
Medicare

The following are brief summaries of complex subjects as of November 16, 2015. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (HHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.¹

Overview

Title XVIII of the Social Security Act, designated “Health Insurance for the Aged and Disabled,” is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons aged 65 or older. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise noncovered aged persons who elect to pay a premium for Medicare coverage. Beginning in July 2001, persons with Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease) are allowed to waive the 24-month waiting period. Beginning March 30, 2010, individuals in the vicinity of Libby, Montana who are diagnosed with an asbestos-related condition are Medicare-eligible. Medicare eligibility could also apply to individuals in other areas who are diagnosed with a medical condition caused by exposure to a public health hazard for which a future public health emergency declaration is made under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (Public Law 96-510). This very broad description of Medicare eligibility is expanded in the next section.

Medicare originally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), which in the past was also known simply as Part B. Part A helps pay for inpatient hospital, home health agency, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage. Part B helps pay for physician, outpatient hospital, home health agency, and other services. To be covered by Part B, all eligible people must pay a monthly premium (or have the premium paid on their behalf).

A third part of Medicare, sometimes known as Part C, is the Medicare Advantage program, which was established as the Medicare+Choice program by the Balanced Budget Act of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries’ options for participation in private-sector health care plans.

The MMA also established a fourth part of Medicare, known as Part D, to help pay for prescription drugs not otherwise covered by Part A or Part B. Part D initially provided access to prescription drug discount cards, on a voluntary basis and at limited cost to all enrollees (except those entitled to Medicaid drug coverage) and, for low-income beneficiaries, transitional limited financial assistance for purchasing prescription drugs and a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out during 2006. In 2006 and later, Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis for all beneficiaries upon payment of a premium, with premium and cost-sharing subsidies for low-income enrollees.

Part D activities are handled within the SMI trust fund but in an account separate from Part B. It should thus be noted that the traditional treatment of “SMI” and “Part B” as synonymous is no longer accurate, since SMI now consists of Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other.

When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2015, almost 56 million are enrolled in one or both of Parts A and B of the Medicare program, and almost 18 million of them have chosen to participate in a Medicare Advantage plan.

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Entitlement and Coverage

Part A is generally provided automatically and free of premiums to persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in federal, state, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees or spouses with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. (As noted previously, the waiting period is waived for persons with Lou Gehrig's Disease, and certain persons in the Libby, Montana vicinity who are diagnosed with asbestos-related conditions are Medicare-eligible. It should also be noted that, over the years, there have been certain liberalizations made to both the waiting period requirement and the limit on earnings allowed for entitlement to Medicare coverage based on disability.) Part A coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 2014, Part A provided protection against the costs of hospital and specific other medical care to over 53 million people (almost 44 million aged and almost 9 million disabled enrollees). Part A benefit payments totaled \$264.9 billion in 2014.

The following health care services are covered under Part A:

- Inpatient hospital care. Coverage includes costs of a semiprivate room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).
- Skilled nursing facility (SNF) care. Coverage is provided by Part A only if the care follows within 30 days (generally) a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital care, and include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period

(described later), with a copayment required for days 21 through 100. Part A does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.

- Home health agency (HHA) care (covered by Parts A and B). The Balanced Budget Act transferred from Part A to Part B those home health services furnished on or after January 1, 1998, that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Parts A and B has no copayment and no deductible.

HHA care, including care provided by a home health aide, may be furnished part time by an HHA in the residence of a homebound beneficiary, if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment (DME) may also be provided, although beneficiaries must pay a 20 percent coinsurance for DME, as required under Part B of Medicare. There must be a plan of treatment and periodic review by a physician. Full-time nursing care, food, blood, and drugs are not provided as HHA services.

- Hospice care. Coverage is provided for services to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program but does pay small coinsurance amounts for drugs and inpatient respice care.

An important Part A component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61 through 90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, the beneficiary can elect to use days of Medicare coverage from a nonrenewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

All citizens (and certain legal aliens) aged 65 or older, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2014, Part B provided protection against the costs of physician and other medical services to over 49 million people (over 41 million aged and over 8 million disabled enrollees). Part B benefits totaled \$261.9 billion in 2014.

Part B covers certain medical services and supplies, including the following:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists;
- Services provided by Medicare-approved practitioners who are not physicians, including certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician;
- Services in an emergency room, outpatient clinic, or ambulatory surgical center, including same-day surgery;
- Home health care not covered under Part A;
- Laboratory tests, X-rays, and other diagnostic radiology services;
- Certain preventive care services and screening tests;
- Most physical and occupational therapy and speech pathology services;
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it;
- Radiation therapy, renal (kidney) dialysis and transplants, and heart, lung, heart-lung, liver, pancreas, bone marrow, and intestinal transplants;
- Approved DME for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, casts, and braces;
- Drugs and biologicals that are not usually self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered);
- Certain services specific to people with diabetes; and
- Ambulance services, when other methods of transportation are contraindicated.

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for certain outpatient hospital services). The preceding description of Part B-covered services should be used only as a general guide, due to the wide range of services covered under Part B and the quite specific rules and regulations that apply.

Medicare Parts A and B, as described above, constitute the original fee-for-service Medicare program. Medicare Part C, also known as Medicare Advantage, is an alternative to traditional Medicare. Although all Medicare beneficiaries can receive their benefits through the traditional fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. Medicare Advantage plans are offered by private companies and organizations and are required to provide at least those services covered by Parts A and B, except hospice services. These plans may (and in certain situations must) provide extra benefits (such as vision or hearing) or reduce cost sharing or premiums. The primary Medicare Advantage plans are:

- Local coordinated care plans (LCCPs), including health maintenance organizations (HMOs), provider-sponsored organizations, local preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law. Generally, each plan has a network of participating providers. Enrollees may be required to use these providers or, alternatively, may be allowed to go outside the network but pay higher cost-sharing fees for doing so.
- Regional PPO plans, which began in 2006 and offer coverage to one of 26 defined regions. Like local PPOs, regional PPOs have networks of participating providers, and enrollees must use these providers or pay higher cost-sharing fees. However, regional PPOs are required to provide beneficiary financial protection in the form of limits on out-of-pocket cost sharing, and there are specific provisions to encourage regional PPO plans to participate in Medicare.
- Private fee-for-service (PFFS) plans, which were not required to have networks of participating providers through 2010. Beginning in 2011, this is still the case for PFFS plans in areas (usually counties) with fewer than two network-based LCCPs and/or regional PPOs, and members may go to any Medicare

provider willing to accept the plan's payment.

However, for PFFS plans in network areas with two or more network-based LCCPs and/or regional PPOs, provider networks are mandatory, and members may be required to use these participating providers.

- Special Needs Plans, which are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain severe and disabling conditions.

For individuals entitled to Part A or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provided access to prescription drug discount cards, at a cost of no more than \$30 annually, on a voluntary basis. For low-income beneficiaries, Part D initially provided transitional financial assistance of up to \$600 per year for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out in 2006.

Since 2006, Part D has provided subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. Enrollment began in late 2005. In 2014, Part D provided protection against the costs of prescription drugs to over 40 million people. Estimated Part D benefits totaled \$77.7 billion in 2014. (This amount includes an estimated \$7.8 billion in benefits financed by enrollee premiums paid directly to the Part D plans. These direct premium amounts are available only on an estimated basis.)

Part D coverage includes most FDA-approved prescription drugs and biologicals. (The specific drugs currently covered in Parts A and B remain covered there.) However, plans may set up formularies for their prescription drug coverage, subject to certain statutory standards. Part D coverage can consist of either standard coverage (defined later) or an alternative design that provides the same actuarial value. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

It should be noted that some health care services are not covered by any portion of Medicare. Noncovered services include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, and hearing aids. These services are not a part of the Medicare program, unless they are a part of a private health plan under the Medicare Advantage program.

Program Financing, Beneficiary Liabilities, and Payments to Providers

All financial operations for Medicare are handled through two trust funds, one for Hospital Insurance (HI, Part A) and one for Supplementary Medical Insurance (SMI, Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. Currently, employers and employees each pay 1.45 percent of a worker's wages, for a combined payroll tax rate of 2.9 percent, while self-employed workers pay 2.9 percent of their net earnings. Since 1994, this tax has been paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) Beginning in 2013, earned income in excess of \$200,000 (for those filing income tax singly) and \$250,000 (for those filing jointly) is subject to an additional Part A payroll tax of 0.9 percent (the earnings thresholds are not indexed). The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

Part A also receives income from the following sources:

- a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries;
- premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily;
- reimbursements from the general fund of the U.S. Treasury for the cost of providing Part A coverage to (1) certain aged persons who retired when Part A began and thus were unable to earn sufficient quarters of coverage (the last surviving members of this group have died, and these reimbursements are complete) and (2) those federal retirees similarly unable to earn sufficient quarters of Medicare-qualified federal employment;
- interest earnings on its invested assets; and
- other small miscellaneous income sources.

