



HEALTH POLICY 101

Medicare 101

May 2024

This publication is available at kff.org/health-policy-101

KFF

The Decision
• Tax vs. penalty — A4
• Obama's win sets stage for more political battles — A5
• Obama's win sets stage for more political battles — A5
• The ruling — A5
• The Medicaid mandate — A6
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case the president's raising taxes to some.
"This is now a time for the American people to make a choice," said presidential nominee Mitt Romney. "You can choose states and larger government, or you want to do a smaller, less intrusive role than the federal government in planning for your future."

Health care industry self-insurers, which account for about 30 percent of the market, are pushing back.

"It's been a year of challenges,

but we're still here," says

John R. Gutfreund, CEO of

HealthCare.com, a self-in-

surer based in New York City.

HealthCare.com has 1.5 mil-

lion members in 30 states.

HealthCare.com is one of

the few self-insurers that have

been able to offer plans in

every state since the begin-

ning of the year.

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This is one chapter of KFF's Health Policy 101, a resource for students and educators of health policy. View its other chapters at the links below or at:
kff.org/health-policy-101

[Medicare 101](#)

[Medicaid 101](#)

[The Affordable Care Act 101](#)

[Employer-Sponsored Health Insurance 101](#)

[The Uninsured Population and Health Coverage](#)

[Health Care Costs and Affordability](#)

[The Regulation of Private Health Insurance](#)

[Health Policy Issues in Women's Health](#)

[Race, Inequality, and Health](#)

[LGBTQ+ Health Policy](#)

[U.S. Public Health 101](#)

[International Comparison of Health Systems](#)

[The U.S. Government and Global Health](#)

[The Role of Public Opinion Polls in Health Policy](#)

[Congress, the Executive Branch, and Health Policy](#)

[The Politics of Health Care and the 2024 Election](#)

Introduction

I have long planned to create an online resource or mini “textbook” for faculty and students interested in health policy. One of the stumbling blocks is that there is no agreed upon definition of “health policy.”

We took a stab at it of sorts at KFF in our headquarters when we created a physical timeline—as shown in the photo above—of the central events in the history of our field on a wall in our headquarters in San Francisco. But, of course, you can’t all visit our offices to see our health policy history wall—and many of you may have quibbles if you did.

For us at KFF, our definition reflects our views and what we do: Health policy centers around, well policy—what the government does, and public programs like Medicare, Medicaid, and the ACA, and heavily emphasizes financing and coverage.

We also focus relentlessly on people, not health professionals and health care institutions (I have never been fond of the word “provider”). Others have a more expansive definition and that’s fine. What I ultimately settled on doing is far simpler: Organizing the basic materials we have on the issues we work on, recognizing that they do not represent every topic of interest to the faculty and students we hope to assist.

The result is the following chapters. We will add chapters over time as we develop them. Our organization changes to play our role as an independent source of analysis, polling, and journalism on national health issues, and as that happens, we will add more content on subjects not covered in this first installment. We will also add chapters as we get feedback from you. And we will update the “101” at least annually as data and circumstances change.

Let me know if this is helpful and how it can be improved. You can reach me at daltman101@kff.org.

Dr. Drew Altman
CEO, KFF

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What Is Medicare?

Medicare is the federal health insurance program established in 1965 under Title XVIII of the Social Security Act for people age 65 or older, regardless of income or medical history, and later expanded to cover people under age 65 with long-term disabilities. Today, Medicare provides health insurance coverage to [66 million people](#), including 58 million people age 65 or older and 8 million people under age 65. Medicare covers a comprehensive set of health care services, including hospitalizations, physician visits, and prescription drugs, along with post-acute care, skilled nursing facility care, home health care, hospice, and preventive services. People can choose to get coverage of Medicare benefits under [traditional Medicare or Medicare Advantage](#) private plans.

Medicare spending comprised [12% of the federal budget in 2022](#) and [21% of national health care spending in 2021](#). Funding for Medicare comes primarily from general revenues, payroll tax revenues, and premiums paid by beneficiaries. Over the longer term, the Medicare program faces financial pressures associated with higher health care costs, growing enrollment, and an aging population.

Who Is Covered by Medicare?

Most people become eligible for Medicare when they reach age 65, regardless of income, health status, or medical conditions. Residents of the U.S., including citizens and permanent residents, are eligible for premium-free Medicare Part A if they have worked at least 40 quarters (10 years) in jobs where they or their spouses paid Medicare payroll taxes and are at least 65 years old. People under age 65 who receive Social Security Disability Insurance (SSDI) payments generally become eligible for Medicare after a two-year waiting period. People diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.

Medicare covers a diverse population in terms of demographics and health status, and this population is expected to grow larger and more diverse in the future as the U.S. population ages. Currently, most people with Medicare are White, female, and between the ages of 65 and 84 (Figure 1). The share of U.S. adults who are age 65 or older is projected to grow from 17% in 2020 to nearly a quarter of the nation's total population in 2060, while people ages 80 and older will account for more than one-third of people 65 and older in 2060, up from one-quarter in 2020. As the U.S. population ages, the number of Medicare beneficiaries is projected to grow from around 63 million people in 2020 to just over 93 million people in 2060. The Medicare population will also grow more racially and ethnically diverse. By 2060, people of color will comprise [close to half](#) (47%) of the U.S. population ages 65 and older, nearly double the share in 2020 (25%).

Figure 1

Selected Demographic Characteristics of Medicare Beneficiaries, 2021

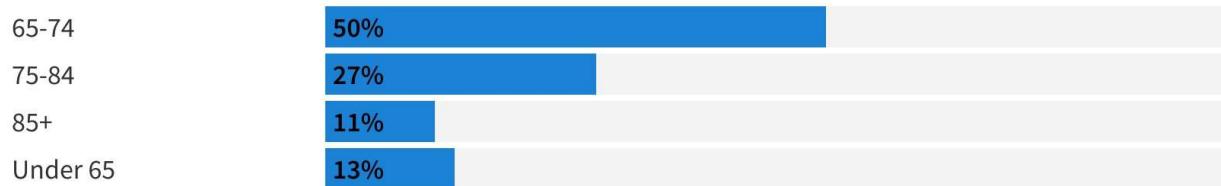
Gender



Race/Ethnicity



Age



Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.

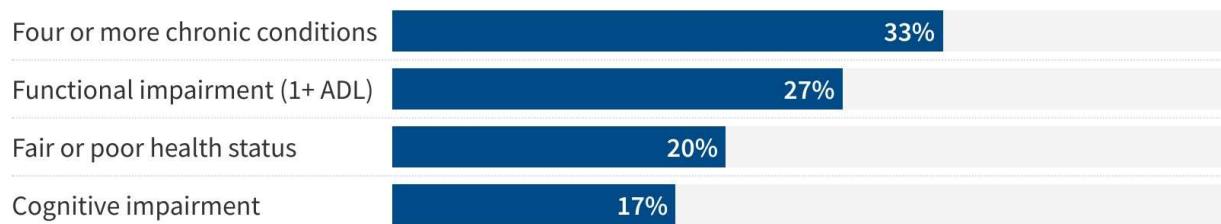
Source: KFF analysis of CMS Medicare Current Beneficiary Survey, 2021 Survey File.



While many Medicare beneficiaries enjoy good health, others live with health problems that affect their quality of life, including multiple chronic conditions, limitations in their activities of daily living, and cognitive impairments. In 2021, one-third (33%) of Medicare beneficiaries had four or more chronic conditions, more than a quarter (27%) had a functional impairment, and 17% had a cognitive impairment (Figure 2).

Figure 2

Selected Measures of Health Status of the Medicare Population, 2021



Note: ADL is activity of daily living. ADLs include the following basic activities: walking, bathing, dressing, getting in/out of a chair, toileting, and eating.

Source: KFF analysis of CMS Medicare Current Beneficiary Survey, 2021 Survey File.



Most Medicare beneficiaries have limited financial resources, including income and assets. In 2023, half of all Medicare beneficiaries had [incomes below \\$36,000 and savings below \\$103,800](#) per person. Median incomes for Medicare beneficiaries are lower among women than men, among people of color than White beneficiaries, and among beneficiaries under age 65 with disabilities than older beneficiaries (Figure 3).

Figure 3

In 2023, Half of All People with Medicare Had Incomes Below \$36,000

Median per capita income among Medicare beneficiaries, 2023

Overall

Overall **\$36,000**



Race/ethnicity

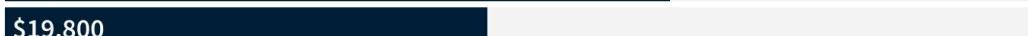
White **\$40,750**



Black **\$27,250**



Hispanic **\$19,800**



Age

Under 65 **\$23,900**



65-74 **\$39,850**



75-84 **\$37,900**



85 or older **\$28,650**



Sex

Female **\$33,750**



Male **\$38,950**



Note: Total household income for couples is split equally between individuals to estimate income for married beneficiaries.

Source: Urban Institute / KFF analysis of DYNASIM data, 2023



What Does Medicare Cover and How Much Do People Pay for Medicare Benefits?

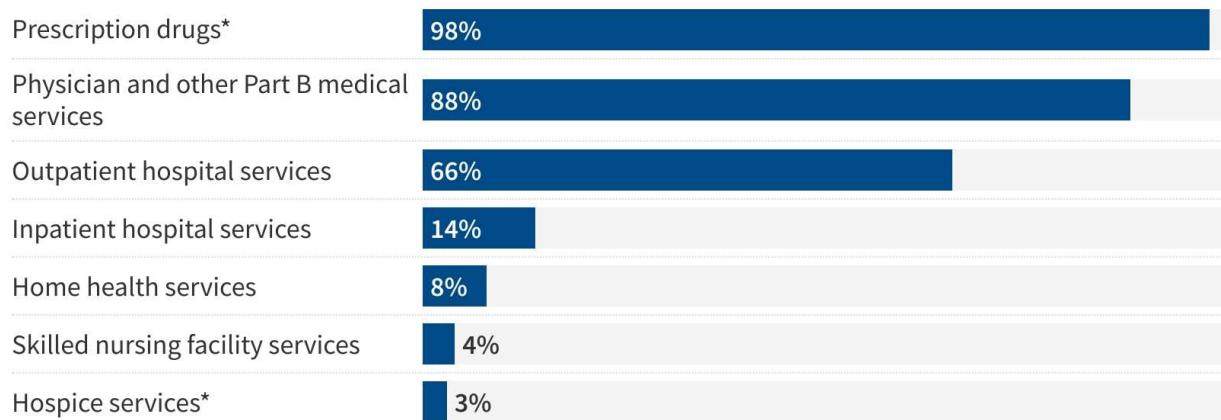
Benefits. Medicare covers a comprehensive set of medical care services, including hospital stays, physician visits, and prescription drugs. Medicare benefits are divided into four parts:

