The Basics of Medicare
Updated With the 2003 Board of Trustees Report

History
- In 1965, Title 18, “Health Insurance for the Aged,” of the Social Security Act created the Medicare program. Medicare consists of two parts: Part A, Hospital Insurance (HI), covers hospital services and some home health care and skilled nursing facility services, and Part B, Supplemental Medical Insurance (SMI), covers physician care, outpatient hospital services, and independent laboratory services.

- In 1972, the Medicare program was expanded to include disabled persons who qualified for benefits under the Disability Insurance (DI) program and certain individuals with end-stage renal (kidney) disease.

- In 1986, all state and local government employees hired after Mar. 31, 1986, and not covered under Social Security, were required to be covered by Medicare.

- In 1997, the Balanced Budget Act of 1997 expanded the delivery of health care under Medicare with the Medicare+Choice program. See below for more details.

- In 1997, under the Balanced Budget Act of 1997, home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI were transferred from the HI program to the SMI program, effective January 1998.

- In 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare+Choice program. See below for more details.

Covered Beneficiaries
- Medicare serves elderly and disabled workers who qualify for DI benefits. Enrollment in Part A (HI) is mandatory, while enrollment in Part B (SMI) is voluntary. In 2002, 34.6 million elderly and 6.0 million disabled individuals were enrolled in Part A, and 32.9 million elderly and 5.2 million disabled individuals were enrolled in Part B.

Financing

Part A: Hospital Insurance (HI)
- The Balanced Budget Act of 1997 contained numerous provisions affecting the Medicare program. These provisions were designed in part to postpone the imminent depletion of the HI trust fund, which, according to the 1997 Board of Trustees’ report, had been projected for 2001. Under this legislation, fund exhaustion is postponed until 2026, based on the intermediate assumptions used in the 2003 Board of Trustees’ report.

- HI payroll taxes for 2003 were based on a combined employer/employee rate of 2.9 percent. The Omnibus Budget Reconciliation Act of 1993 removed any wage base limit for the HI payroll tax, effective Jan. 1, 1994. For years 2004 and afterward, the payroll tax is scheduled to be 2.9 percent. In 2002, total income for the HI trust fund was $178.6 billion: $152.7 billion
came from payroll taxes, $8.3 billion from taxation of Social Security benefits, $14.4 billion from interest and other income,\(^1\) and $1.6 billion from premium payments, and $1.6 billion from miscellaneous revenue.

- In 2002, the average amount reimbursed per enrollee in Part A was $3,689.
- Administrative costs for the Medicare program are low. In 2002, administrative costs for Part A were $2.6 billion, or 1.7 percent of expenditures.

**Part B: Supplementary Medical Insurance (SMI)**
- The SMI trust fund is financed on a year-by-year basis. The SMI program derives its revenues from premium payments by beneficiaries and general revenues from the federal budget. Under current law, no more than 25 percent of SMI's revenues can come from premium payments.
- The average amount reimbursed per enrollee in Part B was $2,915.
- Administrative costs for the Medicare program are low. In 2002, administrative costs for Part B were $2.2 billion, or 1.9 percent of expenditures.

**Federal Budgetary Processes**
- Currently, the U.S. Department of the Treasury credits the Medicare and Social Security trust funds with any annual excess of Medicare and Social Security tax revenues over the amount spent for current benefits. By law, these assets must be invested in special securities issued by the Treasury. The government then spends these “assets” to ease fiscal pressures on other programs. The trust fund surpluses are not reserved for future Medicare and Social Security benefits but are bookkeeping entries showing how much the Medicare and Social Security programs have lent to the Treasury (or alternatively, what is owed to Medicare and Social Security, including interest, by the Treasury). When the trust funds go into negative cash flow, the Treasury must start repaying the money.
- For budgetary purposes, the date on which the trust funds go into negative cash flow (i.e., the benefit payments exceed the income from payroll taxes and the taxation of benefits) is significant because it marks the point at which the government must provide cash from general revenues to the programs rather than receive surplus cash from them to fund other current spending.

**Cost-Sharing Provisions**
- **Part A Hospital Insurance (HI)**
  - Part A requires an enrolled individual to pay various deductibles and co-pays, depending on the facility where the service is provided and the length of stay.
    - **In-patient Hospital Deductible**—For a hospital stay of 1–60 days in 2003, a patient is liable for an $840 deductible. For a hospital stay of 61–90 days in 2003, the patient is liable for a $210 co-pay per day. For a hospital stay of more than 90 days in 2003, a patient is liable for a $420 co-pay per day.
    - **Skilled Nursing Facility**—There is no deductible or co-pay for the first 20 days of a skilled nursing facility stay. If the stay lasts for 21 days or longer, the patient is liable for a $105 co-pay per day in 2003.
• **Part A Premium**—For an individual who is age 65 or older and not otherwise covered by the Medicare program, the monthly premium in 2003 to be covered by Part A is $316.

• The use of Medicare benefits is calculated based on benefit periods and reserve days. The benefit period is the block of time used to determine how much of a deductible and/or co-pay the beneficiary owes. A benefit period begins and ends when he or she has been out of the hospital for 60 consecutive days. For example, if a beneficiary enters the hospital on November 10, 2003, and is released on November 24, 2003, he or she is liable for $840. If the beneficiary is re-admitted to the hospital on December 20, 2003, and released on December 26, 2003, he or she does not have to pay another $840. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period on this example runs until January 24, 2004.

