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# Medicare: Part B Premiums

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## Summary

Medicare is a federal insurance program that pays for covered health care services of most individuals aged 65 and over and certain disabled persons. In 2015, the program is expected to cover about 55 million persons (46 million aged and 9 million disabled) at a total cost of \$649 billion. Most individuals (or their spouses) who are 65 and older, and have worked in covered employment and paid Medicare payroll taxes for 40 quarters, receive premium-free Medicare Part A (Hospital Insurance). Those entitled to Medicare Part A (regardless of whether they are eligible for premium-free Part A), have the option of enrolling in Part B, which covers such things as physician and outpatient services and medical equipment.

Beneficiaries have a 7-month initial enrollment period, but those who enroll in Part B after their initial enrollment period and/or reenroll after a termination of coverage may be subject to a “delayed enrollment penalty,” which is equal to a 10% surcharge for each 12 months of delay in enrollment and/or reenrollment. Under certain conditions, select beneficiaries are exempt from the delayed enrollment penalty; these include working individuals (and their spouses) with group coverage through their current employment, some military retirees, and some international volunteers.

While Part A is financed primarily by payroll taxes paid by current workers, Part B is financed through a combination of beneficiary premiums and federal general revenues. The standard Part B premiums are set to cover 25% of projected per capita Part B program costs for the aged, with federal general revenues accounting for the remaining amount. In general, if projected Part B costs increase or decrease, the premium rises or falls proportionately. However, the Social Security Act includes a provision that holds most Social Security beneficiaries harmless for increases in the Medicare Part B premium; affected beneficiaries’ Part B premiums are reduced to ensure that their Social Security benefits do not decline from one year to the next.

Most Part B participants must pay monthly premiums, which do not vary with a beneficiary’s age, health status, or place of residence. However, since 2007, higher-income enrollees pay higher premiums to cover a higher percentage of Part B costs. Premiums of those receiving benefits through Social Security are deducted from their monthly payments. Additionally, certain low-income beneficiaries may qualify for Medicare cost-sharing and/or premium assistance from Medicaid through a Medicare Savings Program.

Each year, the Centers for Medicare & Medicaid Services (CMS) determines the Medicare Part B premiums for the following year. The standard monthly Part B premium for 2015 is \$104.90. Higher-income beneficiaries, currently defined as those with incomes over \$85,000 a year, or couples with incomes over \$170,000 per year, pay \$146.90, \$209.80, \$272.70, or \$335.70 per month, depending on their income levels.

Current issues related to the Part B premium that may come before Congress include the amount of the premium and its rate of increase (and the potential net impact on Social Security benefits), modifications to the late enrollment penalty, and possible increases in Medicare premiums as a means to reduce federal spending and deficits.

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## Introduction

Medicare is a federal insurance program that pays for covered health care services of most individuals aged 65 and over and certain disabled persons. Medicare serves approximately one in six Americans and virtually all of the population aged 65 and over. In calendar year (CY) 2015, the program is expected to cover about 55 million persons (46 million aged and 9 million disabled) at a total cost of \$649 billion, accounting for approximately 3.5% of GDP.<sup>1</sup> The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS).

Medicare consists of four parts—Parts A through D. Part A covers hospital services, skilled nursing facility services, home health visits, and hospice services. Part B covers a broad range of medical services and supplies, including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Enrollment in Part B is voluntary, however most beneficiaries (about 92%) with Part A also enroll in Part B. Part C (Medicare Advantage) provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.<sup>2</sup>

Each part of Medicare is funded differently.<sup>3</sup> Part A is financed primarily through payroll taxes imposed on current workers (2.9% of earnings, shared equally between employers and workers) which is credited to the Hospital Insurance (HI) Trust Fund. Beginning in 2013, workers with annual wages over \$200,000 for single tax filers, or \$250,000 for joint filers, pay an additional 0.9%.<sup>4</sup> Beneficiaries generally do not pay premiums for Part A. In 2015, total Part A (HI) expenditures are expected to reach \$276 billion, representing about 43% of program costs. Parts B and D, the voluntary portions, are funded through the Supplementary Medical Insurance (SMI) Trust Fund, which is financed primarily by general revenues (transfers from the Treasury) and premiums paid by enrollees. In 2015, about \$3 billion in fees on manufacturers and importers of brand-name prescription drugs will also be used to supplement the SMI trust fund.<sup>5</sup> In 2015, Part B expenditures are expected to reach about \$281 billion and Part D expenditures are expected to reach about \$93 billion, representing 43% and 14% of program costs, respectively. (Part C is financed proportionately through the HI and SMI Trust Funds; expenditures for Parts A and B services provided under Part C are included in the above expenditure figures.)