Payroll taxes are used mainly to pay benefits for current beneficiaries.

The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. As previously noted, SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily financed by contributions from the general fund of the U.S. Treasury and (to a much lesser degree) by beneficiary premiums.

For Part B, the contributions from the general fund of the U.S. Treasury are the largest source of income, since beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. The standard Part B premium rate will be \$121.80 per beneficiary per month in 2016. There are, however, three provisions that can alter the premium rate for certain enrollees. First, penalties for late enrollment (that is, enrollment after an individual's initial enrollment period) may apply, subject to certain statutory criteria. Second, beginning in 2007, beneficiaries whose income is above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their standard monthly premium. Finally, a "hold-harmless" provision, which prohibits increases in the standard Part B premium from exceeding the dollar amount of an individual's Social Security cost-of-living adjustment (COLA), lowers the premium rate for certain individuals who have their premiums deducted from their Social Security checks.

Under the hold-harmless provision, the Part B premium for 2016 remains at the 2015 amount of \$104.90 for about 70 percent of Part B enrollees because the 2016 Social Security COLA, set by statutory formula and announced on October 15, 2015, is 0 percent.

As a result, the Part B account stood to receive adequate income for 2016 only if the required premium increase was borne by about 30 percent of Part B enrollees. Thus, when the COLA was announced, the Part B premium was projected to increase by an unprecedented 52 percent in 2016.

The Bipartisan Budget Act of 2015 (Public Law 114-74), enacted on November 2, 2015, circumvented that situation. The Act specified that the 2016 actuarial rate for enrollees aged 65 or older be determined as if the hold-harmless provision did not apply, thereby making the standard premium rate for 2016 lower than it otherwise would have been.

The Act also mandated that revenue lost because of the lower premium rates (excluding forgone income-related premium revenue) would be replaced by a transfer from the General Fund of the Treasury, with that transfer to be repaid over time. To that end, starting in 2016, the Part B premium includes an additional general-fund repayment charge of \$3.00 (the 2016 standard

premium rate of \$121.80 includes the \$3.00 charge). High-income enrollees pay small amounts in addition to the \$3.00 charge, but because those amounts reduce (dollar for dollar) the general revenue received by the Part B account, they are not included in the general-fund repayments. In the final year of general-fund repayment, the amounts may be modified to avoid overpayment.

Most Medicare beneficiaries who enrolled within the past year are not protected by the hold-harmless provision. Others who are not protected include dual Medicare-Medicaid beneficiaries whose Part B premiums are paid by state Medicaid programs; high-income enrollees who are subject to the income-related monthly adjustment amount; and enrollees who do not have their Part B premiums withheld from their Social Security checks, such as certain federal, state, and local government retirees.

The 2016 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries, according to income level and filing status, are shown in the following table.

2016 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries, by filing status and income level

Income	Income-related monthly adjustment (dollars)	Total monthly premium (dollars)
<i>Beneficiaries who file individual tax returns and are single individuals, heads of households, qualifying widow(ers) with dependent children, or married individuals who lived apart from their spouse for the entire taxable year and file separately</i>		
Less than or equal to \$85,000	0	121.80
Greater than \$85,000 and less than or equal to \$107,000	48.70	170.50
Greater than \$107,000 and less than or equal to \$160,000	121.80	243.60
Greater than \$160,000 and less than or equal to \$214,000	194.90	316.70
Greater than \$214,000	268.00	389.80
<i>Beneficiaries who file joint tax returns</i>		
Less than or equal to \$170,000	0	121.80
Greater than \$170,000 and less than or equal to \$214,000	48.70	170.50
Greater than \$214,000 and less than or equal to \$320,000	121.80	243.60
Greater than \$320,000 and less than or equal to \$428,000	194.90	316.70
Greater than \$428,000	268.00	389.80
<i>Beneficiaries who are married and lived with their spouse at any time during the year but file separate tax returns</i>		
Less than or equal to \$85,000	0	121.80
Greater than \$85,000 and less than or equal to \$129,000	194.90	316.70
Greater than \$129,000	268.00	389.80

For Part D, as with Part B, general fund contributions account for the largest source of income, since Part D beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The Part D base beneficiary premium for 2016 will be \$34.10. The actual Part D premium paid by an individual beneficiary equals the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. As of this writing, it is estimated that the average monthly premium for basic Part D coverage, which reflects the specific plan-by-plan premiums and the estimated number of beneficiaries in each plan, will be about \$32.50 in 2016.

The estimated \$32.50 average premium does not account for three circumstances that also can alter premiums for individual beneficiaries. First, penalties for late enrollment may apply. (Late enrollment penalties do not apply to enrollees who have maintained creditable prescription drug coverage.) Second, beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced premiums or no premiums at all (and are not subject to late enrollment penalties). Third, beginning in 2011, beneficiaries with income above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their monthly premium.

The 2016 Part D income-related monthly adjustment amounts to be paid by beneficiaries, according to income level and filing status, are shown in the following table.

In addition to contributions from the general fund of the U.S. Treasury and beneficiary premiums, Part D also receives payments from the states. With the availability of prescription drug coverage and low-income subsidies under Part D, Medicaid is no longer the primary payer for prescription drugs for Medicaid beneficiaries who also have Medicare, and states are required to defray a portion of Part D expenditures for those beneficiaries.

During the Part D transitional period that began in mid-2004 and phased out during 2006, the general fund of the U.S. Treasury financed the transitional assistance benefit for low-income beneficiaries. Funds were transferred to, and paid from, a Transitional Assistance account within the SMI trust fund.

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. It is important to note that beneficiary premiums and general fund payments for Parts B and D are redetermined annually and separately.

2016 Part D income-related monthly adjustment amounts to be paid by beneficiaries, by filing status and income level

Income	Income-related monthly adjustment (dollars)
<i>Beneficiaries who file individual tax returns and are single individuals, heads of households, qualifying widow(er)s with dependent children, or married individuals who lived apart from their spouse for the entire taxable year and file separately</i>	
Less than or equal to \$85,000	0
Greater than \$85,000 and less than or equal to \$107,000	12.70
Greater than \$107,000 and less than or equal to \$160,000	32.80
Greater than \$160,000 and less than or equal to \$214,000	52.80
Greater than \$214,000	72.90
<i>Beneficiaries who file joint tax returns</i>	
Less than or equal to \$170,000	0
Greater than \$170,000 and less than or equal to \$214,000	12.70
Greater than \$214,000 and less than or equal to \$320,000	32.80
Greater than \$320,000 and less than or equal to \$428,000	52.80
Greater than \$428,000	72.90
<i>Beneficiaries who are married and lived with their spouse at any time during the year but file separate tax returns</i>	
Less than or equal to \$85,000	0
Greater than \$85,000 and less than or equal to \$129,000	52.80
Greater than \$129,000	72.90

Payments to Medicare Advantage plans are financed from both the HI trust fund and the Part B account within the SMI trust fund in proportion to the relative weights of Part A and Part B benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of Parts A and B. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private Medigap insurance; or (3) by Medicaid, if the person is eligible. The term “Medigap” is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by Blue Cross and Blue Shield and various commercial health insurance companies.

In Medicare Advantage plans, the beneficiary’s payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries, in

general, pay the monthly Part B premium. However, some Medicare Advantage plans may pay part or all of the Part B premium for their enrollees as an added benefit. Depending on the plan, enrollees may also pay an additional premium for certain extra benefits provided (or, in a small number of cases, for certain Medicare-covered services).

For hospital care covered under Part A, a beneficiary's fee-for-service payment share includes a one-time deductible amount at the beginning of each benefit period (\$1,288 in 2016). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments (\$322 per day in 2016) are required through the 90th day of a benefit period. Each Part A beneficiary also has a lifetime reserve of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments (\$644 per day in 2016) are required.

For skilled nursing care covered under Part A, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21 through 100, a copayment (\$161 per day in 2016) is required from the beneficiary. After 100 days per benefit period, Medicare pays nothing for SNF care. Home health care requires no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of nonreplaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of the beneficiary's spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the Part A monthly premium rate will be \$411 in 2016; for those with 30 to 39 quarters of coverage, the rate will be reduced to \$226. Penalties for late enrollment may apply. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom coverage has ceased because earnings are in excess of those allowed.

The Part B beneficiary's payment share includes the following: one annual deductible (\$147 in 2016), the monthly premiums, the coinsurance payments for Part B services (usually 20 percent of the remaining allowed charges with certain exceptions noted below), a deductible for blood, certain charges above the

Medicare-allowed charge (for claims not on assignment), and payment for any services not covered by Medicare. For outpatient mental health services, the beneficiary is liable for 20 percent of the approved charges beginning in 2014. This percentage was 50 percent through 2009, then phased down in the intervening years. For services reimbursed under the outpatient hospital prospective payment system, coinsurance percentages vary by service and currently fall in the range of 20 percent to 50 percent. There are no deductibles or coinsurance for certain services, such as lab tests paid under the clinical laboratory fee schedule, HHA services, and some preventive care services (including an initial, "Welcome to Medicare" preventive physical examination and, beginning in 2011, an annual wellness visit to develop or update a prevention plan).

