARP – What is Original Medicare?

How is it paid for?

According to National Health Expenditure (NHE) data released by CMS, Medicare spent $705.9 billion in 2017, a 4.2 percent growth over the previous year. While spending has slowed in recent years, it is expected to increase at a faster rate over the next decade due to the aging of the population, growth in Medicare enrollment as more baby boomers reach eligibility, and overall increases in healthcare costs. The Congressional Budget Office (CBO) projects spending to reach $1,260 billion by year 2028.

Medicare spent 678.7 billion in total in 2016, $128.6 billion of which was to cover prescription drugs. Figure 1 breaks down Medicare prescription drug spending.

As a whole, the U.S. spent $333.4 billion on retail prescription drugs in 2017, or those dispensed at a pharmacy instead of administered by a physician. Medicare was responsible for 30 percent of spending, or about $101 billion, as outlined in Figure 2 below.

[CMS – 2019 Parts A and B Premiums and Deductibles]

[CMS – NHE Fact Sheet]

[CRS – Medicare Overview]

[Healthcare.gov – Glossary]

[KFF – Drug Spending by Payer]

[KFF – MA Facts 2019]

[KFF – Medicare and Rx Drugs]

[KFF – Overview of Medicare]

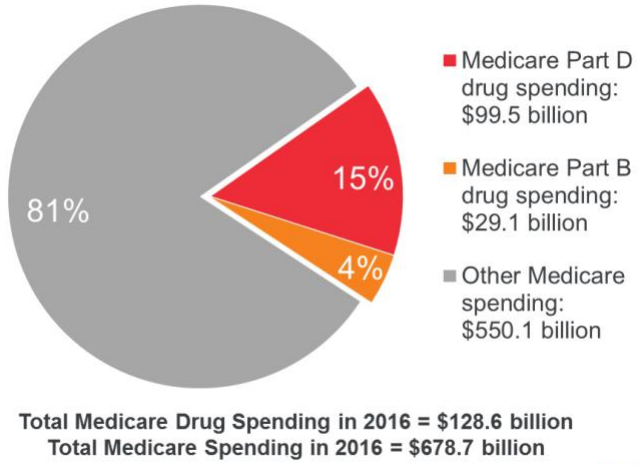
[KFF – Part D Coverage, Costs 2019]

[Medicare – Handbook 2019]

[Medicare – Medigap]

[MedPAC – Payment Basics]

Figure 1



Total Medicare Drug Spending in 2016 = $128.6 billion
Total Medicare Spending in 2016 = $678.7 billion

SOURCE: MedPAC, June 2018 Data Book (Part B drug spending) and 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Tables III.D1 and V.B1.

Figure 2

Total U.S. Retail Prescription Drug Spending in 2017: $333 billion

NOTE: Total prescription drug spending accounts for rebates.
SOURCE: KFF analysis of 2017 data from the National Health Expenditure Accounts.

Funding for Medicare is considered mandatory spending and, therefore, is not subject to Congress' annual appropriations. Medicare has two trust funds, including the Hospital Insurance (HI) Trust Fund, which funds Part A, and the Supplementary Medical Insurance (SMI) Trust Fund, which contributes to Parts B and D. The HI Trust Fund is financed through payroll taxes paid by employees and employers while the SMI portion relies on a combination of general tax revenues and beneficiary premiums to fund it. Specifically, 41 percent of Medicare was funded by general revenues in 2017 followed by 37 percent in payroll contributions and 14 percent in beneficiary premiums. The 2018 Medicare Trustees Report, an annual report to Congress by the Board of Trustees overseeing the funds, projects that the HI Trust Fund will become insolvent in 2026.

Looking Ahead

Policymakers, regulators, researchers, and stakeholders continue to debate how best to reform parts of Medicare to make it more efficient and cost-effective. From Congress passing the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 to CMS implementing numerous reforms, many through the Center for Medicare and Medicaid Innovation (CMMI) created by the Affordable Care Act, policymakers are encouraging the use of new payment models to achieve lower costs. Reforms such as bundled payments and switching to Accountable Care Organizations (ACOs) have allowed Original Medicare to move away from a fee-for-service system to one that focuses more on value and outcomes for patients.

As this debate continues, ensuring Medicare can continue to provide quality benefits to the population it serves while keeping it stable enough to support future generations will be critical.