- Part A, also known as the Hospital Insurance (HI) program, covers inpatient care provided in hospitals and short-term stays in skilled nursing facilities, hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility. An estimated 63.5 million people were enrolled in Part A in 2021. In 2021, 14% of beneficiaries in traditional Medicare had an inpatient hospital stay, while 8% used home health care services, and 4% had a skilled nursing facility stay (Figure 4). (Comparable utilization data for beneficiaries in Medicare Advantage is not available.)
- Part B, the Supplementary Medical Insurance (SMI) program, covers outpatient services such as physician visits, outpatient hospital care, and preventive services (e.g. mammography and colorectal cancer screening), among other medical benefits. An estimated 58 million people were enrolled in Part B in 2021. A larger share of beneficiaries use Part B services compared to Part A services. For example, in 2021, nearly 9 in 10 (88%) traditional Medicare beneficiaries used physician and other medical services covered under Part B and 66% used outpatient hospital services.
- Part C, more commonly referred to as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), as an alternative to traditional Medicare. Medicare Advantage plans cover all benefits under Medicare Part A, Part B, and, in most cases, Part D (Medicare's outpatient prescription drug benefit), and typically offer extra benefits, such as dental services, eyeglasses, and hearing exams. In 2023, [31 million beneficiaries were enrolled in Medicare Advantage](#), which is 51% of Medicare beneficiaries who are eligible to enroll in Medicare Advantage plans. (See “*What Is Medicare Advantage and How Is It Different From Traditional Medicare?*” for additional information.)
- Part D is a voluntary [outpatient prescription drug benefit](#) delivered through private plans that contract with Medicare, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. In 2023, an estimated [50 million beneficiaries are enrolled in Part D](#). In 2021, nearly all Medicare beneficiaries enrolled in Part D (98%) used prescription drugs. (See “*What Is the Medicare Part D Prescription Drug Benefit?*” for additional information.)

Figure 4

Use of Selected Medicare-Covered Services by People with Medicare in 2021

Percent of Medicare beneficiaries using:



Note: *Includes use by beneficiaries in traditional Medicare and Medicare Advantage; other estimates reflect use by traditional Medicare beneficiaries only.

Source: KFF analysis of 2021 Centers for Medicare & Medicaid Services (CMS) Program Statistics Data.



Although Medicare covers a comprehensive set of medical benefits, Medicare does not cover long-term care services. Additionally, coverage of vision services, dental care, and hearing aids is not part of the standard benefit, though [most Medicare Advantage plans offer some coverage of these services](#).

Premiums and cost sharing. Medicare has varying premiums, deductibles, and coinsurance amounts that typically change yearly to reflect program cost changes.

- **Part A:** Most beneficiaries do not pay a monthly premium for Part A services, but are required to pay a deductible for inpatient hospitalizations (\$1,632 in 2024). (People who are working contribute payroll taxes to Medicare and qualify for premium-free Part A at age 65 based on having paid 1.45% of their earnings over at least 40 quarters). Beneficiaries are generally subject to cost sharing for Part A benefits, including extended inpatient stays in a hospital (\$408 per day for days 61-90 and \$816 per day for days 91-150 in 2024) or skilled nursing facility (\$204 per day for days 21-100 in 2024). There is no cost sharing for home health visits.
- **Part B:** Beneficiaries enrolled in Part B, including those in traditional Medicare and Medicare Advantage plans, are generally required to pay a monthly premium (\$174.70 in 2024). Beneficiaries with annual incomes greater than \$103,000 for a single person or \$206,000 for a married couple in 2024 pay a higher, income-related monthly Part B premium, ranging from \$244.60 to \$594. Approximately 8% of all Medicare beneficiaries are expected to pay income-related Part B premiums in 2024. Part B benefits are subject to an annual deductible (\$240 in 2024), and most Part B services are subject to coinsurance of 20 percent.

- Part C: In addition to paying the Part B premium, Medicare Advantage enrollees may be charged a separate monthly premium for their Medicare Advantage plan, although [7 in 10 enrollees were in plans that charged no additional premium in 2023](#). Medicare Advantage plans are generally prohibited from charging more than traditional Medicare, but vary in the deductibles and cost-sharing amounts they charge. Medicare Advantage plans may establish provider networks and require higher cost sharing for services received from non-network providers.
- Part D: Part D plans vary in terms of premiums, deductibles, and cost sharing. People in traditional Medicare who are enrolled in a separate stand-alone Part D plan generally pay a monthly Part D premium unless they qualify for full benefits through the Part D Low-Income Subsidy (LIS) program and are enrolled in a premium-free (benchmark) plan. In 2023, the average enrollment-weighted premium for stand-alone Part D plans was [\\$40 per month](#), substantially higher than the enrollment-weighted average monthly portion of the premium for drug coverage in MA-PDs (\$10 in 2023).

Sources of coverage. Most people with Medicare have [some type of coverage](#) that may protect them from unlimited out-of-pocket costs and may offer additional benefits, whether it's coverage in addition to traditional Medicare or coverage from Medicare Advantage plans, which are required to have an out-of-pocket cap and typically offer [supplemental](#) benefits (Figure 5). However, based on KFF analysis of data from the 2021 Medicare Current Beneficiary Survey, 3 million people with Medicare have no additional coverage, which places them at risk of facing high out-of-pocket spending or going without needed medical care due to costs.

- Medicare Advantage plans now cover more than half of all Medicare beneficiaries enrolled in both Part A and Part B, or 31 million people (in 2021, Medicare Advantage enrollment was just under half of beneficiaries, or around 27 million people). (See “*What Is Medicare Advantage and How Is It Different From Traditional Medicare?*” for additional information.)
- Employer and union-sponsored plans provided some form of coverage to 15.2 million Medicare beneficiaries – one-quarter (26%) of Medicare beneficiaries overall in 2021. Of the total number of beneficiaries with employer coverage, 9.7 million beneficiaries had this coverage in addition to traditional Medicare (32% of beneficiaries in traditional Medicare), while 5.6 million beneficiaries were enrolled in Medicare Advantage employer group plans. (These estimates exclude [5.2 million](#) Medicare beneficiaries with Part A only in 2021, primarily because they or their spouse were active workers and had primary coverage from an employer plan.)
- Medicare supplement insurance, also known as Medigap, covered 2 in 10 (21%) Medicare beneficiaries overall, or 41% of those in traditional Medicare (12.5 million beneficiaries) in 2021. [Medigap policies](#), sold by private insurance companies, fully or partially cover Medicare Part A and Part B cost-sharing requirements, including deductibles, copayments, and coinsurance.

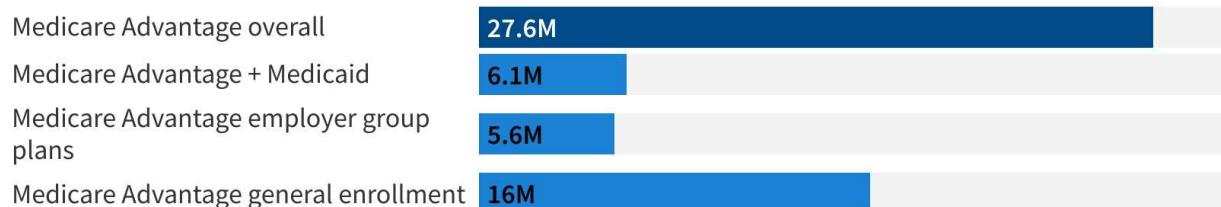
Medicaid, the federal-state program that provides health and long-term services and supports coverage to low-income people, was a source of coverage for 11 million Medicare beneficiaries with low incomes and modest assets in 2021 (19% of all Medicare beneficiaries), including 6.1 million enrolled in Medicare Advantage and 5.0 million in traditional Medicare. (This estimate is somewhat lower than KFF [estimates published elsewhere](#) due to different data sources and methods used.) For these beneficiaries, referred to as dual-eligible individuals, Medicaid typically pays the Medicare Part B premium and may also pay a portion of Medicare deductibles and other cost-sharing requirements. [Most](#) dual-eligible individuals are eligible for full Medicaid benefits, including long-term services and supports.

Figure 5

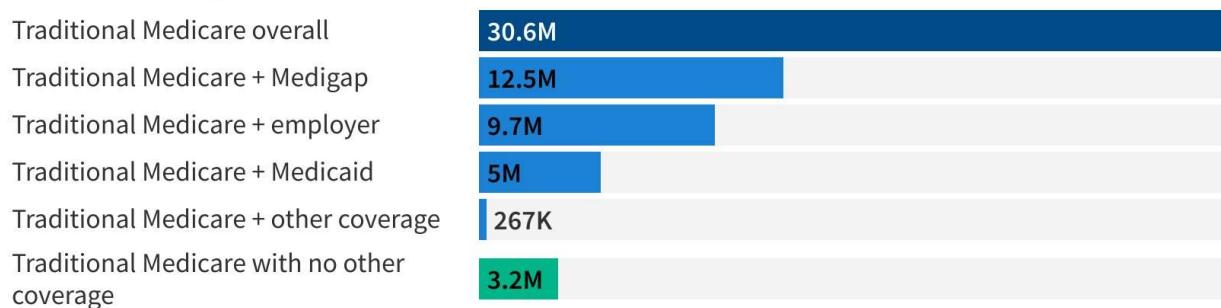
Nearly All People with Medicare Had Coverage Either Through Medicare Advantage Plans or Traditional Medicare Coupled with Some Other Type of Coverage in 2021

Three Million Medicare Beneficiaries in Traditional Medicare Had No Additional Coverage in 2021

Medicare Advantage



Traditional Medicare



Note: Total excludes beneficiaries with Part A only or Part B only for most of the year (n=5.0 million) or Medicare as a Secondary Payer (n=1.6 million).

Source: KFF analysis of CMS Medicare Current Beneficiary Survey, 2021 Survey File.

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What Is Medicare Advantage and How Is It Different From Traditional Medicare?