For the standard Part D benefit design, there is an initial deductible (\$360 in 2016). After meeting the deductible, the beneficiary pays 25 percent of the remaining costs, up to an initial coverage limit (\$3,310 in 2016). A coverage gap starts after an individual's drug costs reach the initial coverage limit and stops when the beneficiary incurs a certain threshold of out-of-pocket costs (\$4,850 in 2016). Previously, the beneficiary had to pay the full cost of prescription drugs while in this coverage gap. However, provisions enacted under the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)—collectively referred to as the Affordable Care Act—lower the out-of-pocket costs in the coverage gap gradually between 2010 and 2020. In 2016, beneficiaries who enter the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies) will receive a 50-percent manufacturer discount and a 5-percent benefit from their Part D plans for applicable prescription drugs and a 42-percent benefit from their plans for nonapplicable drugs. "Applicable" drugs are generally covered brand-name Part D drugs (including insulin and Part D vaccines); "nonapplicable" drugs are generally nonbrand-name (that is, generic) Part D drugs (including supplies associated with the delivery of insulin). Reductions to beneficiary cost sharing in the coverage gap continue to increase in future years such that, by 2020, the coverage gap will be fully phased out, with the beneficiary responsible for 25 percent of prescription drug costs.

The 2016 out-of-pocket threshold of \$4,850 is equivalent to estimated average total covered drug spending of \$7,515.22 under the defined standard benefit design, during the initial coverage period and the coverage gap, for enrollees not eligible for low-income cost-sharing subsidies. This estimated amount is based on an average blend of usage of applicable and nonapplicable drugs by enrollees while in the coverage gap. In determining out-of-pocket costs, the dollar value of the

50-percent manufacturer discount for applicable drugs is included, even though the beneficiary does not pay it. The dollar values of the 42-percent drug plan benefit on nonapplicable drugs and the 5-percent drug plan benefit on applicable drugs do not count toward out-of-pocket spending. Under the defined standard benefit design, the out-of-pocket threshold of \$4,850 for 2016 is equivalent to \$7,062.50 in total covered drug costs for enrollees eligible for low-income cost-sharing subsidies.

For costs incurred after reaching the out-of-pocket threshold, catastrophic coverage is provided, which requires the enrollee to pay the greater of 5 percent coinsurance or a small defined copayment amount (\$2.95 in 2016 for generic or preferred multisource drugs and \$7.40 in 2016 for other drugs). The benefit parameters are indexed annually to the growth in average per capita Part D costs. Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced cost-sharing amounts. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exceptions to this “true out-of-pocket” provision are cost-sharing assistance from the low-income subsidies provided under Part D and from State Pharmacy Assistance programs and, starting in 2011, the 50-percent manufacturer discount on applicable brand-name drugs purchased by enrollees in the Part D coverage gap.

Many Part D plans offer alternative coverage that differs from the standard coverage described above. In fact, the majority of beneficiaries are not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, additional partial coverage in the coverage gap. The monthly premiums required for Part D coverage are described in the previous section.

Payments to Providers

Before 1983, Part A payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under the PPS for acute inpatient hospitals, each stay is categorized into a diagnosis-related group (DRG). Each DRG has a specific predetermined amount associated with it, which serves as the basis for payment. A number of adjustments are applied to the DRG’s specific predetermined amount to calculate the payment for each stay. In some cases the payment the hospital receives is less than the hospital’s actual cost for providing Part A–covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient

hospital stays and other situations. Payments for skilled nursing care, home health care, inpatient rehabilitation hospital care, long-term care hospitals, inpatient psychiatric hospitals, and hospice are made under separate prospective payment systems.

For nonphysician Part B services, home health care is reimbursed under the same prospective payment system as Part A, most hospital outpatient services are reimbursed on a separate prospective payment system, and most payments for clinical laboratory and ambulance services are based on fee schedules. A fee schedule is a comprehensive listing of maximum fees used to pay providers. Most DME costs have also been paid on a fee schedule, but a transition to a competitive bidding process for certain DME began on January 1, 2011, with implementation in nine geographic areas. On July 1, 2013, competitive bidding was expanded to cover about 100 geographic areas in all, and a national mail-order program for diabetic testing supplies was also implemented. By July 1, 2016, for included DME, all areas of the country will be subject to competitive bidding or to payments based on the competitively bid rates.

In general, the prospective payment systems and fee schedules used for Part A and non-physician Part B services are increased each year either by indices related to the “market basket” of goods and services that the provider must purchase or by indices related to the Consumer Price Index (CPI). These indices vary by type of provider. The Affordable Care Act mandates reductions in most of these payment updates. In most cases, the payment updates are reduced by stipulated amounts for 2010–2019 and are further and permanently reduced by growth in economy-wide productivity. Starting dates and amounts of reductions vary by provider. It is likely that the lower payment increases will not be viable in the long range. The best available evidence indicates that most health care providers cannot improve their productivity to this degree because of the labor-intensive nature of most of these services.

For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician’s actual charge, (2) the physician’s customary charge, or (3) the prevailing charge for similar services in that locality. Since January 1992, allowed charges have been defined as the lesser of (1) the submitted charges or (2) the amount determined by a fee schedule. Under 1997 legislation, the fee schedule was to be updated each year by a Sustainable Growth Rate (SGR) system that would limit changes in physician payments according to changes in selected program and national economic factors. However, from 2003 to 2015, Congress repeatedly postponed significant physician fee reductions scheduled under the SGR system.

The Medicare Access and CHIP Reauthorization Act of 2015 permanently repealed SGR and replaced it with a new annual payment update system. A reduction in payment rates that was scheduled to begin on April 1, 2015 under SGR was averted; payment updates for all future years were prescribed; and incentive payments for later years, based on participation by individual physicians in an alternative payment model program or on performance under the merit-based incentive payment system, were set forth in the law. Although scheduled updates in the new system's first several years provide a much more plausible expectation for physician payments than did those of the SGR system, the specified rate updates are not expected to keep up with underlying physician costs in the long term.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are "participating physicians" if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since beneficiaries in the original Medicare fee-for-service program may select their doctors, they can choose participating physicians.

Medicare Advantage plans and their precursors have generally been paid on a capitation basis, meaning that a fixed, predetermined amount per month per member is paid to the plan, without regard to the actual number and nature of services used by the members. The specific mechanisms to determine the payment amounts have changed over the years. In 2006, Medicare began paying capitated payment rates to plans based on a competitive bidding process.

For Part D, each month for each plan member, Medicare pays stand-alone PDPs and the prescription drug portions of Medicare Advantage plans their risk-adjusted bid, minus the enrollee premium. Plans also receive payments representing premiums and cost-sharing amounts for certain low-income beneficiaries for whom these items are reduced or waived. Under the reinsurance provision, plans receive payments for 80 percent of costs in the catastrophic coverage category.

To help them gain experience with the Medicare population, Part D plans are protected by a system of "risk corridors" that allow Medicare to assist with unexpected costs and share in unexpected savings. The risk corridors became less protective after 2007.

Under Part D, Medicare provides certain subsidies to employer and union PDPs that continue to offer coverage to Medicare retirees and meet specific criteria in doing so. These previously tax-exempt retiree drug subsidy (RDS) payments became taxable under the Affordable Care Act beginning in 2013.

Claims Processing

Since the inception of Medicare, fee-for-service claims have been processed by nongovernment organizations or agencies under contract to serve as the fiscal agent between providers and the federal government. These entities apply the Medicare coverage rules to determine appropriate reimbursement amounts and make payments to the providers and suppliers. Their responsibilities also include maintaining records, establishing controls, safeguarding against fraud and abuse, and assisting both providers and beneficiaries as needed.

Before the enactment of the MMA in 2003, contractors known as fiscal intermediaries processed Part A claims for institutional services, including claims for inpatient hospital, SNF, HHA, and hospice services. They also processed outpatient hospital claims for Part B. Similarly, contractors known as carriers handled Part B claims for services by physicians and medical suppliers. By law, the Centers for Medicare & Medicaid Services (CMS) was required to select fiscal intermediaries from among companies that were nominated by health care provider associations and to select carriers from among health insurers or similar companies.

The MMA mandated the replacement of that system with a new system of entities known as Medicare Administrative Contractors (MACs). Each MAC processes and pays fee-for-service claims for both Part A and Part B services to all providers and suppliers within its geographic jurisdiction. MACs are selected through a competitive procedure. This new system is intended to improve Medicare services to beneficiaries, providers, and suppliers, who now have a single point of contact for all claims-related business. CMS will evaluate MACs based in part on customer satisfaction with their services. The new system enables the Medicare fee-for-service program to benefit from economies of scale and competitive performance contracting.