• There is no limit on the number of benefit periods a beneficiary may use in a lifetime, except for hospice care, which entitles a beneficiary to two 90-day periods and one 30-day period.

• Reserve days are used for hospital stays beyond 90 days. A beneficiary is entitled to only 60 reserve days.

• **Part B: Supplementary Medical Insurance (SMI)**
  
  • Since Part B of Medicare is voluntary, participants are required to make a premium payment. Part B premiums are automatically deducted from the enrollee’s Social Security benefit, provided the enrollee receives Social Security benefits. Under current law, no more than 25 percent of SMI’s revenues can come from premium payments.

  • **Premiums**—In 2003, the monthly premium is $58.70.

  • **Annual Deductible**—This is applied to all Part B services except home health care services. In 2003, the annual deductible is $100.

  • **Coinsurance**—Coinsurance payment in 2003 is 20 percent.

• **Medigap**
  
  • Although Medicare eases many financial worries for the elderly, it does not cover 100 percent of all medical services. Medicare’s deductibles and co-payments can be high, particularly for long hospital stays.

  • Medicare does not cover all medical services. Most notable are outpatient prescription drugs, eye exams and glasses, hearing aids, and dental services.

  • To help meet these additional expenses, Medicare beneficiaries frequently purchase what is known as Medigap policies. A Medigap policy is purchased in the individual market.

  • In the 1970s and 1980s, Medicare enrollees encountered problems with purchasing health insurance to supplement Medicare. In the Omnibus Budget Reconciliation Act of 1990 (OBRA ’90), Congress charged the National Association of Insurance Commissioners (NAIC) with developing a variety of Medigap policies. NAIC developed 10 policies ranging from a basic coverage plan, Plan A, to comprehensive coverage, Plan J. Insurance carriers are not required to offer all 10 policies, but if a carrier offers Medigap policies, they must be
from the 10 policies designed by NAIC. Exceptions to this rule are for carriers in Massachusetts, Minnesota, and Wisconsin, states that had Medigap laws in place before OBRA ’90.

- The Centers for Medicare & Medicaid Services maintains an interactive Web page designed to assist an enrollee in obtaining Medigap coverage. The Web site is at the following link: www.medicare.gov/MGCompare/Home.asp

Covered Services

- **Part A: Hospital Insurance (HI)**
  - **Hospitalization**—Covered services include semiprivate room and board, general nursing, miscellaneous hospital services and supplies, inpatient psychiatric hospital care.
  
  - **Posthospital Skilled Nursing Facility Care**—To receive this service, the individual must have been in the hospital for at least three days and enter facility within 30 days after hospital discharge.
  
  - **Home Health Care**—Covered services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies.
  
  - **Hospice Care**—Covered services include medical and support services from a Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief, and other services not otherwise covered by Medicare. Hospice care is usually given in the home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed.
  
  - **Blood**—Covered services include blood received at a hospital or skilled nursing facility during a covered stay.

- **Part B: Supplementary Medical Insurance (SMI)**
  
  - **Medical and Other Services**—Covered services include doctors’ services (not routine medical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs). Part B covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.
  
  - **Clinical Laboratory Services**—Services include blood tests, urinalysis, and more.
  
  - **Home Health Care**—Services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies, and other services.
  
  - **Outpatient Hospital Services**—Services include hospital services and supplies received as an outpatient as part of a doctor’s care.
  
  - **Blood**—Covered services include blood received as an outpatient or as part of a Part B covered service.
Medicare+Choice

- The Medicare+Choice program was created by Congress in the Balanced Budget Act of 1997 to constrain costs and to allow more types of health insurance plans, including managed care plans, to serve Medicare beneficiaries. As of March 2003, 5.3 million Medicare beneficiaries (approximately 14 percent of Medicare beneficiaries) were enrolled in a Medicare HMO. Since 1998, most HMO contracts with the Centers for Medicare & Medicaid Services have operated under the Medicare+Choice program.

- In 1999, 97 plans either withdrew or reduced their service areas, directly affecting 407,000 enrollees. In 2000, 99 plans withdrew, affecting 327,000 enrollees. In 2001, withdrawals and service area reductions affected an estimated 934,000 enrollees. In 2002, 536,000 enrollees were affected by withdrawals and service area reductions.

- In late 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare+Choice program. Under BIPA, as of March 1, 2001, the floor or minimum payment for Medicare+Choice plans in counties in large urban areas is $525 while for all other counties it is $475. Early data suggest that the BIPA minimum payments are having a greater impact in the large urban areas than in the counties with the lower minimum payment.

Trustees in 2003

- Treasury Secretary John W. Snow acts as the Managing Trustee and Thomas A. Scully, Administrator and Chief Operating Officer of the Centers for Medicare & Medicaid Services, serves as acting Secretary of the Medicare trust funds. The other trustees include: Elaine Chao, Secretary of Labor; Tommy G. Thompson, Secretary of Health and Human Services; Jo Anne B. Barnhart, Commissioner of Social Security; John L. Palmer, and Thomas R. Saving.

For additional detailed information on the Medicare program, go to www.medicare.gov/ which is maintained by the Centers for Medicare & Medicaid Services, part of the U.S. Department of Health and Human Services.


1Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income.