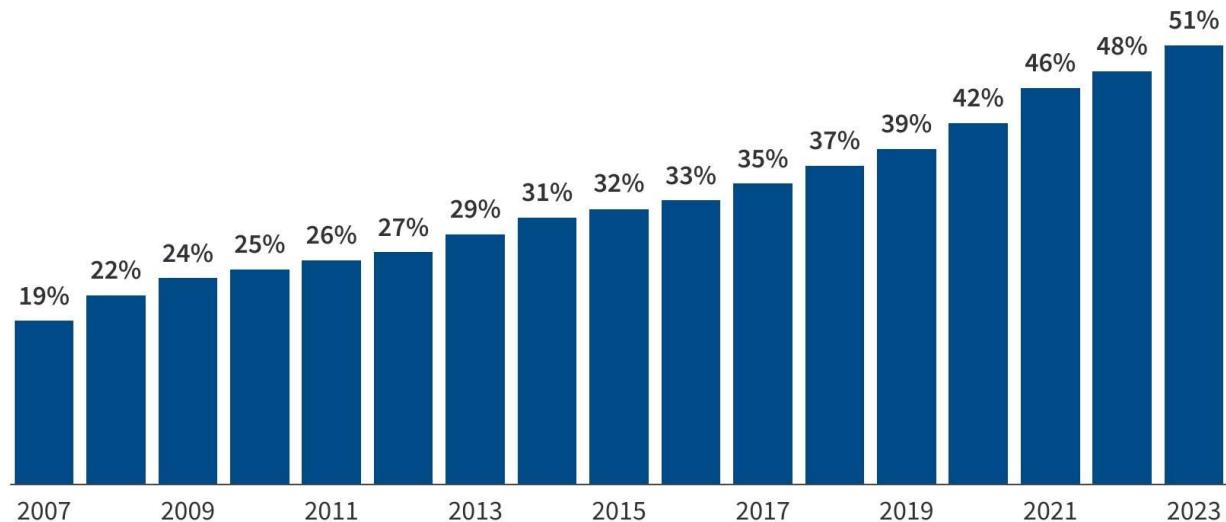
Medicare Advantage, also known as Medicare Part C, allows beneficiaries to receive their Medicare benefits from a private health plan, such as an HMO or PPO. Medicare pays private insurers to provide Medicare-covered benefits (Part A and B, and often Part D) to enrollees. [Virtually all](#) Medicare Advantage plans include an out-of-pocket limit for benefits covered under Parts A and B, and [most offer additional benefits](#) not covered by traditional Medicare, such as vision, hearing, and dental. The average Medicare beneficiary can choose from [43 Medicare Advantage plans](#) offered by eight insurance companies in 2024. These plans vary across many dimensions, including premiums, cost-sharing requirements, out-of-pocket limits, extra benefits, provider networks, prior authorization and referral requirements, denial rates, and prescription drug coverage.

[More than half of all eligible Medicare beneficiaries \(51%\)](#), are currently enrolled in a Medicare Advantage plan, up from 25% in 2010 (Figure 6). The share of eligible Medicare beneficiaries in Medicare Advantage plans varies across states, [ranging from 2% in Alaska to 60% in Alabama, Hawaii, and Michigan](#). Growth in Medicare Advantage enrollment is due to a number of factors. Medicare beneficiaries are attracted to Medicare Advantage due to the multitude of extra benefits, the simplicity of one-stop shopping (in contrast to traditional Medicare where beneficiaries might purchase a Part D plan and a Medigap plan), and the availability of plans with no premiums beyond the Part B premium, driven in part by the current payment system that generates high gross margins in this market (see “*How Does Medicare Pay Private Plans in Medicare Advantage and Medicare Part D?*” for additional information). Insurers market these plans aggressively, airing [thousands of TV ads](#) for Medicare Advantage during the Medicare open enrollment period. In some cases, Medicare beneficiaries have no choice but to be enrolled in a Medicare Advantage plan for their retiree health benefits as [some employers are shifting their retirees into these plans](#); if they are dissatisfied with this option, they may have to give up retiree benefits altogether, although they would retain Medicare and have the option to choose traditional Medicare (potentially with a Medigap supplement).

Figure 6

More Than Half (51%) of Eligible Medicare Beneficiaries Are Enrolled in a Medicare Advantage Plan in 2023

Share of Medicare beneficiaries enrolled in Medicare Advantage, 2007-2023



Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. 60 million people are enrolled in Medicare Parts A and B in 2023.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023.

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There are several differences between Medicare Advantage and traditional Medicare. Medicare Advantage plans can establish provider networks, the size of which can vary considerably for both [physicians](#) and [hospitals](#), depending on the plan and the county where it is offered. These provider networks may also change over the course of the year. Medicare Advantage enrollees who seek care from an out-of-network provider may pay higher cost sharing or pay completely out of-pocket for their care. In contrast, traditional Medicare beneficiaries may see any provider that accepts Medicare and is accepting new patients. In 2019, [89% of non-pediatric office-based physicians accepted new Medicare patients](#), with little change over time. [Only 1%](#) of all non-pediatric physicians formally opted out of the Medicare program in 2023.

Medicare Advantage plans also often use tools to manage utilization and costs, such as requiring enrollees to receive [prior authorization](#) before a service will be covered and requiring enrollees to obtain a referral for specialists or mental health providers. In 2023, virtually all Medicare Advantage enrollees were in plans that [required prior authorization](#) for some services, most often higher-cost services. Over 35 million prior authorization requests were submitted to Medicare Advantage plans in 2021 (Figure 7). Prior authorization and referrals to specialists are applied less frequently in traditional Medicare, with prior authorization generally applying to a [limited set of services](#).

Figure 7

Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021

Requests for prior authorization of services overall and per Medicare Advantage enrollee, by firm, in 2021



Note: Excludes requests that were withdrawn or dismissed. Anthem BCBS plans are not included in the analysis because of data quality issues.

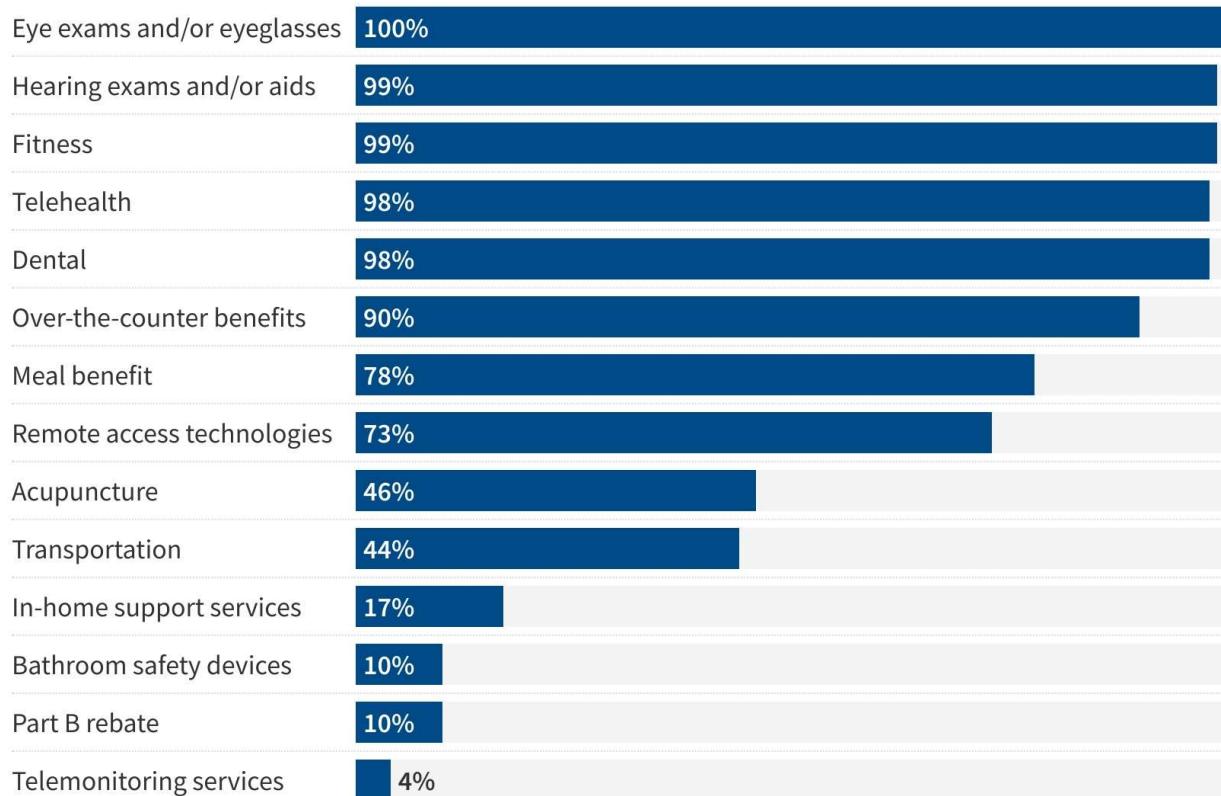
Source: KFF analysis of Technical Specifications Public Use File of Contract Year (CY) 2022 Part C and D Reporting Requirements. **KFF**

Medicare Advantage plans are required to use payments from the federal government that exceed their costs of covering Part A and B services ([known as rebates](#)) to provide supplemental benefits to enrollees, such as lower cost sharing, extra benefits not covered by traditional Medicare, or rebates toward Part B and/or Part D premiums. Examples of extra benefits include [eyeglasses](#), [hearing exams](#), [preventive dental care](#), and gym memberships (Figure 8). (See “*How Does Medicare Pay Private Plans in Medicare Advantage and Medicare Part D?*” for a discussion of how Medicare pays Medicare Advantage plans). Additionally, Medicare Advantage plans must include a cap on out-of-pocket spending, providing protection from catastrophic medical expenses. Traditional Medicare does not have an out-of-pocket limit, though some have protection from catastrophic costs if they purchase a Medigap policy. (See “*What Does Medicare Cover and How Much Do People Pay for Medicare Benefits?*” for a brief discussion of Medigap.)

Figure 8

Most Medicare Advantage Enrollees in Plans Available for General Enrollment Have Access to Some Benefits Not Covered by Traditional Medicare in 2023

Share of Medicare Advantage enrollees with access to supplemental benefits in 2023



Note: Dental includes plans that only provide preventive benefits, such as cleanings. Analysis excludes employer group health plans (EGHPs). Individual plans are plans open for general enrollment and exclude EGHPs and SNPs. There are about 19.6 million Medicare Advantage enrollees in non-EGHP and non-SNP plans. There are about 5.7 million Medicare Advantage enrollees in SNPs.

Source: KFF analysis of CMS Medicare Advantage Enrollment and Benefit Files, 2023.

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What Is the Medicare Part D Prescription Drug Benefit?

[Medicare Part D](#), Medicare's voluntary outpatient prescription drug benefit, was established by the Medicare Modernization Act of 2003 (MMA) and launched in 2006. Before the addition of the Part D benefit, Medicare did not cover the cost of outpatient prescription drugs. Under Part D, Medicare helps cover prescription drug costs through private plans that contract with Medicare to offer the Part D benefit to enrollees, which is unlike coverage of Part A and Part B benefits under traditional Medicare, and beneficiaries must enroll in a Part D plan if they want this benefit.

A total of [50.5 million people](#) with Medicare are currently enrolled in plans that provide the Medicare Part D drug benefit, including plans open to everyone with Medicare (stand-alone prescription drug plans, or PDPs, and Medicare Advantage drug plans, or MA-PDs) and plans for specific populations (including retirees of a former employer or union and Medicare Advantage Special Needs Plans, or SNPs). [More than 13 million](#) low-income beneficiaries receive extra help with their Part D plan premiums and cost sharing through the Part D Low-Income Subsidy Program (LIS).

For 2024, the average Medicare beneficiary has a choice of [21 stand-alone Part D plans and 36 Medicare Advantage drug plans](#). These plans vary in terms of premiums, deductibles and cost sharing, the drugs that are covered, any utilization management restrictions that apply, and pharmacy networks. People in traditional Medicare who are enrolled in a separate stand-alone Part D plan generally pay a monthly Part D premium unless they qualify for full benefits through the Part D LIS program and are enrolled in a premium-free (benchmark) plan. In 2023, the average enrollment-weighted premium for stand-alone Part D plans was [\\$40 per month](#). In 2023, most stand-alone Part D plans included a deductible, averaging [\\$411](#). Plans generally impose a tiered structure to define cost-sharing requirements and cost-sharing amounts charged for covered drugs, typically charging lower cost-sharing amounts for generic drugs and preferred brands and higher amounts for non-preferred and specialty drugs, and a mix of flat dollar copayments and coinsurance (based on a percentage of a drug's list price) for covered drugs.