The transition from fiscal intermediaries and carriers to MACs began in 2005, and the last intermediary and carrier contracts ended in September 2013. Under the initial implementation of the MAC system, Part A and Part B claims were processed by fifteen "A/B MACs," with the exception of (1) DME claims, which were processed by four specialty MACs, and (2) home health and hospice claims, which were processed by four other specialty MACs. CMS is in the process of consolidating

the A/B MAC jurisdictions from fifteen to ten. As of August 2015, there are twelve A/B MACs, and the four home health and hospice MACs have been integrated into A/B MAC jurisdictions.

Claims for services provided by Medicare Advantage plans (that is, claims under Part C) are processed by the plans themselves.

Part D plans are responsible for processing their claims, akin to Part C. However, because of the “true out-of-pocket” provision discussed previously, CMS has contracted the services of a facilitator, who works with CMS, Part D drug plans (stand-alone PDPs and the prescription drug portions of Medicare Advantage plans), and carriers of supplemental drug coverage to coordinate benefit payments and track the sources of cost-sharing payments. Claims under Part D also have to be submitted by the plans to CMS, so that certain payments based on actual experience (such as payments for low-income cost-sharing and premium subsidies, reinsurance, and risk corridors) can be determined.

Because of its size and complexity, Medicare is vulnerable to improper payments, ranging from inadvertent errors to outright fraud and abuse. Although providers are responsible for submitting accurate claims, and MACs are responsible for ensuring that only such claims are paid, there are additional groups whose duties include the prevention, reduction, and recovery of improper payments.

Quality improvement organizations (QIOs, formerly called peer review organizations or PROs) are groups of practicing health care professionals who are paid by the federal government to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. One function of QIOs is to ensure that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

The ongoing effort to address improper payments intensified after enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), which created the Medicare Integrity Program (MIP). The MIP provides CMS with dedicated funds to identify and combat improper payments, including those caused by fraud and abuse, and, for the first time, allows CMS to award contracts competitively with entities other than carriers and intermediaries to conduct these activities. MIP funds are used for (1) audits of cost reports, which are financial documents that hospitals and other institutions are required to submit annually to CMS; (2) medical reviews of claims to determine whether services provided are medically reasonable and necessary; (3) determinations of whether Medicare or other insurance

sources have primary responsibility for payment; (4) identification and investigation of potential fraud cases; and (5) education to inform providers about appropriate billing procedures. In addition to creating the MIP, HIPAA established a fund to provide resources for the Department of Justice—including the Federal Bureau of Investigation—and the Office of Inspector General (OIG) within the Department of Health and Human Services (HHS) to investigate and prosecute health care fraud and abuse.

The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) established and funded the Medicare-Medicaid Data Match Program, which is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information. As is the case under the MIP, CMS can contract with third parties. The funds also can be used (1) to coordinate actions by CMS, the states, the Attorney General, and the HHS OIG to prevent improper Medicaid and Medicare expenditures and (2) to increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and the recoupment of fraudulent, wasteful, or abusive expenditures.

The Affordable Care Act includes many provisions intended to improve the accuracy of payments and to link those payments to quality and efficiency in the Medicare program. One of the most important provisions establishes the Center for Medicare and Medicaid Innovation (CMMI) in CMS to test innovative payment and service delivery models, with the goal of reducing Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) expenditures while preserving or enhancing quality of care.

Administration

HHS has the overall responsibility for administration of the Medicare program. Within HHS, responsibility for administering Medicare rests with CMS. The Social Security Administration (SSA) assists, however, by initially determining an individual’s Medicare entitlement, by withholding Part B premiums from the Social Security benefit checks of most beneficiaries, and by maintaining Medicare data on the Master Beneficiary Record, which is SSA’s primary record of beneficiaries.

The MMA requires SSA to undertake a number of additional Medicare-related responsibilities, including making low-income subsidy determinations under Part D, notifying individuals of the availability of Part D subsidies, withholding Part D premiums from monthly Social Security cash benefits for beneficiaries who request such an arrangement, and, for 2007 and later, determining the individual’s Part B premium if the Part B income-related monthly adjustment applies. For 2011 and later, the Affordable Care Act requires SSA to

determine the individual's Part D premium if the Part D income-related monthly adjustment applies. The Internal Revenue Service (IRS) in the Department of the Treasury collects the Part A payroll taxes from workers and their employers. IRS data, in the form of income tax returns, play a role in determining which Part D enrollees are eligible for low-income subsidies (and to what degree) and which Part B and Part D enrollees are subject to the income-related monthly adjustment amounts in their premiums (and to what degree).

A Medicare Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the federal government, oversees the financial operations of the HI and SMI trust funds. The Secretary of the Treasury is the managing trustee. Each year, around the first day of April, the Board of Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds.

State agencies (usually state health departments under agreements with CMS) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with CMS, these agencies then certify the facilities that are qualified.

Medicare Financial Status

Medicare is the largest health care insurance program—and the second-largest social insurance program—in the United States. Medicare is also complex, and it faces a number of financial challenges in both the short term and the long term. These challenges include:

- The solvency of the HI trust fund, which fails the Medicare Board of Trustees' test of short-range financial adequacy. Current trust fund assets are insufficient to meet 100 percent of projected annual expenditures and are not expected to attain the 100 percent level under the Trustees' intermediate assumptions.
- The long-range health of the HI trust fund, as the trust fund fails the Trustees' long-range test of close actuarial balance.
- The rapid growth projected for SMI costs as a percent of Gross Domestic Product. (The Part B and Part D accounts in the SMI trust fund are automatically in financial balance—in both the short range and the long range—since premiums and general revenue financing rates are reset each year to match estimated costs. However, the rapid growth of the SMI expenditures nevertheless places steadily increasing demands on beneficiaries and taxpayers.)
- The likelihood that the lower payment rate updates to most categories of Medicare providers for 2011 and

later, as mandated by the Affordable Care Act, will not be viable in the long range.

- The likelihood that the payment rates specified under the new Part B update system will not keep up with underlying physician costs in the long term, which could reduce access to or quality of physician services for beneficiaries; or that Congress will override the specified updates (as repeatedly occurred for the SGR system updates), which would in turn lead to higher costs.

A detailed description of these issues is beyond the scope of this summary. For more information, see the Medicare Trustees Report (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>).

Data Summary

The Medicare program covers most of our nation's aged population, as well as many people who receive Social Security disability benefits. In 2014, Part A covered over 53 million enrollees with benefit payments of \$264.9 billion, Part B covered over 49 million enrollees with benefit payments of \$261.9 billion, and Part D covered over 40 million enrollees with benefit payments of \$77.7 billion. Administrative costs in 2014 were about 1.7 percent, 1.5 percent, and 0.5 percent of expenditures for Part A, Part B, and Part D, respectively. Total expenditures for Medicare in 2014 were \$613.3 billion.

Medicare: History of Provisions

This section is a summary of selected Medicare provisions, based on general interest, as of November 1, 2014. It should be used only as a broad overview of the history of the provisions of the Medicare program. This section does not render any legal, accounting, or other professional advice and is not intended to explain fully all the provisions and exclusions of the relevant laws, regulations, and rulings of the Medicare program. Original sources of authority should be researched and utilized.

Insured Status

Entitlement to Medicare Part A (also known as Hospital Insurance, or HI) Benefits

1965. Individual aged 65 or older entitled to monthly benefits under the Social Security or Railroad Retirement program, or aged 65 before 1968, or 3 quarters of coverage (QC) after 1965 and before attainment of age 65.

1967. Three QC for each year after 1966 and before attainment of age 65.

1972. Disabled individual, under age 65, entitled to disability benefits for 24 consecutive months under the Social Security or Railroad Retirement program (excludes spouses and children of disabled individuals). Individual under age 65 who has end-stage renal disease (ESRD) and who is either fully or currently insured, or is entitled to monthly benefits under the Social Security or Railroad Retirement program, or is the spouse or dependent child of such an insured individual or beneficiary. Entitlement begins on the first day of the third month following the initiation of a course of renal dialysis and ends with the 12th month following the month in which either the dialysis terminates or the individual has a renal transplant.

Individual aged 65 or older enrolled in the Part B program who is not otherwise entitled to HI benefits, upon voluntary participation with payment of HI premium.

1980. Individual who would be entitled to monthly benefits under the Social Security or Railroad Retirement program if application were made.

Disabled individual under age 65 entitled to disability benefits for at least 24 months, not necessarily consecutive, under the Social Security or Railroad Retirement program.

Coverage extended for up to 36 months for disabled individuals whose disability continues but whose monthly benefit ceased because they engaged in substantial gainful activity.

Second waiting period eliminated if a former disabled-worker beneficiary becomes entitled again within 5 years (7 years for disabled widows and widowers and disabled children aged 18 or older).

1982. Federal employees covered under HI on the basis of QC for earnings as federal employees or on the basis of deemed QC for earnings as federal employees before 1983.

1983. Employees of nonprofit organizations, effective January 1, 1984.

1986. Mandatory coverage for state and local government employees not covered under Social Security and hired after March 31, 1986.

