OVERVIEW OF MEDICARE
Medicare is the federal health insurance program created in 1965 for all people age 65 and older, regardless of income or medical history, and now covers 50 million Americans. In conjunction with Social Security, Medicare plays a vital role in providing financial security to seniors and younger beneficiaries with disabilities. In 2012, Medicare spending is estimated to account for 15% of total federal spending and 21% of total national health spending.

Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. Medicare was expanded in 1972 to include people under age 65 with permanent disabilities. Nonelderly people who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.

The Affordable Care Act of 2010 includes a number of provisions that affect Medicare, including enhanced benefits (free prevention services and phasing out the Part D coverage gap), spending reductions affecting plans and providers, delivery system reforms, premium increases for higher-income beneficiaries, and a payroll tax on earnings for higher-income people. In addition, the law authorizes a new Independent Payment Advisory Board tasked with constraining the growth in Medicare spending over time.

CHARACTERISTICS OF PEOPLE ON MEDICARE
Medicare covers a diverse population (Figure 1). In 2010, half of all people on Medicare had incomes below $22,000, and half of all Medicare beneficiaries had less than $53,000 in savings. More than one quarter of all beneficiaries report being in fair or poor health, and roughly the same share have a cognitive/mental impairment. Eight million beneficiaries (17%) are nonelderly people with disabilities. Two million beneficiaries (5%) live in a long-term care facility.

THE STRUCTURE OF MEDICARE
Medicare is organized into four parts (Figure 2).

Part A covers inpatient hospital stays, skilled nursing facility stays, home health visits (also covered under Part B), and hospice care, and accounts for 31% of benefit spending in 2012. Part A benefits are subject to a deductible ($1,156 in 2012) and coinsurance.

Part B covers physician visits, outpatient services, preventive services, and home health visits, and accounts for 20% of benefit spending in 2012. Part B benefits are subject to a deductible ($140 in 2012), and cost sharing generally applies for most Part B benefits.

Part C refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO), and receive all Medicare-covered benefits. Payments to Medicare Advantage plans to cover Part A and Part B benefits is estimated to account for 22% of benefit spending in 2012. More than 13 million beneficiaries are enrolled in a Medicare Advantage plan in 2012 (27% of all beneficiaries).

Part D is the voluntary, subsidized outpatient prescription drug benefit, with additional subsidies for beneficiaries with low incomes and modest assets. The Part D benefit is offered through private plans that contract with Medicare, both stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs). Part D accounts for 11% of benefit spending. About 32 million beneficiaries are enrolled in a Medicare Part D plan in 2012.

BENEFIT GAPS AND SUPPLEMENTAL COVERAGE
Medicare provides protection against the costs of many health care services, but has relatively high deductibles and cost-sharing requirements, no limit on out-of-pocket spending, and (until 2020) a coverage gap (“doughnut hole”) in the prescription drug benefit. Moreover, Medicare does not pay for many services needed by elderly and disabled beneficiaries, such as long-term care or dental services.

Most beneficiaries have some form of supplemental insurance to help with Medicare’s cost-sharing requirements and fill in the benefit gaps.
Employer-sponsored plans provide supplemental coverage to about one in three beneficiaries. Over time, fewer seniors are expected to get retiree health benefits as the share of employers offering retiree health benefits to their employees has dropped from 66% in 1988 to 25% in 2012 (KFF/HRET 2012).

In 2009, 24% had a Medicare supplemental insurance policy, known as Medigap, either as their only source of supplemental coverage, or as one of multiple sources.

Medicaid helps pay for Medicare’s premiums and cost sharing for 20% of Medicare beneficiaries with low incomes and modest assets (known as “dual eligibles”). Most of these beneficiaries also qualify for full Medicaid benefits, which include long-term care.

Twelve percent of Medicare beneficiaries had no supplemental coverage in 2009, including a disproportionate share of the under-65 disabled, the near poor (incomes between 100% and 200% of the poverty level), rural residents, and black beneficiaries.

**OUT-OF-POCKET SPENDING**

Health expenses, including premiums, accounted for 15% of Medicare household budgets in 2010, three times the share of spending on health care in non-Medicare households (Figure 3).

**MEDICARE SPENDING NOW AND IN THE FUTURE**

Medicare spending is projected to grow from $550 billion in 2012 to $1.1 trillion in 2022. The aggregate annual growth in Medicare spending is influenced by the growing number of beneficiaries and factors that affect health spending generally, including both increasing volume of services and rising prices. Between 2011 and 2020, Medicare spending per capita is projected to grow at 3.1% annually, nearly 2 percentage points slower than private health spending, as measured by GDP per capita (Figure 4).

**HOW MEDICARE IS FINANCED**

Medicare is financed by general revenues (40%), payroll tax contributions (38%), beneficiary premiums (13%), and other sources.

- **Part A** is funded mainly by a 2.9% payroll tax on earnings paid by employers and employees (1.45% each) deposited into the Hospital Insurance Trust Fund. Beginning in 2013, the Medicare payroll tax will increase on earnings for higher-income taxpayers (> $200,000/individual and $250,000/couple) by 0.9 percentage points (from 1.45% to 2.35%). The Part A Trust Fund is projected to be solvent through 2024.

- **Part B** is funded by general revenues and beneficiary premiums ($99.90 per month in 2012). Medicaid pays Part B premiums on behalf of beneficiaries who qualify for Medicaid based on low incomes and assets. Beneficiaries with higher incomes ($85,000 for individuals; $170,000 for couples) pay a higher, income-related monthly Part B premium, ranging from $339.90 to $319.70 per month in 2012. The income thresholds for the income-related premium will remain at 2010 levels through 2019.

- **Part C**, the Medicare Advantage program provides benefits under Parts A, B, and D, and is not separately financed. The average premium for Medicare Advantage prescription drug plans in 2013 is projected to be $39 per month (weighted by 2012 enrollment).

- **Part D** is funded by general revenues, beneficiary premiums, and state payments. The average premium for PDPs in 2013 is projected to be $40 (weighted by 2012 enrollment). As of 2011, Part D enrollees with higher incomes pay an income-related premium surcharge, with the same income thresholds used for Part B. In 2013, premium surcharges will range from $11.60 to $66.60 per month for higher-income beneficiaries.

**FUTURE CHALLENGES**

Medicare faces a number of critical issues and challenges, perhaps none greater than providing affordable, quality care to an aging population while keeping the program financially secure for future generations. The 2010 health reform law included numerous changes designed to improve Medicare benefits, slow the growth in Medicare spending, and improve the quality and delivery of care. In the near term, further changes to Medicare could be considered as part of a broader effort to reduce the federal deficit and debt. Policymakers may also address Medicare’s physician payment system in order to avoid a large scheduled reduction in physician fees that result from the sustainable growth rate (SGR) formula, as they have done in the past.

As policymakers consider changes to Medicare, it will be important to monitor not only the effect of these changes on total health care expenditures, including Medicare spending, but also the impact on beneficiaries’ access to quality care and out-of-pocket costs.

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