Part B beneficiary premiums are set at a rate each year equal to 25% of expected per capita Part B program costs for the aged for the year.<sup>6</sup> In 2015, most beneficiaries pay the standard monthly Part B premium of \$104.90.<sup>7</sup> Higher-income enrollees pay higher premiums set to cover a higher

<sup>1</sup> Estimates from the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 22, 2015, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>.

<sup>2</sup> For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

<sup>3</sup> See CRS Report R43122, *Medicare Financial Status: In Brief*, by Patricia A. Davis, and CRS Report R41436, *Medicare Financing*, by Patricia A. Davis.

<sup>4</sup> See Internal Revenue Service, *Questions and Answers for the Additional Medicare Tax*, at <http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax>.

<sup>5</sup> For additional information see archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey.

<sup>6</sup> Beneficiary premiums cover approximately 13.2% of the costs of “traditional” Medicare (Parts A and B combined), 12.6 % from Part B premiums, and 0.6 % from voluntary Part A premiums. See **Appendix D** for information on Part A premiums.

<sup>7</sup> Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015,” 79 *Federal Register* 61314, October 10, 2014, at (continued...)

percentage of Part B costs,<sup>8</sup> while those with low incomes may qualify for premium assistance through one of several Medicare Savings Programs administered by Medicaid.<sup>9</sup> Individuals who receive Social Security or Railroad Retirement Board retirement or disability benefits have their Part B premiums automatically deducted from their benefit checks. Part B premiums are generally announced in the fall prior to the year that they are in effect (for example, the 2015 Part B premiums were announced in October 2014).<sup>10</sup>

In addition to premiums, Part B beneficiaries must also pay other out-of-pocket costs when they use services. The annual deductible for Part B services is \$147 in 2015. After the annual deductible is met, beneficiaries are responsible for coinsurance costs, which are generally 20% of Medicare-approved Part B expenses.

This report provides an overview of Medicare Part B premiums, including information on Part B eligibility and enrollment, late enrollment penalties, collection of premiums, determination of annual premium amounts, premiums for high-income enrollees, premium assistance for low-income enrollees, protections for Social Security recipients from rising Part B premiums, and historical Medicare Part B premium trends. This report also provides a summary of various premium-related issues that may be of interest to Congress. Specific Medicare and Social Security publications and other resources for beneficiaries, and those who provide assistance to them, are cited where appropriate.

## Medicare Part B Eligibility and Enrollment

An individual (or the spouse of an individual) who has worked in covered employment and paid Medicare payroll taxes for 40 quarters is entitled to receive premium-free Medicare Part A benefits upon turning 65. Those who have paid in for fewer than 40 quarters may enroll in Medicare Part A by paying a premium.<sup>11</sup> All persons entitled to Part A (regardless of whether they are eligible for premium-free Part A) are also entitled to enroll in Part B. An aged person not entitled to Part A may enroll in Part B if he or she is aged 65 or over and either a U.S. citizen, or an alien lawfully admitted for permanent residence, who has resided in the United States continuously for the immediately preceding five years.

Those who are receiving Social Security or Railroad Retirement Board (RRB) benefits are automatically enrolled in Medicare, and coverage begins the first day of the month they turn 65.<sup>12</sup> These individuals will receive a Medicare card and a “Welcome to Medicare” package about three months before their 65<sup>th</sup> birthday.<sup>13</sup> Those who are automatically enrolled in Medicare Part

(...continued)

<http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf>.

<sup>8</sup> Depending on their level of income, beneficiaries subject to the income-related monthly adjustment pay a total monthly premium of 35%, 50%, 65%, or 80% of expected per capita Part B costs for the aged. See “Income-Related Premium.”