1987. Second waiting period eliminated if a former disabled beneficiary becomes entitled again (no time limit).

1989. Disabled individuals under age 65 who are no longer entitled to Social Security disability benefits because their earnings exceeded the substantial gainful activity level have the option to purchase Medicare coverage by paying the HI and Supplementary Medical Insurance (SMI) Part B premiums.

2000. The 24-month waiting period (otherwise required for an individual to establish Medicare eligibility on the basis of a disability) is waived for persons with amyotrophic lateral sclerosis, effective July 1, 2001. The entitlement to Medicare begins with the first month of the Social Security Administration's determination of eligibility for Disability Insurance benefits.

2010. Individuals in the vicinity of Libby, Montana who are diagnosed with an asbestos-related condition are Medicare-eligible beginning March 30, 2010. Medicare eligibility could also apply to individuals in other areas who are diagnosed with a medical condition caused by exposure to a public health hazard for which a future public health emergency is declared under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

Entitlement to Medicare Part B (also known as Supplementary Medical Insurance Part B Account, or SMI Part B) Benefits

1965. U.S. resident (citizen or lawfully admitted alien with 5 years continuous residence) aged 65 or older or any individual entitled to HI benefits, upon voluntary participation with payment of Part B premium.

1972. Individual under age 65 entitled to HI benefits, upon voluntary participation with payment of Part B premium.

Entitlement to Medicare Part D (also known as Supplementary Medical Insurance Part D Account, or SMI Part D) Benefits

2003. For temporary Medicare-endorsed prescription drug discount card program (as a prelude to the new Part D prescription drug program), individual entitled or enrolled under Part A or enrolled in Part B, except those enrolled in Medicaid and entitled to Medicaid outpatient drug coverage, upon voluntary participation with payment of up to \$30 annual enrollment fee. Under a Transitional Assistance provision, a drug card-eligible beneficiary whose income does not exceed 135 percent of the federal poverty level and does not have third-party prescription drug coverage is entitled to further benefits. Enrollment begins in May 2004, access to discounts begins in June 2004, and program phases out as drug benefit becomes available in 2006 (see next entry).

Beginning January 1, 2006, individual entitled to benefits under Part A or enrolled under Part B, upon voluntary enrollment (including payment of Part D premium, if applicable) in either a stand-alone PDP or an integrated Medicare Advantage plan that offers Part D coverage in its benefit package.

Medicare Benefits

Under Part A

- 1965.** In each benefit period, inpatient hospital services, 90 days. Includes semiprivate accommodations, operating room, hospital equipment (including renal dialysis), laboratory tests and X-ray, drugs, dressings, general nursing services, and services of interns and residents in medical osteopathic or dentistry training. Inpatient psychiatric hospital care limited to 190-day lifetime maximum. Outpatient hospital diagnostic services. Post-hospital extended-care services, 100 days (including physical, occupational, and speech therapy). Post-hospital home health services, 100 visits. Deductible and coinsurance provisions (see Table 2.C1).
- 1967.** Lifetime reserve of 60 additional days of inpatient hospital services. Outpatient hospital diagnostic services transferred to SMI.
- 1972.** Services of interns and residents in podiatry training.
- 1980.** Unlimited home health visits in a year. Requirement for prior hospitalization eliminated. Home health services provided for up to 4 days a week and up to 21 consecutive days.
- Alcohol detoxification facility services.
- 1981.** Part A coinsurance is based on the deductible for the calendar year in which services are received rather than the deductible in effect at the time the beneficiary's spell of illness began, starting in 1982.
- Alcohol detoxification facility services eliminated.
- 1982.** Beneficiaries expected to live 6 months or less may elect to receive hospice care benefits instead of other Medicare benefits. May elect maximum of two 90-day and one 30-day hospice care periods, effective November 1, 1983, to October 1, 1986.
- 1984.** For DME provided by home health agencies, the payment amount is reduced from 100 percent of costs to 80 percent of reasonable charges.
- 1986.** Set the Part A deductible for 1987 at \$520 with resulting increases in cost sharing. Increased the Part A deductible annually by the applicable percentage increase in the hospital prospective payment rates.
- Hospice care benefit (enacted in 1982) made permanent.
- 1987.** Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).
- 1988.** Enrollee pays annual hospital deductible (set at \$560 for 1989) and Medicare pays balance of covered charges, regardless of the number of days of hospitalization (except for psychiatric hospital care, which is still limited by 190-day lifetime maximum).
- The number of days in a skilled nursing facility (SNF) changed to 150 per year. Deletes the requirement for a prior hospital stay of 3 or more consecutive days.
- Expands home health care to provide care for less than 7 days per week and up to 38 consecutive days.
- Hospice care extended beyond 210 days when beneficiary is certified as terminally ill.
- All 1988 provisions became effective January 1, 1989.
- 1989.** The spell of illness and benefit period coverage of laws before 1988 return to the determination of inpatient hospital benefits in 1990 and later. After the deductible is paid in benefit period, Medicare pays 100 percent of covered costs for the first 60 days of inpatient hospital care. Coinsurance applies for the next 30 days in a benefit period.
- The requirement for a prior hospital stay of 3 or more consecutive days is reinstated for SNF services. Coverage returns to 100 days post-hospital care per spell of illness with a daily coinsurance rate in effect for days 21 through 100.
- Home health services return to a limit of 21 consecutive days of care. Provision providing for home health care for fewer than 7 days per week continued due to a court decision.
- Hospice care is returned to a lifetime limit of 210 days.
- 1990.** Hospice care is extended beyond 210 days when beneficiary is certified as terminally ill.
- 1997.** Home health services not associated with a hospital or SNF stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or an SNF stay. The cost to the SMI trust fund of the transferred services will phase in over a 6-year period (that is, the HI trust fund will transfer funds to the SMI trust fund during that period).
- Limits on the number of hours and days that home health care can be provided have been clarified. *Part-time* now defined as skilled nursing and home health aide services (combined) furnished any number of days per week, for less than 8 hours per day and 28 or fewer hours per week. *Intermittent* now defined as skilled nursing care provided for fewer than 7 days each week, or less than 8 hours each day (combined) for 21 days or less.

Hospice benefit periods are restructured to include two 90-day periods, followed by an unlimited number of 60-day periods.

Medicare coverage provided for a number of prevention initiatives, most of which are covered under SMI program. HI program affected mainly by two of the initiatives: (1) annual prostate cancer screening for male beneficiaries aged 50 or older, effective January 1, 2000, and (2) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances.

2000. The homebound criterion for home health services is clarified to specify that beneficiaries who require home health services may attend adult day care for therapeutic, psychosocial, or medical treatment and still remain eligible for the home health benefit. Homebound beneficiaries may also attend religious services without being disqualified from receiving home health benefits.

Screening colonoscopies are covered for all beneficiaries, not just for those at high risk, beginning July 1, 2001. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous one, or 4 years after a screening flexible sigmoidoscopy. (See 1997.)

Under Part B

1965. Physician and surgeon services. In-hospital services of anesthesiologists, pathologists, radiologists, and psychiatrists. Limited dental services. Home health services, 100 visits in calendar year. Other medical services including various diagnostic tests, limited ambulance services, prosthetic devices, rental of DME used at home (including equipment for dialysis), and supplies used for fractures. For deductible and coinsurance provisions, see Table 2.C1.

Beginning in 1966, the beneficiary pays a \$50 deductible, with a 3-month carryover provision.

1967. Outpatient hospital diagnostic services transferred from HI. Includes physical therapy services in a facility. Purchase of DME.

1972. Physical therapy services furnished by a therapist in his or her office or individual's home (calendar year limit of \$100). Chiropractor services (limited to manual manipulation of the spine). Outpatient services include speech pathology services furnished in, or under arrangements with, a facility or agency. Services of a doctor of optometry in furnishing prosthetic lenses.

Beginning in 1973, the beneficiary pays a \$60 deductible.

1977. Services in rural health clinics.

1980. Home health services. Deductible applicable to home health services is eliminated, effective July 1, 1981.

Facility costs of certain surgical procedures performed in freestanding ambulatory surgical centers.

Increase in annual limit for outpatient therapy from \$100 to \$500.

Recognizes comprehensive outpatient rehabilitation facilities as Medicare providers.

1981. Beginning in 1982, the beneficiary pays a \$75 deductible, with the carryover provision eliminated.

1984. Hepatitis B and pneumococcal vaccines and blood clotting factors and necessary supplies are included as Part B benefits. Debridement of mycotic toenails is limited.

For outpatient physical therapy services, includes services of a podiatrist. For outpatient ambulatory surgery, includes services of a dentist and podiatrist furnished in his or her office.

1986. Includes vision care services furnished by an optometrist.

For occupational therapy services, includes services furnished in an SNF (when Part A coverage has been exhausted), in a clinic, rehabilitation agency, public health agency, or by an independently practicing therapist.