The standard design of the Medicare Part D benefit currently has four distinct phases, where the share of drug costs paid by Part D enrollees, Part D plans, drug manufacturers, and Medicare varies. Based on changes in the Inflation Reduction Act, [these shares will change in 2024 and 2025](#) (Figure 9). Most notably, the benefit includes catastrophic coverage for enrollees with high drug costs, a phase where Part D enrollees not receiving low-income subsidies have been responsible for paying 5% of their total drug costs. In 2024, costs in the catastrophic phase will change: the 5% coinsurance requirement for Part D enrollees will be eliminated and Part D plans will pay 20% of total drug costs in this phase instead of 15%. In 2025, out-of-pocket drug costs for Part D enrollees will be capped at \$2,000. These changes are expected to help [well over 1 million Part D enrollees](#) with high drug costs each year.

Figure 9

The Share of Medicare Part D Drug Costs Paid by Enrollees, Plans, Drug Manufacturers, and Medicare Will Change in 2024 and 2025

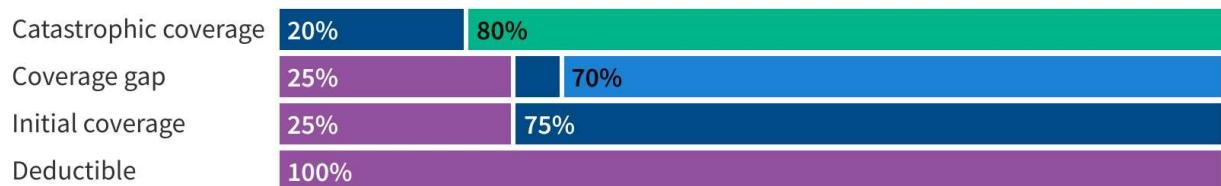
Share of total drug costs paid by:

■ Part D enrollees ■ Part D plans ■ Drug manufacturers ■ Medicare

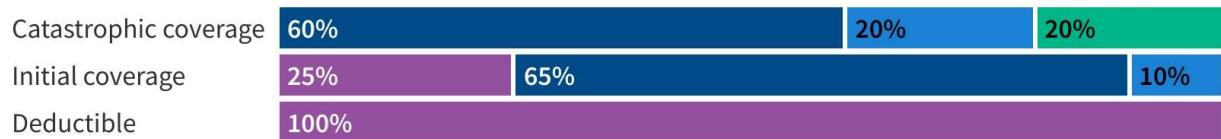
2023



2024



2025



Note: The manufacturer discount applies to brand-name drug costs only. For generic drug costs, plans pay 75% in the coverage gap phase in 2023 and 2024, and 75% in the initial coverage phase in 2025, and Medicare will pay 40% in the catastrophic coverage phase in 2025.

Source: KFF, based on Medicare Part D benefit design changes in the Inflation Reduction Act.



The [Inflation Reduction Act of 2022](#), signed into law by President Biden on August 16, 2022, includes [several provisions to lower prescription drug costs](#) for people with Medicare and reduce drug spending by the federal government, including several changes related to the Part D benefit. These provisions include (but are not limited to) (Figure 10):

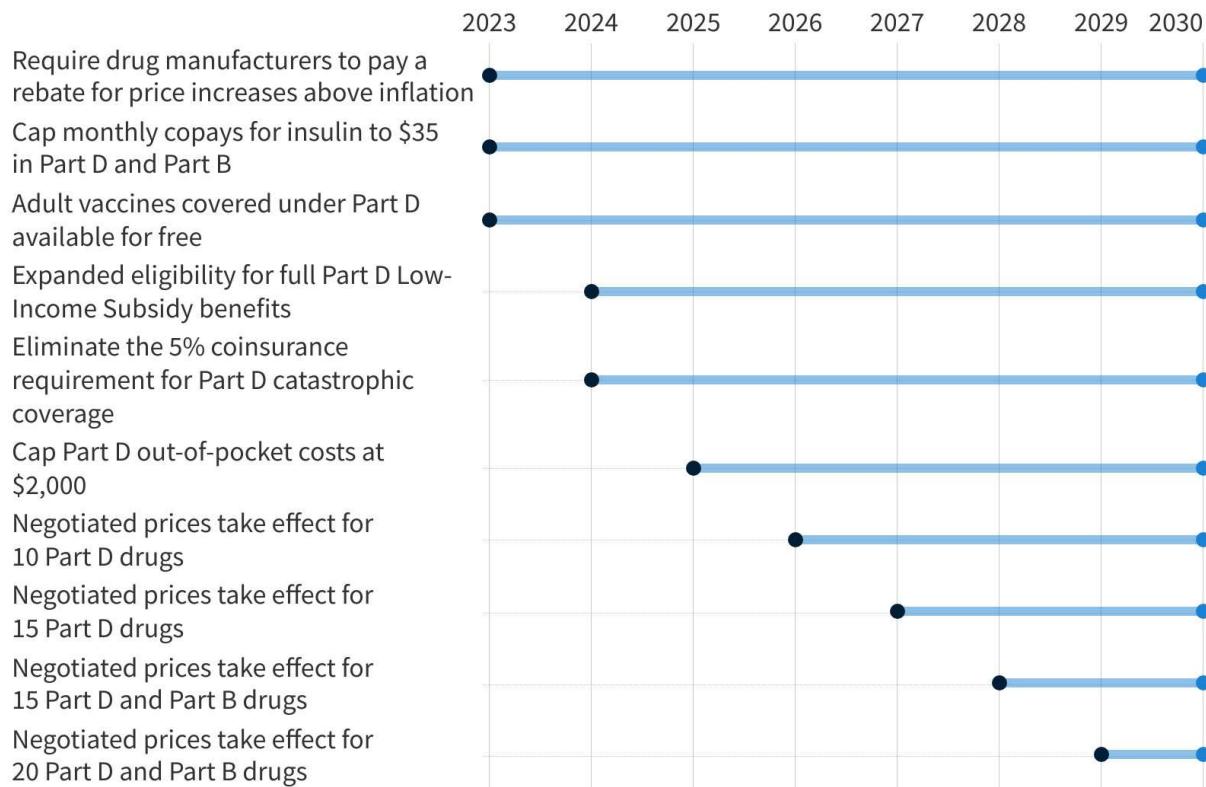
- Requiring the Secretary of the Department of Health and Human Services to [negotiate the price of some drugs](#) covered under Medicare, with negotiated prices first available for 10 Part D drugs in 2026 (and first available for Part B drugs in 2028). The law that established the Part D benefit included a provision known as the [“noninterference”](#) clause, which, to date, has prevented the HHS Secretary from being involved in price negotiations between drug manufacturers and pharmacies and Part D plan sponsors. In addition, the

Secretary of HHS does not currently negotiate prices for drugs covered under Medicare Part B (administered by physicians).

- Adding a hard cap on out-of-pocket drug spending under Part D, which will phase in beginning in 2024, with a \$2,000 cap on out-of-pocket spending in 2025. As noted above, under the original design of the Part D benefit, enrollees have had catastrophic coverage for high out-of-pocket drug costs, but there has been no limit on the total amount that beneficiaries pay out of pocket each year.
- Limiting the price of insulin products to no more than \$35 per month in all Part D plans and in Part B and making adult vaccines covered under Part D available for free as of 2023. Until these provisions took effect, beneficiary costs for insulin and adult vaccines were subject to varying cost-sharing amounts.
- Expanding eligibility for full benefits under the Part D Low-Income Subsidy program in 2024, eliminating the partial LIS benefit for individuals with incomes between 135% and 150% of poverty. Beneficiaries who receive full LIS benefits pay no Part D premium or deductible and only modest copayments for prescription drugs until they reach the catastrophic threshold, at which point they face no additional cost sharing.
- Requiring drug manufacturers to pay a rebate to the federal government if prices for drugs covered under Part D and Part B increase faster than the inflation rate, with the initial period for measuring Part D drug price increases running from October 2022-September 2023. Previously, Medicare had no authority to limit annual price increases for drugs covered under Part B or Part D. Year-to-year drug price increases exceeding inflation are not uncommon and affect people with both Medicare and private insurance.

Figure 10

Implementation Timeline of the Prescription Drug Provisions in the Inflation Reduction Act



Source: KFF analysis of provisions in the Inflation Reduction Act of 2022 (P.L. 117-169).

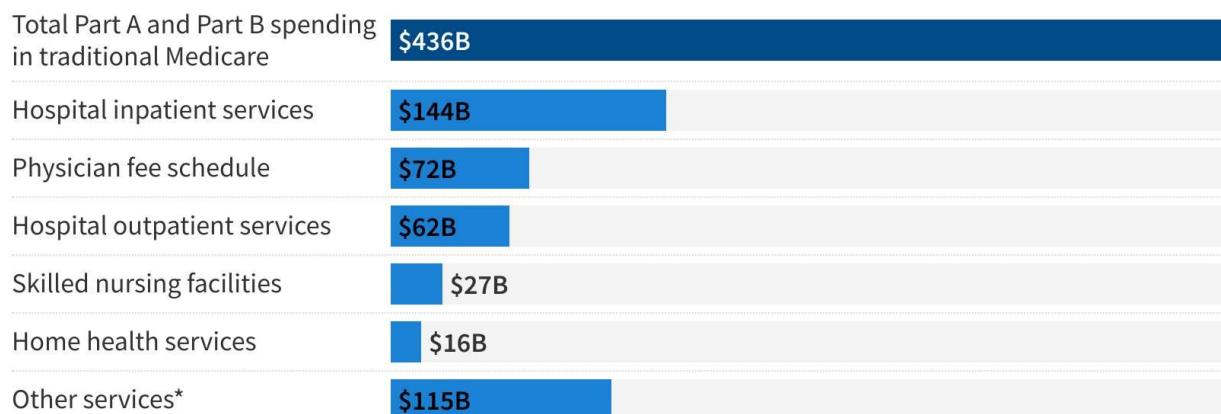
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How Does Medicare Pay Hospitals, Physicians, and Other Providers in Traditional Medicare?

In 2023, Medicare is estimated to spend \$436 billion on benefits covered under Part A and Part B for beneficiaries in traditional Medicare. Medicare pays providers in traditional Medicare using various payment systems depending on the setting of care (Figure 11).

Figure 11

Spending on Part A and Part B Benefits in Traditional Medicare is Estimated to be \$436 Billion in 2023



Note: Amounts in billions (B). *Other services include ambulance services, ambulatory surgical centers, community mental health centers, durable medical equipment, federally qualified health centers, hospice services, hospital outpatient services that are not paid for using the outpatient prospective payment system, independent and physician in-office laboratory services, outpatient dialysis, outpatient therapy services, certain Part B prescription drugs, rural health clinic services, and the payment of Part B premiums for qualifying individuals.