<sup>9</sup> See Medicare.gov, “Medicare Savings Programs” at <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html>.

<sup>10</sup> The 2014 Part B premium rates were announced on October 9, 2014. See U.S. Department of Health and Human Services, “2015 Medicare Part B Premiums and Deductibles to Remain the Same as Last Two Years,” press release, October 9, 2014, at <http://www.hhs.gov/news/press/2014pres/10/20141009a.html>.

<sup>11</sup> For additional information on Part A premiums, see **Appendix D**.

<sup>12</sup> For additional information on enrolling in Medicare Parts A and B, see Medicare publication “Enrolling in Medicare Part A & Part B,” at <http://www.medicare.gov/Pubs/pdf/11036.pdf>.

<sup>13</sup> See “Welcome to Medicare” publication at <http://www.medicare.gov/Publications/Pubs/pdf/11095.pdf>. When first (continued...)

A are also automatically enrolled in Part B.<sup>14</sup> However, because beneficiaries must pay a premium for Part B coverage, they have the option of turning it down.<sup>15</sup> Disabled persons who have received cash payments for 24 months under the Social Security or RRB disability programs also automatically receive a Medicare card and are enrolled in Part B unless they specifically decline such coverage.<sup>16</sup> Those who choose to receive coverage through a Medicare Advantage plan (Part C) must enroll in Part B.

Persons who are not receiving Social Security or RRB benefits, for example because they are still working<sup>17</sup> or have deferred enrollment because they have not yet reached their full retirement benefit eligibility age,<sup>18</sup> must file an application with the Social Security Administration or RRB for Medicare benefits.<sup>19</sup> There are two kinds of enrollment periods, one that occurs when individuals are initially eligible for Medicare, and the later, an annual general enrollment period for those who missed signing up during their initial enrollment period. A beneficiary may drop Part B enrollment and reenroll an unlimited number of times, however premium penalties may be incurred.

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becoming eligible for Medicare, beneficiaries need to make a number of choices regarding the benefits they wish to sign up for and how they wish to receive them. For example, new enrollees need to decide whether they wish to remain in traditional Medicare (Parts A and B, the default option) or if they would like to receive their A and B benefits through a private Medicare Advantage Plan (Part C). Additionally, beneficiaries will need to decide whether they would like to sign up for an outpatient prescription drug plan (Part D). These options are described in the “Welcome to Medicare” package. For free personalized health insurance counseling, beneficiaries may contact their local State Health Insurance Assistance Programs (SHIPs); contact information may be found at <http://www.medicare.gov/contacts/> and <https://www.shiptalk.org/About/SHIPProfileSearchForm.aspx>.

<sup>14</sup> Those who live in Puerto Rico are not automatically enrolled in Medicare Part B. See Social Security Administration Publication “Medicare in Puerto Rico,” at <http://www.socialsecurity.gov/pubs/EN-05-10521.pdf>. They need to sign up for it during the initial enrollment period or possibly be subject to a penalty. H.R. 1418, S. 1453, and S. 1961 introduced in the 114<sup>th</sup> Congress, would extend this automatic enrollment to residents of Puerto Rico, and create a special enrollment period and reduce late enrollment penalties for those who did not sign up for Part B when first eligible.

<sup>15</sup> Should a beneficiary decline Part B coverage, a new Medicare card will be issued that indicates that the beneficiary has Part A coverage only.

<sup>16</sup> Individuals with Amyotrophic Lateral Sclerosis (ALS) are not subject to the 24 month waiting period and Medicare coverage begins the first day of the month during which disability benefits start. Additionally, the Medicare coverage period for persons diagnosed with end-stage renal disease (ESRD) generally begins in the third month after the month when dialysis begins.

<sup>17</sup> For additional information, see CMS, “Helping You Help Your Employees with Medicare Enrollment,” September 25, 2015, at <http://blog.cms.gov/2015/09/25/helping-you-help-your-employees-with-medicare-enrollment/> and CMS, “Employer Community: Information about Medicare Enrollment,” at <https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers/Employer-Community.html>.