Includes outpatient (in addition to previously covered inpatient) immunosuppressive drugs for 1 year after covered transplant.

Includes occupational therapy services provided in certain delivery settings.

For ambulatory surgical procedures performed in ambulatory surgical centers, hospital outpatient departments, and certain physician offices, the Part B coinsurance and deductible are no longer waived.

1987. Increases the maximum payment for mental health services and includes outpatient mental health services provided by ambulatory hospital-based or hospital-affiliated programs under the supervision of a physician.

Services provided by clinical social workers when furnished by risk-sharing HMOs and competitive medical plans, physician assistants in rural health manpower shortage areas, clinical psychologists in rural health clinics and community mental health centers, and certified nurse midwives.

Coverage of outpatient immunosuppressive drugs (see 1986) is broadened and clarified to include

prescription drugs used in immunosuppressive therapy.

Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1988. Beginning January 1, 1990, the beneficiary pays a \$75 deductible and 20 percent coinsurance, but once out-of-pocket expenses for the deductible and coinsurance exceed \$1,370, Medicare pays 100 percent of allowable charges for remainder of year.

Beginning in 1991, Medicare pays 50 percent of the cost of outpatient prescription drugs above \$600. When fully implemented in 1993, Medicare will pay 80 percent of prescription drug costs above a deductible that assumes that 16.8 percent of Part B enrollees will exceed the deductible.

Certain prescription drugs administered in an outpatient or home setting, including immunosuppressive drugs (previously covered for 1 year after a covered transplant), home intravenous drugs, and certain others, will be covered in 1990 under a new prescription drug provision.

1989. Provisions enacted in 1988 and to begin in 1990 and 1991 are repealed, and benefits are restored to levels in effect before January 1, 1989.

Limits on mental health benefits eliminated in 1990. Coverage extended to services of clinical psychologists and social workers.

The annual payment limits of \$500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to \$750 for 1990 and later. (See 1980.)

1990. Beginning in 1991, routine mammography screenings are covered.

The Part B deductible is set at \$100 in 1991 and subsequent years.

Beginning in 1992, physicians' services are reimbursed on a fee-schedule basis.

1993. Includes coverage of oral, self-administered anti-cancer drugs.

Lengthens the coverage period for immunosuppressive drugs after a transplant to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter. (See 1986.)

The annual payment limits of \$750 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to \$900 for 1994 and later. (See 1989.)

1997. Home health services not associated with a hospital or SNF stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or an SNF stay. The cost to the SMI trust fund of the transferred services will phase in over a 6-year period, while the cost of the home health services will phase into the SMI premium over 7 years.

Coverage provided for a number of prevention initiatives, including (1) annual screening mammograms for female beneficiaries aged 40 or older, with SMI deductible waived; (2) screening pap smear and pelvic exam (including clinical breast exam) every 3 years or annually for beneficiaries at higher risk, with SMI deductible waived; (3) annual prostate cancer screening for male beneficiaries aged 50 or older, effective January 1, 2000; (4) colorectal screening procedures, including fecal occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances; (5) diabetes outpatient self-management training in nonhospital-based programs (previously covered in hospital-based programs only) and blood glucose monitors and testing strips for all diabetics (previously provided for insulin-dependent diabetics only), effective July 1, 1998; (6) procedures to identify bone mass, detect bone loss, or determine bone quality for certain qualified beneficiaries, at frequencies determined by the secretary of Health and Human Services, effective July 1, 1998.

Beginning January 1999, an annual beneficiary limit of \$1,500 will apply to all outpatient physical therapy services, except for services furnished by a hospital outpatient department. A separate \$1,500 limit will also apply to outpatient occupational therapy services, except for services furnished by hospital outpatient departments. Beginning with 2002, these caps will be increased by the percentage increase in the Medical Economic Index. (See 1993.)

1999. The coverage period for immunosuppressive drugs after a transplant is lengthened to 44 months, for individuals who exhaust their 36 months of coverage in 2000. For those exhausting their 36 months of coverage in 2001, at least 8 more months will be covered. (The secretary of Health and Human Services will specify the increase, if any, beyond 8 months.) For those exhausting their 36 months of coverage in 2002, 2003, or 2004, the number of additional months may be more or fewer than 8. (The secretary will specify the increase for each of these years.) (See 1993.)

The annual payment limits of \$1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services furnished by independent practitioners (that is, not by a hospital outpatient department) are suspended for 2000 and 2001. (See 1997.)

2000. Coverage for screening pap smears and pelvic exams (including a clinical breast exam) is provided every 2 years (increased from every 3 years) beginning July 1, 2001. (Annual coverage continues for beneficiaries at higher risk, and SMI deductible continues to be waived.) (See 1997.)

Annual coverage of glaucoma screenings is provided for certain high-risk beneficiaries, effective January 1, 2002.

Screening colonoscopies are covered for all beneficiaries, not just for those at high risk, beginning July 1, 2001. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous one, or 4 years after a screening flexible sigmoidoscopy. (See 1997.)

Coverage is provided for medical nutrition therapy services under certain circumstances for beneficiaries who have diabetes or a renal disease, effective January 1, 2002.

The amount of a beneficiary's copayment for a procedure in a hospital outpatient department is limited, beginning April 1, 2001, to the hospital inpatient deductible applicable for that year. Also, the secretary of Health and Human Services must reduce the effective copayment rate for outpatient services to a maximum rate of 57 percent in 2001 (for services received after April 1), 55 percent in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and later.

Time and budget limitations are removed on the coverage of immunosuppressive drugs, making coverage of these drugs a permanent benefit for beneficiaries who have received a covered organ transplant. (See 1999.)

The annual payment limits of \$1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services provided by independent practitioners (that is, not by a hospital outpatient department), which were suspended for 2000 and 2001, are also suspended for 2002. (See 1999.)

The homebound criterion for home health services is clarified to specify that beneficiaries who require home health services may attend adult day care for therapeutic, psychosocial, or medical treatment and still remain eligible for the home health benefit. Homebound beneficiaries may also attend religious

services without being disqualified from receiving home health benefits.

2003. The Part B deductible remains at \$100 through 2004 and increases to \$110 in 2005. Beginning in 2006, it will be increased each year by the annual percentage increase in the Part B aged actuarial rate.

A one-time, initial preventive physical exam is covered within 6 months of a beneficiary's first coverage under Part B, beginning January 1, 2005, for beneficiaries whose Part B coverage begins on or after that date.

Certain screening blood tests are covered for the early detection of cardiovascular disease and abnormalities associated with elevated risk for such disease, including certain tests for cholesterol and other lipid or triglyceride levels, effective January 1, 2005, under frequency standards to be established (but not to exceed once every 2 years).

Diabetes screening tests, including a fasting plasma glucose test and other such tests determined appropriate by the secretary of Health and Human Services, are covered for beneficiaries at risk for diabetes, beginning January 1, 2005, under frequency standards to be established (but not to exceed two times per year).

2005. The colorectal screening benefit (see 1997 and 2000) is exempt from the Part B deductible, effective January 2007.

Exceptions to the financial limits on therapy services not provided by a hospital outpatient department are allowed for services furnished in 2006, if such services are determined to be medically necessary. (See 1997, 1999, and 2000.)

2006. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through December 31, 2007. (See 2005.)

2007. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through July 1, 2008. (See 2005 and 2006.)

2008. For outpatient mental health services, the percentage of approved charges for which the beneficiary is liable phases down from 50 percent to 20 percent, over the 5-year period 2010–2014.

For the one-time, initial preventive examination (see 2003), the Part B deductible is waived, the eligibility period is extended from 6 months to 1 year after enrollment in Part B, measurement of body mass index is covered, and, upon agreement with the beneficiary, end-of-life planning is covered. Effective January 1, 2009.

Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through December 31, 2009. (See 2005, 2006, and 2007.)

2009. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through March 31, 2010. (See 2005, 2006, 2007, and 2008.)

2010. An annual wellness visit to develop or update a personalized prevention plan is covered, with no beneficiary cost sharing, effective January 1, 2011.

Beneficiary cost sharing is eliminated for preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force, and the Part B deductible is waived for colorectal cancer screening tests, both effective January 1, 2011.

Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through December 31, 2011. (See 2005, 2006, 2007, 2008, and 2009.)

2011. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through February 29, 2012. (See 2005, 2006, 2007, 2008, 2009, and 2010.)

2012. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through December 31, 2012. (See 2005, 2006, 2007, 2008, 2009, 2010, and 2011.)

2013. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through March 31, 2014. (See 2005, 2006, 2007, 2008, 2009, 2010, 2011, and 2012.)

2014. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through March 31, 2015. (See 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013.)

2015. Exceptions to the financial limits on nonhospital therapy services when deemed medically appropriate are extended through December 31, 2017. (See 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, and 2014.)

Under Parts A and B

1965. Requires that Medicare be secondary payer to benefits provided by liability insurance policies or under no-fault insurance.

1981. Requires that Medicare be secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely on the basis of end-stage renal disease (ESRD) for up to 12 months.