Source: KFF analysis of Congressional Budget Office (CBO) Medicare Baseline, May 2023.



Medicare relies on a number of different approaches when determining payments to providers for Part A and Part B services delivered to beneficiaries in traditional Medicare. These providers include hospitals (for both inpatient and outpatient services), physicians, skilled nursing facilities, home health agencies, and several other types of providers. Of the \$436 billion in estimated spending on Medicare benefits covered under Part A and Part B in traditional Medicare in 2023, \$144 billion (33%) is for hospital inpatient services and \$62 billion (14%) is for hospital outpatient services, \$72 billion (17%) is for services covered under the physician fee schedule, and \$158 billion (36%) is for all other Part A or Part B services for beneficiaries in traditional Medicare.

Medicare uses prospective payment systems for most providers in traditional Medicare. These systems generally require that Medicare pre-determine a base payment rate for a given unit of service (e.g. a hospital stay, an episode of care, a particular service). Then, based on certain variables, such as the provider's geographic location and the complexity of the patient receiving the service, Medicare adjusts its payment for each unit of

service provided. Medicare updates payment rates annually for most payment systems to account for inflation adjustments.

The main features of hospital, physician, outpatient, and skilled nursing facility payment systems (altogether accounting for 70% of spending on Part A and Part B benefits in traditional Medicare) are described below:

- **Inpatient hospitals (acute care):** Medicare pays hospitals per beneficiary discharge using the [Inpatient Prospective Payment System](#). The rate for each discharge corresponds to one of [over 750 different categories of diagnoses](#) – called Medicare Severity Diagnosis Related Groups (MS-DRGs), which reflect the principal diagnosis, secondary diagnoses, procedures performed, and other patient characteristics. DRGs that are likely to incur more intense levels of care and/or longer lengths of stay are assigned higher payments. Medicare's payments to hospitals also account for a portion of hospitals' capital and operating expenses.

Medicare also makes additional payments to hospitals in particular situations. These include additional payments for rural or isolated hospitals that meet certain criteria. Further, Medicare makes additional payments to help offset costs incurred by hospitals that are not otherwise accounted for in the inpatient prospective payment system. These include add-on payments for treating a disproportionate share (DSH) of low-income patients, as well as for covering costs associated with care provided by medical residents, known as indirect medical education (IME). While not part of the Inpatient Prospective Payment System, Medicare also pays hospitals directly for the costs of operating residency programs, known as [Graduate Medical Education \(GME\)](#) payments.

- **Physicians and other health professionals:** Medicare reimburses physicians and other health professionals (e.g. nurse practitioners) based on the [Physician Fee Schedule](#) for [over 10,000 services](#). Payment rates for these services are determined based on their relative value and other provider expenses, including malpractice insurance and office-based practice costs, which are all adjusted to account for differences across geography, and then are multiplied by a conversion factor, which is updated every year. Payment rates specified under the Physician Fee Schedule are subject to further adjustments under the [Quality Payment Program](#), established by the [Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#). Clinicians can receive payment increases if they participate in qualified [advanced alternative payment models \(A-APMs\)](#), which bear some financial risk for the costs of patient care, while those who participate in the [Merit-based Incentive Payment System \(MIPS\)](#) may receive payment increases or decreases (or no change) depending on their performance on specific quality measures. (See “*What Is Medicare Doing to Promote Alternative Payment Models?*” for more information about alternative payment models in Medicare.)

While not part of the Physician Fee Schedule, Medicare also pays for a limited number of drugs that physicians and other health care providers administer. For drugs administered by physicians, which are covered under Part B, Medicare reimburses providers based on a formula set at 106% of the Average Sales Price (ASP), which is the average price to all non-federal purchasers in the U.S, inclusive of rebates (other than rebates paid under the Medicaid program).

- **Hospital outpatient departments:** Medicare pays hospitals for ambulatory services provided in outpatient departments, using [the Hospital Outpatient Prospective Payment System](#), based on the classification of individual services into Ambulatory Payment Classifications (APC) with similar characteristics and expected costs. Final determination of Medicare payments for outpatient department services is complex. It incorporates both individual service payments and payments “packaged” with other services, partial hospitalization payments, as well as numerous exceptions, such as payments for new technologies. Medicare payment rates for services provided in hospital outpatient departments are typically higher than for similar services provided in physicians’ offices, and evidence indicates that providers [have shifted the billing of services to higher-cost settings](#). There is bipartisan interest in proposals to expand so-called “site-neutral” payments, meaning that Medicare would [align payment rates](#) for the same service across settings.
- **Skilled Nursing Facilities (SNFs):** SNFs are freestanding or hospital-based facilities that provide post-acute inpatient nursing or rehabilitation services. Medicare pays SNFs based on the [Skilled Nursing Facility Prospective Payment System](#), and payments to SNFs are determined using a base payment rate, adjusted for geographic differences in labor costs, case mix, and, in some cases, length of stay. Daily rates consider six care components – nursing, physical therapy, occupational therapy, speech-language pathology services, nontherapy ancillary services and supplies, and non-case mix (room and board services).

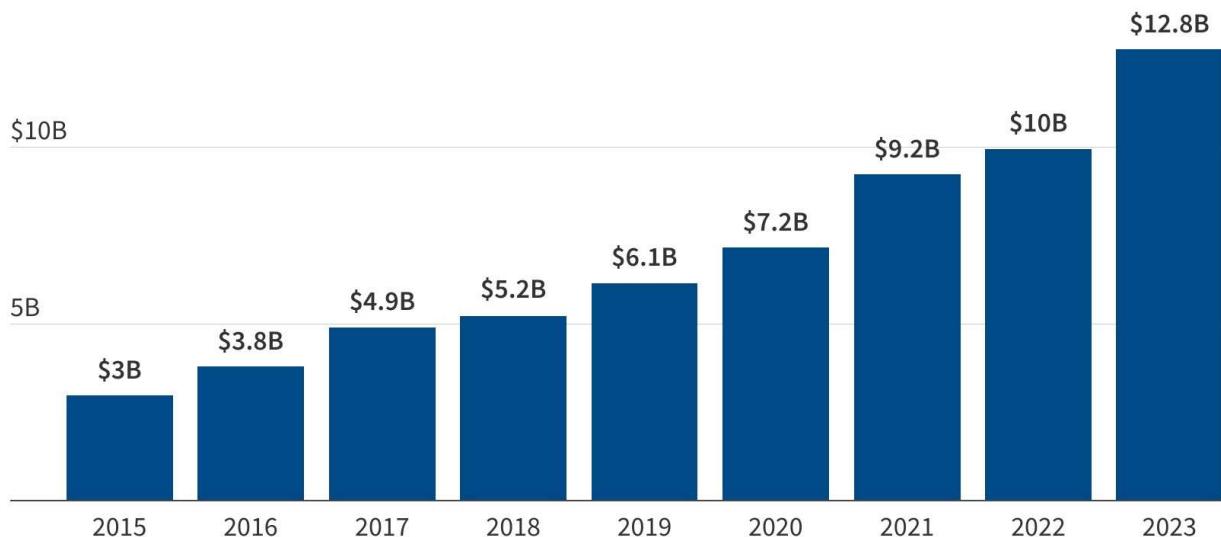
How Does Medicare Pay Private Plans in Medicare Advantage and Medicare Part D?

Medicare Advantage. Medicare pays insurers offering Medicare Advantage plans a set monthly amount per enrollee. The payment is determined through an annual process in which plans submit “bids” for how much they estimate it will cost to provide benefits covered under Medicare Parts A and B for an average beneficiary. The bid is compared to a county “benchmark”, which is the maximum amount the federal government will pay for a Medicare Advantage enrollee and is a percentage of estimated spending in traditional Medicare in the same county, ranging from 95 percent in high-cost counties to 115 percent in low-cost counties. When the bid is below the benchmark in a given county, plans receive a portion of the difference (“the rebate”), which they must use to lower cost sharing, pay for extra benefits, or reduce enrollees’ Part B or Part D premiums. Payments to plans are risk adjusted, based on the health status and other characteristics of enrollees, including age, sex, and Medicaid enrollment. In addition, Medicare adopted a quality bonus program that increases the benchmark for plans that receive at least four out of five stars under the quality rating system, which increases plan payments.

Generally, Medicare pays more to private Medicare Advantage plans for enrollees than their costs would be in traditional Medicare. The [Medicare Payment Advisory Commission \(MedPAC\) reports](#) that while it costs Medicare Advantage insurers 82% of what it costs traditional Medicare to pay for Medicare-covered services, plans receive payments from CMS that are [122%](#) of spending for similar beneficiaries in traditional Medicare, on average. The higher spending stems from features of the formula used to determine payments to Medicare Advantage plans, including setting benchmarks above traditional Medicare spending in half of counties and higher benchmarks due to the quality bonus program, resulting in [bonus payments of nearly \\$13 billion in 2023](#). This amount is more than four times greater than spending on bonus payments in 2015 (Figure 12).

Figure 12

Total Spending on Medicare Advantage Plan Bonuses More Than Quadrupled Between 2015 and 2023



Source: KFF analysis of CMS Enrollment and Plan Quality and Performance Ratings Files, 2015-2023.



The higher spending in Medicare Advantage is also related to the impact of coding intensity, where Medicare Advantage enrollees look sicker than they would if they were in traditional Medicare, resulting in plans receiving higher risk adjustments to their monthly per person payments, translating to [an estimated \\$83 billion in excess payments to plans in 2024](#).

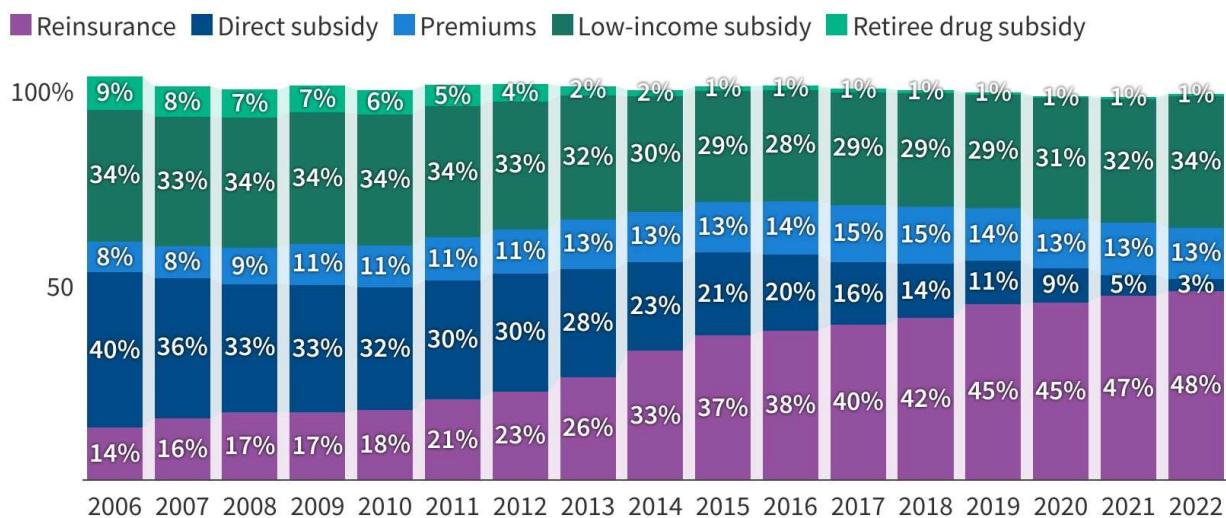
Higher payments to Medicare Advantage allow plans to offer extra benefits attractive to enrollees. However, these benefits come at a cost to all beneficiaries through higher premiums and [contribute to the strain on the Medicare Part A Hospital Insurance Trust Fund](#). (See “*How Much Does Medicare Spend and How Is the Program Financed?*” for additional information.)