<sup>18</sup> In the past, individuals were generally eligible to receive both full Social Security retirement benefits and Medicare coverage starting at the age of 65. However, the age to receive full retirement benefits has changed for some people, depending on the year they were born. For example, those turning 65 in 2015 will not be eligible for full Social Security benefits until the age of 66. See <http://www.ssa.gov/planners/retire/retirechart.html>.

<sup>19</sup> To apply, individuals can call or visit their local Social Security office or call Social Security at 1-800-772-1213. Some people may also apply online if they meet certain rules, at <http://www.ssa.gov/medicareonly/>. For RRB retirees, application information may be found at <http://www.rrb.gov/forms/opa/rb20/rb20.asp>. See also Social Security Administration Publication “Apply Online For Medicare In Less Than 10 Minutes—Even If You Are Not Ready To Retire,” at <http://www.socialsecurity.gov/pubs/EN-05-10530.pdf>, and “How to Apply Online for Medicare Only,” at <http://www.socialsecurity.gov/pubs/EN-05-10531.pdf>.

## Initial Enrollment Periods

Those who are not automatically enrolled in Medicare may sign up during a certain period when they first become eligible. The *initial enrollment* period is seven months long and begins three months before the month in which the individual first turns 65. (See **Table 1.**) Beneficiaries who do not file an application for Medicare benefits during their initial enrollment period could be subject to the Part B delayed enrollment penalty (see “Late Enrollment Premium Penalty and Exemptions” below). If an individual accepts the automatic enrollment in Medicare Part B, or enrolls in Medicare Part B during the first three months of the initial enrollment period, coverage will start with the month in which an individual is first eligible, that is, the month of the individual’s 65<sup>th</sup> birthday. Those who enroll during the last four months will have their coverage start date delayed from one to three months after enrollment.<sup>20</sup> The initial enrollment period of those eligible for Medicare based on disability or permanent kidney failure is linked to the date the disability or treatment began.<sup>21</sup>

**Table 1. Initial Enrollment Period**  
Month of Enrollment and Effective Dates

	<b>3 months before the month one turns 65</b>	<b>The month during which one turns 65</b>	<b>Up to 3 months after the month one turns 65</b>
<b>Effective Dates</b>	If one signs up during the first 3 months of one’s initial enrollment period, Part B coverage starts the 1 <sup>st</sup> day of one’s birthday month. <sup>a</sup>	If one enrolls during one’s birthday month, the start date will be the 1 <sup>st</sup> day of the next month.	The start date will be delayed if one enrolls during the last 3 months of the initial enrollment period. <ul style="list-style-type: none"> <li>• If one signs up in the month after the month one turns 65, coverage starts 2 months after enrollment.</li> <li>• If one signs up 2 or 3 months after the month one turns 65, coverage starts 3 months after enrollment.</li> </ul>
<b>Example for someone turning 65 during the month of June</b> The 7 month initial enrollment period would run from March 1 <sup>st</sup> through September 30 <sup>th</sup> .	If one enrolls in March, April, or May, coverage begins June 1 <sup>st</sup> .	If one enrolls in June, coverage begins July 1 <sup>st</sup> .	<ul style="list-style-type: none"> <li>• If one enrolls in July, coverage begins September 1<sup>st</sup>.</li> <li>• If one enrolls in August, coverage begins November 1<sup>st</sup>.</li> <li>• If one enrolls in September, coverage begins December 1<sup>st</sup>.</li> </ul>

**Source:** Social Security Administration Publication No. 05-10043.

- a. If one’s birthday falls on the 1<sup>st</sup> of the month, then the enrollment period starts a month earlier and coverage may begin on the 1<sup>st</sup> day of the month prior to one’s birthday month.

<sup>20</sup> An eligibility, enrollment date, and premium calculator may be found on the Medicare.gov website at <https://www.medicare.gov/eligibilitypremiumcalc/>.

<sup>21</sup> For additional information on eligibility for the disabled under 65, see archived CRS Report RS22195, *Social Security Disability Insurance (SSDI) and Medicare: The 24-Month Waiting Period for SSDI Beneficiaries Under Age 65*, by Scott D. Szymendera.