1982. For workers and their spouses aged 65 to 69, Medicare is the secondary payer when benefits are provided under an employer-based group health plan (applicable to employers with 20 or more employees who sponsor or contribute to the group plan).

Health maintenance organizations (HMOs) will be authorized as providers of benefits. The secretary of Health and Human Services must certify the prospective payment mechanism for HMOs before implementation.

1984. Medicare secondary-payer provisions are extended to spouses aged 65 to 69 of workers under age 65 whose employer-based group health plan covers such spouses.

For HMOs, includes medical and other health services furnished by clinical psychologists.

1985. Provides payment for liver transplant services.

1986. Extends the working-age, secondary-payer provision to cover workers and their spouses beyond age 69.

For HMOs that offered organ transplants as a basic health service on April 15, 1985, such services may be offered from October 1, 1985, through April 1, 1988.

For disabled individuals who are covered by employer-based health plans (with at least 100 employees), Medicare is the secondary payer, effective for the period from 1987 to 1991.

1987. Requires HMOs and competitive medical plans that cease to contract with Medicare to provide or arrange supplemental coverage of benefits related to preexisting conditions for the lesser of 6 months or the duration of an exclusion period.

Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

Clarifies that the secondary-payer provision for disabled individuals covered under employer-based health plans for employers with at least 500 employees applies to employers who are government entities.

1990. Requires that Medicare be the secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely on the basis of ESRD for up to 18 months (extended from 12 months), effective February 1, 1991, to January 1, 1996.

The secondary-payer provision for disabled beneficiaries covered under large employer plans (see 1986) is effective through September 30, 1995.

1993. The secondary-payer provision for disabled beneficiaries covered under large employer plans is effective through September 30, 1998.

The secondary-payer provision for beneficiaries with ESRD applies to all beneficiaries with end-stage renal disease, not only those entitled to Medicare solely on the basis of ESRD. The extension to include the first 18 months of an individual's entitlement on the basis of ESRD is effective through September 30, 1998.

1996. The Medicare Integrity Program (MIP) is created, providing dedicated funds to identify and combat improper payments, including those caused by fraud and abuse, and, for the first time, allowing for contracts to be awarded competitively to entities other than carriers and intermediaries to conduct these activities.

1997. Established an expanded set of options for the delivery of health care under Medicare, referred to as Medicare+Choice (and also known as "Medicare Part C"). All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service program. In addition, most beneficiaries can choose instead to receive their Medicare benefits through one of the following Medicare+Choice plans: (1) coordinated care plans (such as HMOs, provider-sponsored organizations, and PPOs), (2) Medical Savings Account (MSA)/High Deductible plans (through a demonstration available for up to 390,000 beneficiaries), or (3) private fee-for-service plans. Except for MSA plans, all Medicare+Choice plans are required to provide the current Medicare benefit package (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. MSA plans provide Medicare benefits after a single high deductible is met, and enrollees receive an annual deposit in their medical savings account. Transition rules for current Medicare HMO program also provided. (See also HMO provision of 1982.)

The provision making Medicare the secondary payer for disabled beneficiaries covered under large employer plans, previously scheduled to expire September 30, 1998, made permanent.

The provision making Medicare the secondary payer for the first 12 months of entitlement because of ESRD, which had been extended on a temporary basis (through September 30, 1998) to include the first 18 months of entitlement, has been extended, permanently, to include the first 30 months of entitlement on the basis of ESRD.

2003. Medicare+Choice is renamed Medicare Advantage. (It is still sometimes referred to as "Medicare Part C.") As before, beneficiaries enrolled in both Part A and

Part B can receive their Medicare benefits through the original fee-for-service program; most can opt instead to use a Medicare Advantage plan in their area. Medicare Advantage plans include (1) Medicare Managed Care plans (like HMOs), (2) Medicare Preferred Provider Organization plans (PPOs), (3) Private Fee-for-Service plans, and (4) Medicare Specialty plans (available in some areas to provide Medicare benefits for certain people with special needs, such as beneficiaries in institutions). Beginning in 2006, Medicare Advantage plan choices will be expanded to include regional PPOs. Participating regional PPOs will be required to serve an entire region (10 to 50 regions are to be established), and there are provisions to encourage plan participation. Regional PPOs must have a single deductible for benefits under Parts A and B, and they must include catastrophic limits for out-of-pocket expenditures. Beginning in 2006, the adjusted community rate (ACR) process for determining plan payments is replaced by a competitive bidding process. (Historical reference points to this item include the Medicare+Choice provision of 1997 and the HMO provision of 1982, both of which are displayed in this section.)

2007. Group health plans are required to provide information identifying situations in which the plan is, or has been, primary to Medicare, effective January 2009. Effective June 2009, liability insurance, no-fault insurance, and workers' compensation plans must submit specific information to enable appropriate determinations concerning coordination of benefits and any applicable recovery claims.

Under Part D

2003. Under temporary Medicare-endorsed prescription drug discount card program, for eligible beneficiaries voluntarily enrolling and paying up to \$30 annually, discounts on certain prescription drugs, as specified by card sponsors. Under Transitional Assistance provision, eligible beneficiaries whose incomes do not exceed 135 percent of the federal poverty level and do not have third-party prescription drug coverage are eligible for (1) financial assistance of up to \$600 per year for purchasing prescription drugs and (2) a subsidized enrollment fee under the temporary Medicare-endorsed prescription drug discount card program. Enrollment begins in May 2004, access to discounts begins in June 2004, and program phases out as drug benefit becomes available in 2006 (see next entry).

Beginning January 1, 2006, upon voluntary enrollment in either a stand-alone PDP or an integrated Medicare Advantage plan that offers Part D coverage in its benefit, subsidized prescription drug coverage. Most FDA-approved drugs and biologicals are

covered. However, plans may set up formularies for their drug coverage, subject to certain statutory standards. (Drugs currently covered in Parts A and B remain covered there.) Part D coverage can consist of either standard coverage or an alternative design that provides the same actuarial value. (For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.) Standard Part D coverage is defined for 2006 as having a \$250 deductible, with 25 percent coinsurance (or other actuarially equivalent amounts) for drug costs above the deductible and below the initial coverage limit of \$2,250. The beneficiary is then responsible for all costs until the \$3,600 out-of-pocket limit (which is equivalent to total drug costs of \$5,100) is reached. For higher costs, there is catastrophic coverage; it requires enrollees to pay the greater of 5 percent coinsurance or a small copay (\$2 for generic or preferred multisource brand and \$5 for other drugs). After 2006, these benefit parameters are indexed to the growth in per capita Part D spending (see Table 2.C1). In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception is cost-sharing assistance from Medicare's low-income subsidies (certain beneficiaries with low incomes and modest assets will be eligible for certain subsidies that eliminate or reduce their Part D premiums, cost-sharing, or both) and from State Pharmacy Assistance Programs. A beneficiary premium, representing 25.5 percent of the cost of basic coverage on average, is required (except for certain low-income beneficiaries, as previously mentioned, who may pay a reduced or no premium). For PDPs and the drug portion of Medicare Advantage plans, the premium will be determined by a bid process; each plan's premium will be 25.5 percent of the national weighted average plus or minus the difference between the plan's bid and the average. To help them gain experience with the Medicare population, plans will be protected by a system of risk corridors, which allow Part D to assist with unexpected costs and to share in unexpected savings; after 2007, the risk corridors became less protective. To encourage employer and union plans to continue prescription drug coverage to Medicare retirees, subsidies to these plans are authorized; the plan must meet or exceed the value of standard Part D coverage, and the subsidy pays 28 percent of the allowable costs associated with enrollee prescription drug costs between a specified cost threshold (\$250 in 2006, indexed thereafter) and a specified cost limit (\$5,000 in 2006, indexed thereafter).

2008. Part D plans are required to include two classes of drugs in their formularies: (1) benzodiazepines and (2) for the treatment of epilepsy, cancer, or chronic

mental disorder, barbiturates. Effective January 1, 2013.

2010. Beneficiaries who enter the coverage gap in 2010 receive a \$250 rebate and, starting in 2011, beneficiaries receive a 50-percent discount on covered brand-name prescription drugs. (The dollar value of this discount counts toward out-of-pocket spending, even though the beneficiary does not pay it.) Additionally, reductions in beneficiary cost sharing for both brand-name and generic drugs during the coverage gap are to be phased in beginning in 2011, such that by 2020, the coverage gap will be closed, and beneficiaries will be responsible for 25 percent of their prescription drug costs (see Table 2.C1).

Retiree drug subsidies paid to employers and unions that provide continued prescription drug coverage to Medicare retirees (and meet specific criteria in doing so) are taxable beginning in 2013.

Medicare Financing

Hospital Insurance Taxes

See Table 2.A3.

2010. Beginning in 2013, an additional Part A payroll tax of 0.9 percent is collected on earned income exceeding \$200,000 (for those filing income tax singly) and \$250,000 (for those filing jointly). The earnings thresholds are not indexed.