Medicare Part D. Medicare pays Part D plans, both stand-alone prescription drug plans and Medicare Advantage plans that offer drug coverage, based on an annual competitive bidding process. Plans submit bids yearly to Medicare for their expected costs of providing the drug benefit plus administrative expenses. Plans receive a direct subsidy per enrollee, which is risk-adjusted based on the health status of their enrollees, plus reinsurance payments from Medicare for the highest-cost enrollees and adjustments for the low-income subsidy (LIS) status of their enrollees. (Unlike Medicare Advantage, there is no quality bonus program that provides higher payments to Part D plans with higher Part D quality ratings.) Risk-sharing arrangements with the federal government (“risk corridors”) limit plans’ potential total losses or gains.

Under reinsurance, Medicare currently subsidizes 80% of total drug spending incurred by Part D enrollees with relatively high drug spending above the catastrophic coverage threshold and plans pay 20% in 2024 (up from 15% in prior years). In the aggregate, Medicare's reinsurance payments to Part D plans accounted for close to half of total Part D spending (48%) in 2022, up from 14% in 2006 (increasing from \$6 billion in 2006 to [\\$57 billion in 2022](#)) (Figure 13).

Figure 13

Spending for Catastrophic Coverage (“Reinsurance”) Accounted for Nearly Half (48%) of Total Medicare Part D Spending in 2022, up from 14% in 2006



Source: KFF analysis of data from the 2016-2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table IV.B10.



Beginning in 2025, under a provision of the Inflation Reduction Act, Medicare's share of costs for brand-name drugs above the catastrophic threshold will [decrease from 80% to 20%](#), shifting more of the responsibility for these costs to Part D plans and drug manufacturers. (See “*What Is the Medicare Part D Prescription Drug Benefit?*” for more detail on plan liability under various phases of the Part D benefit and more information on changes to Part D included in the Inflation Reduction Act.)

For 2024, [Medicare's actuaries estimate](#) that Part D plans will receive direct subsidy payments averaging \$383 per enrollee overall, \$2,588 for enrollees receiving the LIS, and \$1,153 in reinsurance payments for very high-cost enrollees.

What Is Medicare Doing to Promote Alternative Payment Models?

While Medicare has traditionally paid providers on a fee-for-service basis, the program is implementing various [alternative payment models](#) designed to tie payments under traditional Medicare to provider performance on quality and spending. Although the overarching goals of these various models are similar—[improving the quality and affordability of patient care, advancing health equity, and reducing health care costs](#)—the specific aims vary by model.

A notable example of an alternative payment model within Medicare is the [Medicare Shared Savings Program \(MSSP\)](#), a permanent accountable care organization (ACO) program in traditional Medicare established by the Affordable Care Act (ACA) that offers financial incentives to providers for meeting or exceeding savings targets and quality goals. ACOs are groups of doctors, hospitals, and other health care providers who voluntarily form partnerships to collaborate and share accountability for the quality and cost of care delivered to their patients. The MSSP currently offers different participation options to ACOs, allowing these organizations to share in savings only or both savings and losses, depending on their level of experience and other factors.

ACOs have a defined patient population for the purpose of calculating annual savings or losses. Beneficiaries in traditional Medicare may choose to align themselves to an ACO ([voluntary alignment](#)) or may be [assigned to a particular ACO](#) based on where they received a plurality of their primary care services. In either case, beneficiaries are free to seek treatment from any provider who accepts Medicare and are not limited to ACO-affiliated providers. This contrasts with enrollment in Medicare Advantage, where beneficiaries are generally limited to seeing providers in their plan's network or face higher out-of-pocket costs for seeing out-of-network providers.

In 2022, the Medicare Shared Savings Program saved Medicare an estimated [\\$1.8 billion](#) relative to annual spending targets. As of 2023, there are [456 MSSP ACOs nationwide](#), with over [573,000 participating clinicians](#) and [10.9 million beneficiaries](#) aligned to MSSP ACOs (Figure 14).

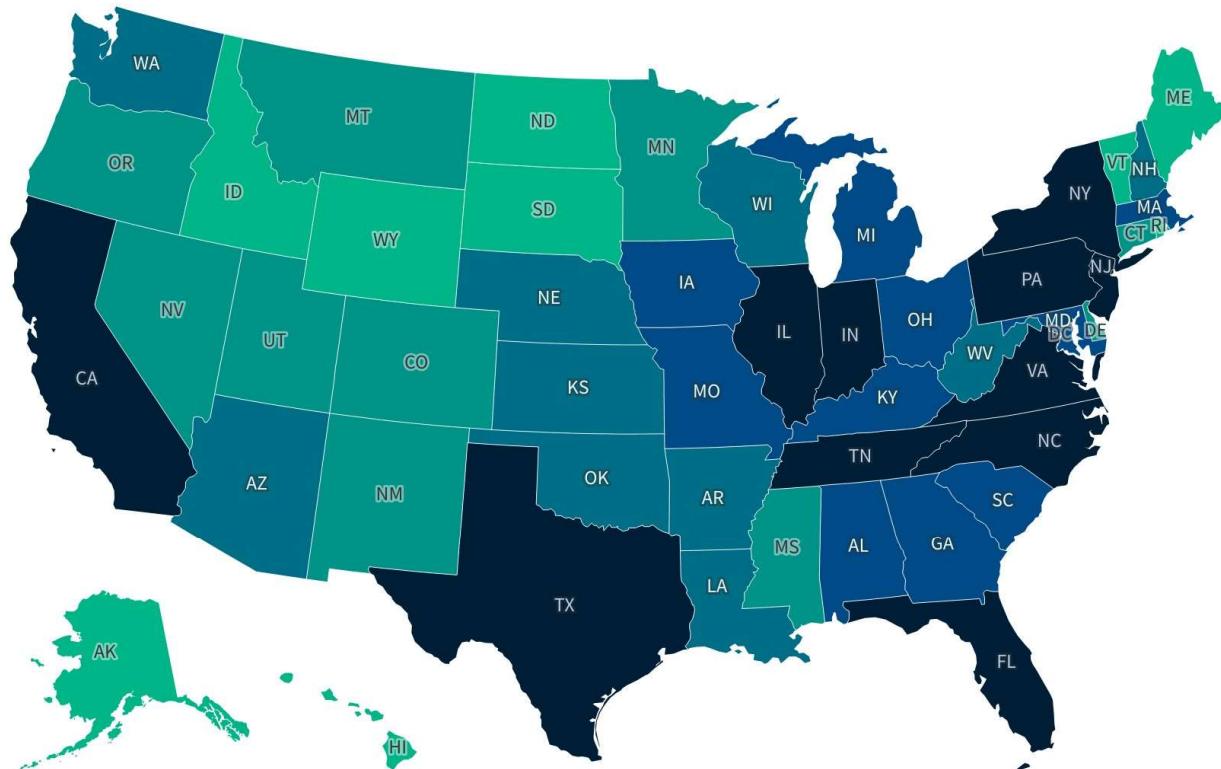
Figure 14

Medicare Shared Savings Program ACOs Are Operating in Every State and the District of Columbia

Service areas of the 456 MSSP ACOs operating as of January 2023

MSSP ACOs per state and DC

■ < 9 ■ 9–15 ■ 15–21 ■ 21–30 ■ ≥ 30



Note: MSSP is Medicare Shared Savings Program. ACO is accountable care organization. Counts do not sum to the total number of active MSSP ACOs, as many ACOs have service areas that include more than one state.

Source: KFF analysis of Centers for Medicare & Medicaid Services, Information on Shared Savings Program (SSP) Accountable Care Organizations (ACOs), January 2023

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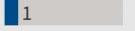
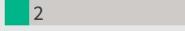
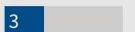
The ACA also established the [Center for Medicare and Medicaid Innovation \(CMMI, also known as the Innovation Center\)](#), an operating center within the Centers for Medicare & Medicaid Services tasked with designing and testing alternative payment models to address concerns about rising health care costs, quality of care, and inefficient spending within the Medicare, Medicaid, and CHIP programs. Since its start in 2010, CMMI has launched [more than 70 models across six different categories](#), including accountable care models, disease-specific models, health plan models, and others (Figure 15). CMMI models are designed to be tested over a limited number of years, but Congress gave CMMI the authority to expand models nationwide permanently if they meet [certain quality and savings criteria](#). As of 2023, [six models](#) have shown statistically significant savings,

and [four](#) have met the requirements for permanent expansion into the wider Medicare program, including the [Medicare Diabetes Prevention Program](#) and the [Home Health Value-Based Purchasing Model](#).

Figure 15

The Center for Medicare and Medicaid Innovation (CMMI) has Implemented Numerous Programs and Pilot Projects to Test New Payment Models

CMMI model categories and category descriptions

Category	Description	Active Models	Completed Models	Examples
Accountable Care Models	Models in which an individual provider, group of providers, or hospital takes financial responsibility for improving quality of care	 5	 12	ACO REACH Next Generation ACO
Disease-Specific and Episode-Based Models	Models designed to improve care around a specific disease, medical condition, procedure, or care episode	 9	 8	Comprehensive Care for Joint Replacement Model Emergency Triage, Treat, and Transport (ET3) Model
Health Plan Models	Models designed to incorporate Medicare Advantage plans	 1	 2	Medicare Care Choices Model Medicare Advantage Value-Based Insurance Design Model
Prescription Drug Models	Models designed to improve access and lower cost-related barriers to prescription drugs	 1	 2	Part D Senior Savings Model Part D Enhanced Medication Therapy Management Model
State & Community-Based Models	Models designed to operate through state and community-based organizations	 6	 10	Maryland Total Cost of Care Model Vermont All-Payer ACO Model
Statutory Models	Models and demonstrations that require testing as determined by Congress or the Secretary of Health and Human Services	 3	 15	Independence at Home Demonstration Rural Community Hospital Demonstration

Note: CMMI designates a model as active if it is preparing for implementation, currently ongoing, or has an ongoing evaluation.

