An Introduction to the U.S. Medicare Program

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What is Medicare?

Medicare is a national health insurance program created by the Congress of the United States in 1965 through the Social Security Act. The program provides health insurance to U.S. citizens ages 65 and older, young people with disabilities, and people with certain diseases. As a social insurance program, Medicare enables the elderly and the disabled to have access to insurance benefits regardless of income and medical history. Medicare accounts for a growing share in the U.S. economy: from 3.5 percent of gross domestic products (GDP) in 2013 to a projected 6.9 percent of GDP by 2088 (The Boards of Trustees, 2014). For these reasons, the topic of Medicare and its effects have received much attention from policy makers, the public, and academics.

The Four Parts of Medicare

Part A, also called Hospital Insurance, automatically covers almost all people ages 65 and older, as well as some people younger than 65 who have certain disabilities. The main focus of Part A coverage is inpatient hospital care. A Medicare enrollee who enters a hospital must pay an initial deductible, as well as a copayment for hospital stays that exceed 60 days, but otherwise Medicare pays for all other inpatient expenses.

Part B, also called Supplemental Medical Insurance, is available to almost all individuals age 65 and older. Part B provides coverage for doctor services, as well as emergency room, outpatient, and ambulance care. Part B technically is optional, and it requires that enrollees pay a monthly premium payment. However, because those

premium requirements are relatively small, the overwhelming majority of Part A enrollees also choose to enroll in Part B.

Part C, also called Medicare Advantage, is an alternative to Part B. Part C covers similar medical services to Part B, but the monthly premium generally is lower. In return for that lower premium, enrollees must obtain covered medical services through various managed care organizations. The goal of Part C, from the government's perspective, is to reduce growth in health care spending.

Part D, also called Prescription Drug Insurance, started in 2006, and is similar to Part B, in that it is technically optional. But unlike Part B, Part D exclusively covers prescription drugs. Part D enrollees must pay a month premium. In addition, enrollees must pay all of their drug expenses up to $325 (as of 2013). After meeting that deductible, enrollees then pay 25% of drug expenses up to $2970, after which enrollees must pay 100% of their drug expenses. However, expenses in excess of $4750 are paid entirely by Part D. (That 100% payment requirement between $2970 and $4750 is often called the "donut hole.")

How Medicare is paid for?

Medicare is financed through two trust funds: the Hospital Insurance Trust Fund (HI), and the Supplementary Medical Insurance Trust Fund (SMI). These funds are held by the U.S. Treasury and used exclusively for Medicare. The HI fund is paid for by payroll taxes and other sources including a part of income taxes from certain Social Security beneficiaries, the premiums from voluntary participants, and interest earned

from the fund investment. For SMI, the primary source of financing is the fund amount authorized by the Congress, premiums from Part B and D enrollees and interest earned from the fund investment. (The Boards of Trustees, 2014) Generally, HI pays for Part A, and the SMI fund pays for Parts B and D. In 2013, revenues for HI and SMI were 251.1 billion dollars and 324.7 billion dollars, respectively.

Impact of Medicare

The introduction of Medicare appears to have had minimal impact on elderly mortality, the most objective and easily measurable indicator of health. On the other hand, Medicare has resulted in a substantial decrease in out-of-pocket medical spending, suggesting that Medicare has been associated with large reductions in out-of-pocket medical spending risk (For a more detailed discussion of the impacts of Medicare, see Finkelstein and McKnight (2008)).

Medicare and the Affordable Care Act

The Affordable Care Act (ACA) requires that an individual have minimum essential coverage. It also establishes health insurance marketplaces to facilitate the purchase of health insurance. Through those marketplaces, individuals can select from various standardized health insurance policies that are eligible for federal subsidies. Two questions arise for Medicare beneficiaries: Does having Medicare coverage satisfy the ACA's essential coverage requirement? And what is the cost of transitioning from a marketplace plan to Medicare and vice versa?

To the first question, Part A Medicare beneficiaries are considered covered in accordance with the ACA and are not required to enter the market places. However, having only Medicare Part B does not satisfy the essential coverage requirement. As a result, individuals who only have Medicare Part B must pay a fee mandated by the ACA for not having the minimum coverage.

To the second question, if an individual becomes eligible for Medicare coverage, he or she can choose to either cancel or keep the current marketplace plan. However, when the Medicare Part A coverage begins, the income based savings on marketplace plans are lifted, making the option to stay in a marketplace plan more costly than to enroll in Medicare.

Long-Run Challenges

As Medicare currently is structured, current workers pay for health care spending of current Medicare enrollees. However, as baby boomers age into Medicare eligibility, the number of workers per Medicare enrollee will decrease from 3.4 in 2010 to a projected 2.3 in 2030. Consequently, there will be more financial pressure to either increase taxes on current workers, increase cost sharing for future Medicare enrollees, and/or decrease Medicare benefits.

Finkelstein, A. and R. McKnight (2008). "What did Medicare do? The initial impact of Medicare on mortality and out of pocket medical spending." *Journal of Public Economics*, 92, 1644-1668.

The Boards of Trustees, F. H. (2014). *The 2014 Annual Report of The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.*