Appropriations from General Revenues

1965. For HI costs attributable to transitionally insured beneficiaries.

For HI costs attributable to noncontributory wage credits granted for military service prior to 1957 (see Table 2.A2).

For the Part B program, an amount equal to participant premiums.

1972. For cost of Part B not met by enrollee premiums.

1982. For HI costs attributable to beneficiaries having transitional entitlement based on Medicare-qualified federal employment.

1983. For HI taxes on noncontributory wage credits granted for military service (a) from the inception of HI program through 1983 and (b) on a current basis, annually, beginning in 1984 (see Table 2.A2).

2002. Eliminated for HI taxes on noncontributory wage credits granted for military service on a current basis, for all years after calendar year 2001 (see Table 2.A2).

2003. For Part D costs not met by enrollee premiums or otherwise, beginning in January 2006. (That is,

transfers from general revenues [plus smaller income sources, particularly the payments from states described below] will pay for (1) the 74.5 percent subsidy to PDPs and the prescription drug portion of Medicare Advantage plans [which remains after enrollee premiums of 25.5 percent, on average], in the form of a direct subsidy and reinsurance, and (2) for other Part D costs, such as low-income subsidies and subsidies to employers who provide qualifying drug coverage to their Medicare-eligible retirees.)

Beginning January 2007, for Part B beneficiaries meeting certain income thresholds and thus paying income-related adjustment amounts in addition to their standard Part B premiums (see “Medicare Financing, Participant Premiums, 2003”), the per capita general revenue appropriations to Part B (see 1965 and 1972) are supposed to be reduced accordingly.

2010. Beginning January 2011, for Part D beneficiaries meeting certain income thresholds and thus paying income-related adjustment amounts in addition to their Part D premiums (see “Medicare Financing, Participant Premiums, 2010”), the per capita general revenue appropriations to Part D (see 2003) are supposed to be reduced accordingly.

Participant Premiums

See Table 2.C1.

1965. Part B enrollee premium rate (originally \$3 per month) to be established annually such that it will pay one-half of program costs.

1972. Part B enrollee premium rate increase limited to rate of increase in OASDI cash benefits.

HI premium (originally \$33 per month) to be established annually. Only individuals not otherwise entitled to HI but desiring voluntary participation need to pay the HI premium.

1983. Part B enrollee premiums for July 1983 to December 31, 1983, frozen at premium level of June 30, 1983. Premiums for January 1, 1984, to December 31, 1985, set to cover 25 percent of aged program costs.

1984. Part B enrollee premiums for January 1, 1986, to December 31, 1987, will be set to cover 25 percent of aged program costs. Increases in the Part B premium may not exceed the dollar amount of the Social Security COLA.

For calculating the amount of Part B premium surcharge for individuals aged 65–70 not previously enrolled in Part B, the number of years an individual did not enroll because of coverage by employer group health insurance will not be taken into account.

1985. Extends through calendar year 1988 the requirement that Part B premiums be set to

cover 25 percent of aged program costs and that increases in the Part B premium may not exceed the dollar amount of the Social Security COLA.

Premium-paying individuals who do not purchase Part A coverage within a specific time after becoming eligible because of age are subject to a 10 percent penalty for each 12 months they are late in enrolling. There is a cutoff on the length of time these individuals will have to pay an enrollment penalty. The 10 percent premium penalty would be limited to twice the number of years enrollment was delayed. Therefore, if enrollment was delayed 1 year, the penalty would be assessed for 2 years. Individuals in this category and already enrolled will have the length of time the higher premium was paid credited to them.

1987. Extends through calendar year 1989 the provisions requiring that the Part B premium be set to cover 25 percent of aged program costs, prohibiting any increase in the premium if there is no Social Security COLA, and continuing to hold beneficiaries harmless from Social Security check reductions as a result of a premium increase.

1988. Increases in the Part B premium may not exceed the dollar amount of the Social Security COLAs for 1989 and beyond.

1989. Extends through calendar year 1990 the requirement that Part B premiums be set to cover 25 percent of aged program costs.

1990. The Part B premium is set at \$29.90 in 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994, and \$46.10 in 1995.

1993. Part B enrollee premiums for January 1, 1996, to December 31, 1998, will be set to cover 25 percent of aged program costs.

1997. The Part B premium is permanently set at 25 percent of program costs.

2003. Beginning January 2007, the Part B premium is increased for beneficiaries meeting certain income thresholds. (Beneficiaries with modified adjusted gross incomes under \$80,000 will continue to pay premiums that are 25 percent of twice the actuarial rate. *Actuarial rate* is defined as one-half of the Part B expected monthly cost per enrollee. For beneficiaries with incomes greater than \$80,000 and less than or equal to \$100,000, the applicable percentage is 35 percent; for those with incomes greater than \$100,000 and less than or equal to \$150,000, the percentage is 50 percent; for incomes greater than \$150,000 and less than or equal to \$200,000, the percentage is 65 percent; and for incomes greater than \$200,000, the percentage is 80 percent. For married couples who file joint tax returns, the income thresholds are doubled. For beneficiaries

who are married and lived with their spouses at any time during the taxable year but who file separate tax returns from their spouses, with incomes greater than \$80,000 and less than or equal to \$120,000, the percentage is 65 percent; with incomes greater than \$120,000, the percentage is 80 percent. These thresholds are to be updated each calendar year by the Consumer Price Index (CPI). There is a 5-year adjustment period for this provision as well; that is, the amount of premium above 25 percent of twice the actuarial rate is phased in—at 20, 40, 60, 80, and 100 percent for 2007 to 2011 and later, respectively.)

For military retirees, their spouses (including eligible divorced spouses and widows and widowers), and dependent children who enroll(ed) in Part B during the period from 2001 to 2004, the late enrollment penalty imposed on beneficiaries who do not enroll in Part B upon becoming eligible for Medicare is waived for premium payments for January 2004 and later. (Also, a special enrollment period for these beneficiaries is to begin as soon as possible and end December 31, 2004.)

For Part D, beginning in January 2006, a beneficiary premium, representing 25.5 percent of the cost of basic coverage on average, is required (except for certain low-income beneficiaries who may pay a reduced or no premium). For PDPs and the drug portion of Medicare Advantage plans, the premium will be determined by a bid process; each plan's premium will be 25.5 percent of the national weighted average plus or minus the difference between the plan's bid and the average. A late enrollment penalty will apply for certain beneficiaries who fail to enroll at the first opportunity and who do not maintain creditable coverage elsewhere (external prescription drug coverage, such as through a retiree group health plan that meets or exceeds the actuarial value of standard Part D coverage).

2005. The phase-in of the income-related Part B premium (see 2003) is shortened from 5 years to 3 years, beginning January 1, 2007. (That is, the amount of premium above 25 percent of twice the actuarial rate is phased in at 1/3 for 2007, 2/3 for 2008, and 3/3 for 2009 and later.)

For beneficiaries who are volunteering outside the United States through a 12-month or longer program sponsored by a tax-exempt organization and who have other health insurance, the late enrollment penalties imposed on beneficiaries who do not enroll in Part B upon becoming eligible for Medicare are waived, effective January 2007, and a special enrollment period for these beneficiaries is established.

2008. The policy waiving the late enrollment penalty for Part D enrollees who meet certain low-income and

limited-resources requirements is codified into statute. (The policy was in effect through 2008 and the law is effective beginning January 1, 2009.)

2010. The income thresholds used to calculate Part B income-related premiums are frozen at 2010 levels for 2011 through 2019.

Beginning in January 2011, Part D enrollees whose income exceeds certain thresholds are required to pay higher Part D premiums. The income thresholds and premium adjustments are to be set in the same manner as those under Part B (including the use of frozen thresholds in 2011–2019).

2015. The income thresholds used to calculate Part B and Part D income-related premiums are lowered, beginning in 2018, for the two highest income ranges specified in the law. As a result, certain high-income beneficiaries will be subject to paying higher premium amounts.

In addition, the income thresholds for 2020 and later are to be adjusted annually for inflation, and the inflation adjustments are to be based on the new threshold levels (as described above), rather than on the thresholds that would have been in place had they not been frozen since 2011 (as was required by previous statute). As a result, more beneficiaries will be subject to paying higher premium amounts.

Income from Taxation of OASDI Benefits

1993. The additional income tax revenues resulting from the increase in the taxable percentage applicable to OASDI benefits (an increase from 50 percent to 85 percent, see Table 2.A31) are transferred to the HI trust fund.

Payment from States

2003. Beginning in January 2006, with the availability of drug coverage and low-income subsidies under Part D, Medicaid will no longer be primary payer for full-benefit dual eligibles, and states are required to make payments to defray a portion of the Part D drug expenditures for these beneficiaries. States pay 90 percent of the estimated costs for 2006, phasing down over a 10-year period to 75 percent for 2015 and later.

Interfund Borrowing

1981. See Table 2.A6.

1983. See Table 2.A6.

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