Source: KFF based on data from CMS, Innovation Models, October 2023



According to the Congressional Budget Office (CBO), the activities of CMMI increased federal spending by [\\$5.4 billion](#) from 2011 to 2020, which CBO attributes in part to the mixed success of many models at generating sufficient savings to offset their high upfront costs. (CBO had initially projected that CMMI would reduce federal spending by [\\$2.8 billion](#) in its first decade of operation.) However, [a review of select CMMI models](#) provides evidence of improvements in care coordination, team-based care, and other care delivery changes, even in the absence of savings. CBO projects that CMMI's activities will come closer to the breakeven point regarding federal spending over the next decade (2024-2033).

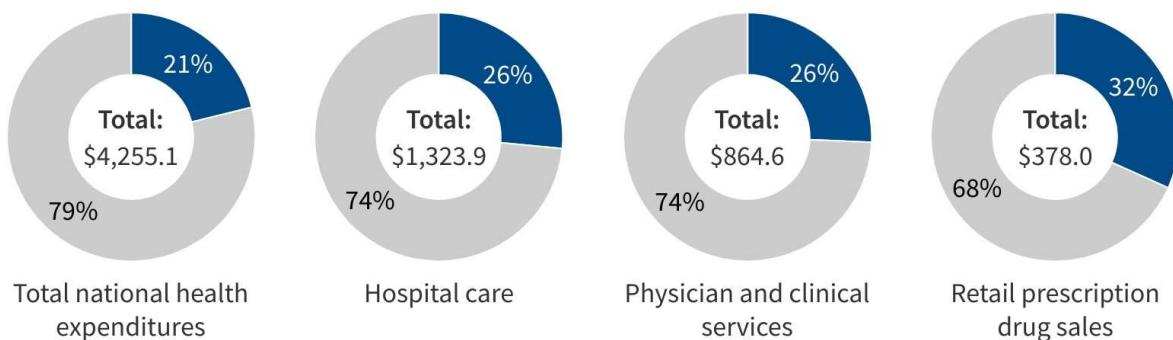
How Much Does Medicare Spend and How Is the Program Financed?

Spending. Medicare plays a significant role in the health care system, accounting for 21% of total [national health spending](#) in 2021, 26% of spending on both hospital care and physician and clinical services, and 32% of spending on retail prescription drug sales (Figure 16).

Figure 16

In 2021, Medicare Accounted for 21% of Total National Health Spending

■ Medicare ■ Other payers



Note: Amounts in billions.

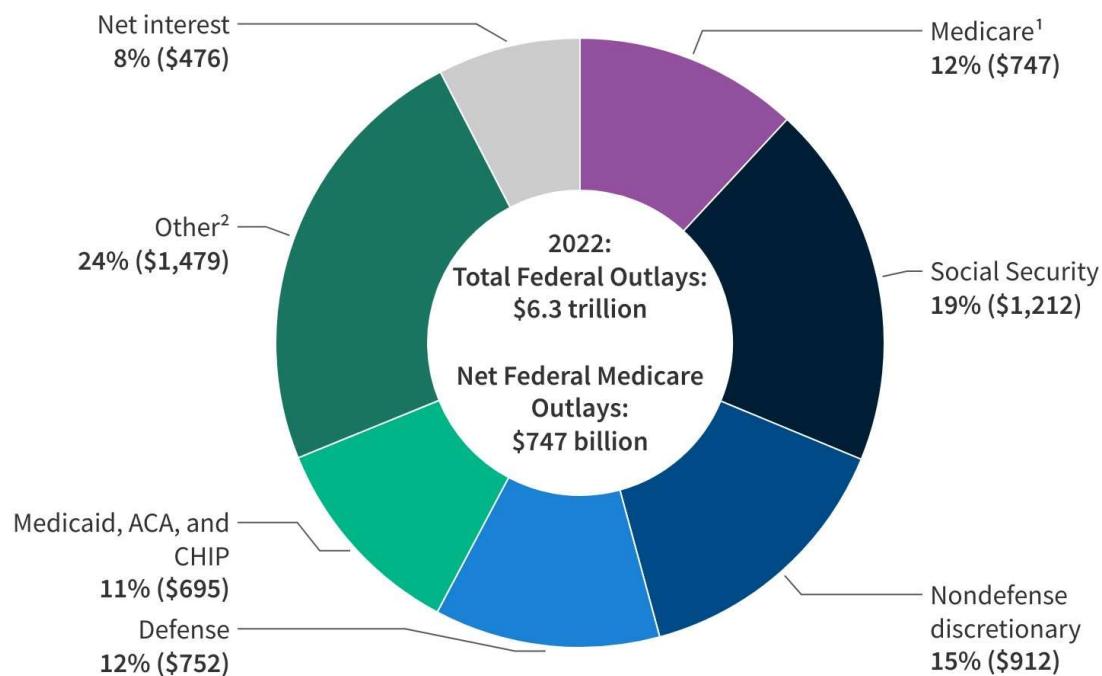
Source: KFF analysis of 2021 national health expenditure data from Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; Table 4: National Health Expenditures by Source of Funds and Type of Expenditures.



In 2022, Medicare spending, net of income from premiums and other offsetting receipts, totaled \$747 billion and accounted for [12% of the federal budget](#)—a similar share as spending on Medicaid, the ACA, and the Children’s Health Insurance Program combined, and defense spending (Figure 17).

Figure 17

In 2022, Medicare Spending Accounted for 12% of the Federal Budget



Note: Amounts in billions. Amounts are for federal fiscal year 2022. ¹Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. ²Includes spending on other mandatory outlays minus income from offsetting receipts. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program.

Source: KFF analysis of federal spending from Congressional Budget Office, 10-Year Budget Projections, May 2022.

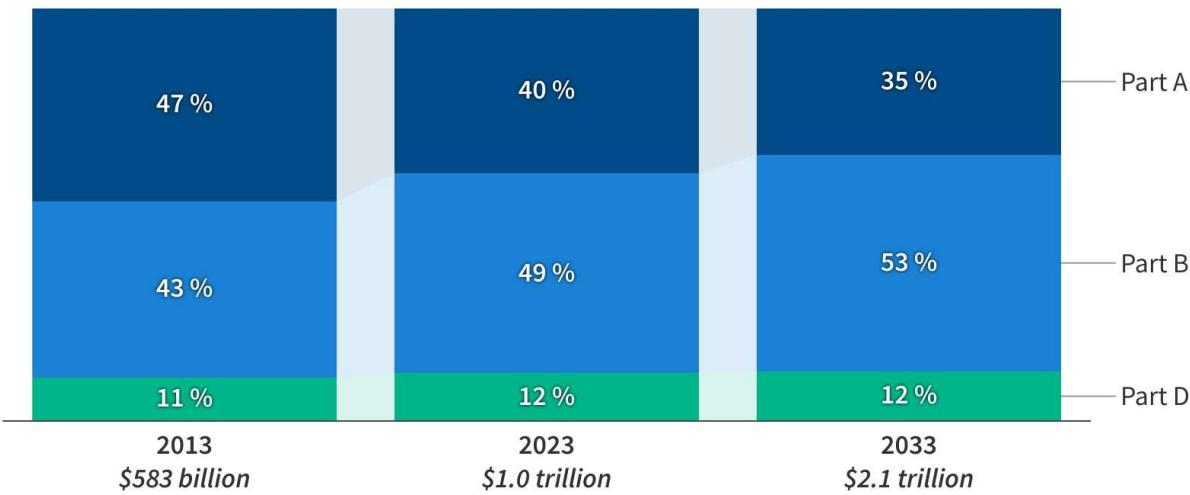
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In 2023, Medicare benefit payments are estimated to [total \\$1 trillion](#), up from [\\$583 billion in 2013](#) (including spending for Part A, Part B, and Part D benefits in both traditional Medicare and Medicare Advantage). Medicare spending per person has also grown, increasing from \$5,800 to \$15,700 between 2000 and 2022 – or 4.6% average annual growth over the 22-year period. In recent years, however, growth in Medicare spending per person has been [lower in Medicare than in private health insurance](#).

Spending on Medicare Part A benefits (mainly hospital inpatient services) has decreased as a share of total Medicare spending over time as care has shifted from inpatient to outpatient settings, leading to an increase in spending on Part B benefits (including physician services, outpatient services, and physician-administered drugs). Spending on Part B services now accounts for the largest share of Medicare benefit spending (49% in 2023) (Figure 18). Moving forward, Medicare spending on physician services and other services covered under Part B is expected to grow to more than half of total Medicare spending by 2033, while spending on hospital care and other services covered under Part A is projected to decrease further as a share of the total.

Figure 18

Spending on Physician Services and Other Medicare Part B Services Now Accounts for the Largest Share of Total Medicare Benefits Spending



Note: Amounts in billions. Amounts include spending on both traditional Medicare and Medicare Advantage.

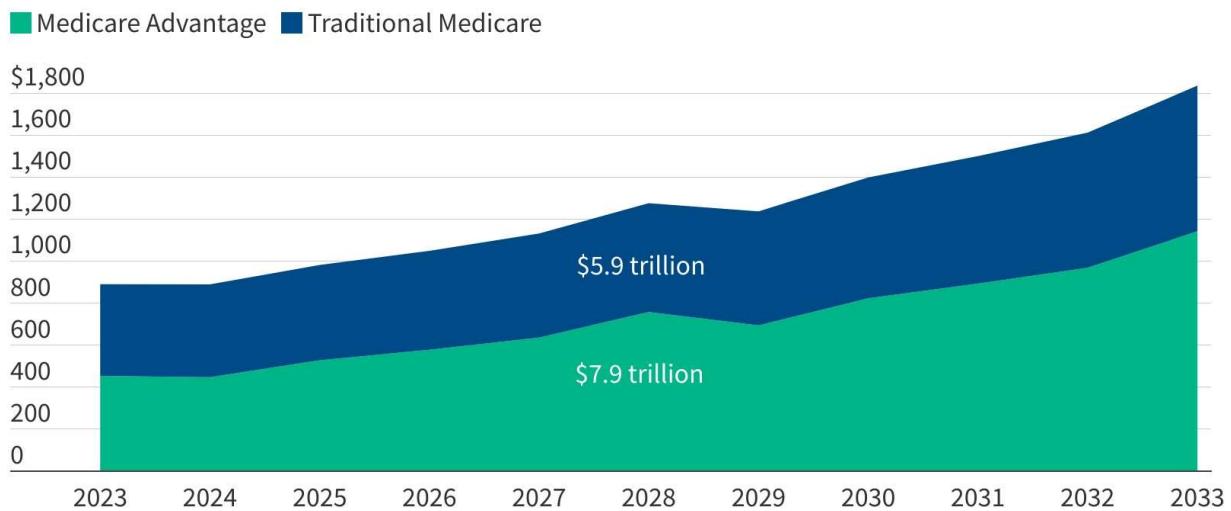
Source: KFF analysis of Congressional Budget Office (CBO) Medicare Baseline, April 2014 (2013 data) and May 2023 (2023 and 2033 data).



Payments to Medicare Advantage plans for Part A and Part B benefits tripled as a share of total Medicare spending between 2013 and 2023, from [\\$145 billion](#) to [\\$454 billion](#), partly due to steady enrollment growth in Medicare Advantage plans. Growth in spending on Medicare Advantage also reflects that Medicare pays more to private Medicare Advantage plans for enrollees than their costs in traditional Medicare, on average. (See “*How Does Medicare Pay Private Plans in Medicare Advantage and Medicare Part D?*” for additional information.) These higher payments have contributed to growth in spending on Medicare Advantage and overall Medicare spending. In 2023, [just over](#) half of all Medicare program spending for Part A and Part B benefits was for Medicare Advantage plans, up from [just under 30% in 2013](#). Between 2023 and 2033, Medicare Advantage payments are projected to total nearly \$8 trillion, \$2 trillion more than spending under traditional Medicare (Figure 19).

Figure 19

Medicare Advantage Payments are Projected to Total Nearly \$8 Trillion Between 2023 and 2033, \$2 Trillion More than Spending Under Traditional Medicare



Note: Annual amounts in billions. Includes spending on Part A and Part B benefits only, excluding Part D.

Source: KFF analysis of data from Congressional Budget Office, Medicare baseline, May 2023.

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Financing. Medicare funding, which totaled \$989 billion in 2022, comes primarily from general revenues (43%), payroll tax revenues (36%), and premiums paid by beneficiaries (16%). Other sources include taxes on Social Security benefits, payments from states, and interest.

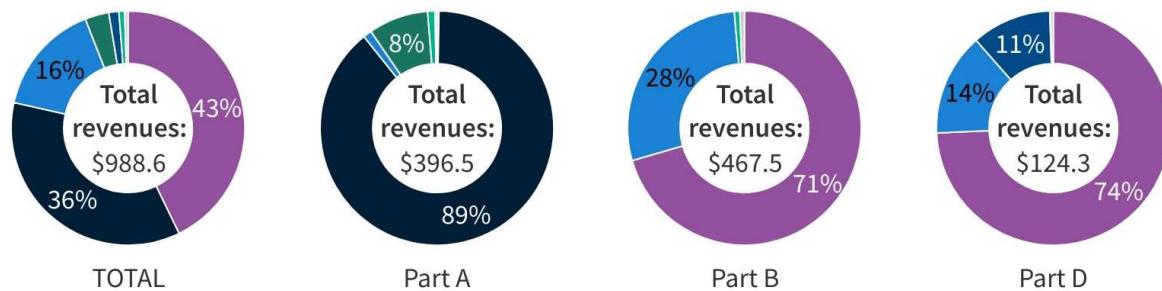
The different parts of Medicare are funded in varying ways, and revenue sources dedicated to one part of the program cannot be used to pay for another part (Figure 20).

Figure 20

Medicare Revenues Come from Different Sources, Primarily General Revenues, Payroll Taxes, and Premiums Paid by Beneficiaries

Revenues in billions for calendar year 2022, by source:

■ General revenues ■ Payroll taxes ■ Premiums ■ Taxation of Social Security benefits
■ Payments from states ■ Interest ■ Other revenue



Source: KFF analysis of data from the 2023 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, Table II.B1, March 2023.

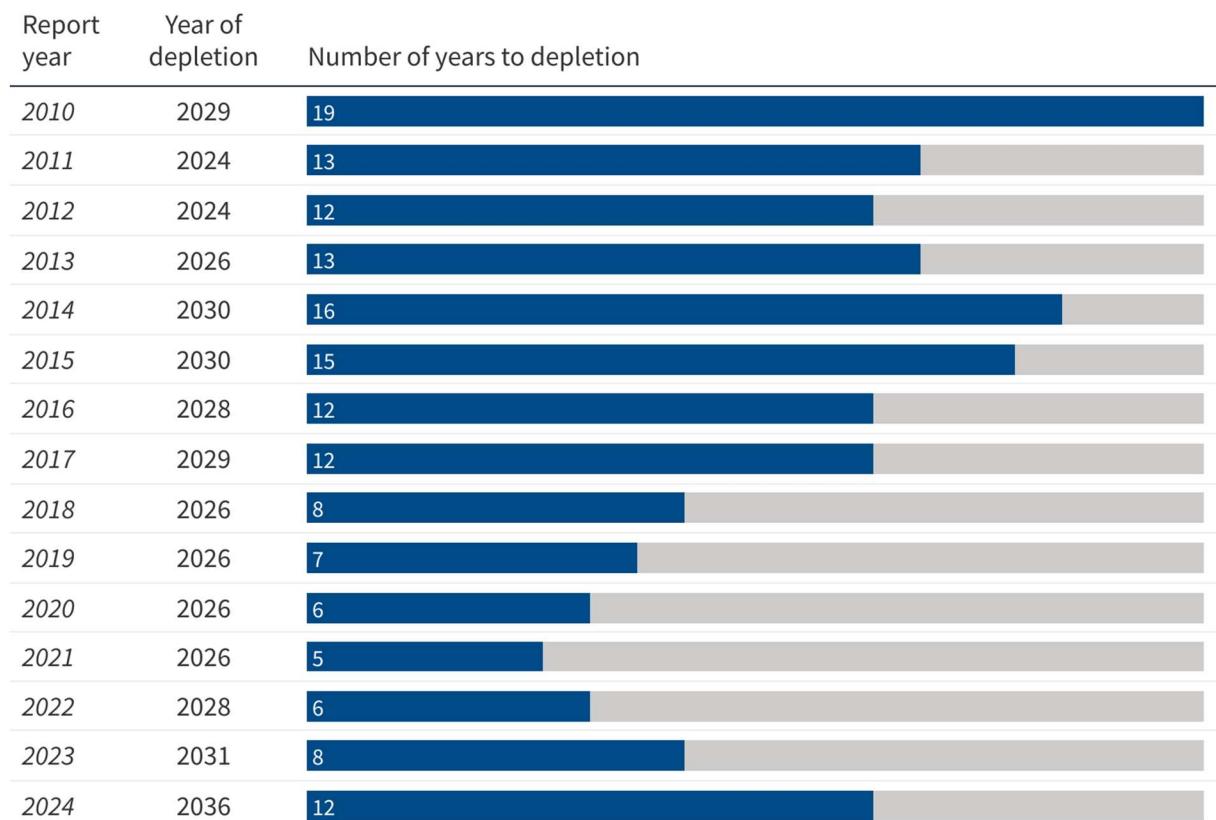


- Part A, which covers inpatient hospital stays, skilled nursing facility (SNF) stays, some home health visits, and hospice care, is financed primarily through a 2.9% tax on earnings paid by employers and employees (1.45% each). Higher-income taxpayers (more than \$200,000 per individual and \$250,000 per couple) pay a higher payroll tax on earnings (2.35%). Payroll taxes accounted for 89% of Part A revenue in 2022.
- Part B, which covers physician visits, outpatient services, preventive services, and some home health visits, is financed primarily through a combination of general revenues (71% in 2022) and beneficiary premiums (28%) (and 1% from interest and other sources). The standard Part B premium that most Medicare beneficiaries pay is calculated as 25% of annual Part B spending, while beneficiaries with annual incomes over \$103,000 per individual or \$206,000 per couple pay a higher, income-related Part B premium reflecting a larger share of total Part B spending, ranging from 35% to 85%.
- Part D, which covers outpatient prescription drugs, is financed primarily by general revenues (74%) and beneficiary premiums (14%), with an additional 11% of revenues coming from state payments for beneficiaries enrolled in both Medicare and Medicaid. Higher-income enrollees pay a larger share of the cost of Part D coverage, as they do for Part B.
- The Medicare Advantage program (sometimes referred to as Part C) does not have its own separate revenue sources. Funds for Part A benefits provided by Medicare Advantage plans are drawn from the Medicare HI trust fund. Funds for Part B and Part D benefits are drawn from the Supplementary Medical Insurance (SMI) trust fund. Beneficiaries enrolled in Medicare Advantage plans pay the Part B premium and may pay an additional premium if required by their plan. In 2023, [73% of Medicare Advantage enrollees](#) pay no additional premium.

Measuring the level of reserves in the Medicare Hospital Insurance trust fund, out of which Part A benefits are paid, is a common way of measuring Medicare's financial status. Each year, Medicare's actuaries provide an estimate of the year when the reserves are projected to be fully depleted. In 2024, the Medicare Trustees [projected](#) sufficient funds would be available to pay for Part A benefits in full until 2036, 12 years from now. At that point, in the absence of Congressional action, Medicare will be able to pay 89% of costs covered under Part A using payroll tax revenues. Since 2010, the projected year of trust fund reserve depletion has ranged from 5 years out (in 2021) to 19 years out (in 2010) (Figure 21).

Figure 21

The Medicare Hospital Insurance Trust Fund Reserves Are Projected to Be Depleted in 2036



Source: KFF based on Part A trust fund depletion date projections from the 2010-2024 annual reports of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Fund.



The level of reserves in the Part A Trust Fund is affected by growth in the economy, which affects revenue from payroll tax contributions, health care spending and utilization trends, and demographic trends: an increasing number of beneficiaries as the population ages, especially between 2010 and 2030 when the baby boom

generation reaches Medicare eligibility age, and a declining ratio of workers per beneficiary making payroll tax contributions.

Part B and Part D do not have financing challenges similar to Part A, because both are funded by beneficiary premiums and general revenues that are set annually to match expected outlays. However, future increases in spending under Part B and Part D will require increases in general revenue funding and higher premiums paid by beneficiaries.

Future Outlook

Looking to the future, Medicare faces a number of challenges from the perspective of beneficiaries, health care providers and private plans, and the federal budget. These include:

- How best to address the fiscal challenges arising from an aging population and increasing health care costs through spending reductions and/or revenue increases.
- Whether and how to improve coverage for Medicare beneficiaries, including an out-of-pocket limit in traditional Medicare, enhanced financial support for lower-income beneficiaries, and additional benefits, such as dental and vision.
- How to control spending while ensuring fair and adequate payments to hospitals, physicians and other providers, and Medicare Advantage plans, including whether and how to reduce overpayments to Medicare Advantage plans.
- How to address the implications for traditional Medicare of rapid growth in Medicare Advantage enrollment.

Consideration of possible changes to Medicare will involve careful deliberation about the potential implications for federal spending and taxpayers, the solvency of the Medicare Hospital Insurance trust fund, total health care spending, the affordability of health care for Medicare's growing number of beneficiaries, many of whom have limited incomes, and access to high-quality medical care.

Resources

- [What to Know about Medicare Spending and Financing](#)
- [An Overview of the Medicare Part D Prescription Drug Benefit](#)
- [Medicare Advantage in 2023: Enrollment Update and Key Trends](#)
- [Key Facts About Medicare Part D Enrollment and Costs in 2023](#)
- [What to Know about the Medicare Open Enrollment Period and Medicare Coverage Options](#)
- [Explaining the Prescription Drug Provisions in the Inflation Reduction Act](#)
- [A Snapshot of Sources of Coverage Among Medicare Beneficiaries](#)
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