## General Enrollment Period

An individual who does not sign up for Medicare during the initial enrollment period must wait until the next *general enrollment* period. In addition, persons who decline Part B coverage when first eligible, or terminate Part B coverage, must also wait until the next general enrollment period to enroll or reenroll. The general enrollment period lasts for three months from January 1<sup>st</sup> to March 31<sup>st</sup> of each year, with coverage beginning on July 1<sup>st</sup> of that year. A delayed enrollment penalty may apply.<sup>22</sup>

## Late Enrollment Premium Penalty and Exemptions

Beneficiaries who do not sign up for Part B when first eligible, or who drop it and then sign up again later, may have to pay a late enrollment penalty for as long as they are enrolled in Part B.<sup>23</sup> Monthly premiums for Part B may go up 10% for each full 12-month period that one could have had Part B, but did not sign up for it (see “Calculation of Penalty” below). Some may be exempt from paying a late enrollment penalty if they meet certain conditions that allow them to sign up for Part B during a Special Enrollment Period (SEP). (See “Exemptions to Penalty.”) In 2014, about 1.4% of Part B enrollees (about 750,000) paid this penalty.<sup>24</sup> On average, their total premiums (standard premium plus penalty) were about 29% higher than what they would have been had they not been subject to the penalty.

Those who receive premium assistance through a Medicare Savings Program do not pay the late enrollment penalty.<sup>25</sup> Additionally, for those disabled persons under the age of 65 subject to a premium penalty, once the individual reaches the age of 65, he or she qualifies for a new enrollment period and would no longer pay a penalty.

The penalty provision was included in the original Medicare legislation enacted in 1965 to help prevent adverse selection by creating a strong incentive for all eligible beneficiaries to enroll in Part B.<sup>26</sup> Adverse selection occurs when only those persons who think they need the benefits actually enroll in the program. When this happens, per capita costs are driven up, and premiums go up, thereby causing more persons (presumably the healthier and less costly ones) to drop out of the program.<sup>27</sup> With most eligible persons over the age of 65 enrolled in Part B, the costs are

<sup>22</sup> The Part B general enrollment period is different from the Medicare Advantage and Part D annual enrollment period which runs from October 15 to December 7 each year with coverage effective the following January.

<sup>23</sup> For more information, see Medicare.gov “Part B Late Enrollment Penalty,” at <http://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html>.

<sup>24</sup> Figures provided to CRS by the Centers for Medicare & Medicaid Services, September 2015.

<sup>25</sup> The state pays the standard premium regardless of the date the beneficiary first became eligible for Medicare Part B. See Social Security Program Operations Manual, Section HI 00815.001, “State Buy-In Program General Description” at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0600815001>; and Section HI 00815.039, “Effect of Buy-In on the Individual” at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0600815039>.

<sup>26</sup> Social Security Act §1839(b).

<sup>27</sup> Specifically, adverse selection occurs when beneficiaries, who generally have more information than insurers about their own health status and expected health care needs, make insurance purchasing decisions based on their expected use of the insurance benefit. Their decision to purchase insurance is based on a comparison of the value of the insurance coverage, given their expected use, and the cost of the insurance. Should only (or disproportionately) persons who are high health care users enroll in the program, per capita costs would increase, thereby making the health insurance purchase decision less attractive for healthier, and presumably less costly, beneficiaries who then, in turn, might drop out of the program. Subsequent iterations of this cycle would drive premium costs higher and higher for a smaller and smaller subset of ever sicker and costlier beneficiaries.

spread over the majority of this population and per capita costs are less than would be the case if adverse selection had occurred.

As the Part B late enrollment penalty is tied to Medicare eligibility and not to access to covered services, individuals who live in areas where Medicare benefits are generally not provided, such as outside of the United States or in prison, could still be subject to the Part B late enrollment penalty if they do not sign up for (or if they drop) Part B when eligible.<sup>28</sup> To illustrate, if a retired Medicare-eligible individual stopped paying Part B premiums while living overseas for a three-year period, and reenrolled when returning to the United States, he or she would not be entitled to a SEP. This individual would instead need to enroll during the general enrollment period, and may also be subject to late enrollment penalties based on that three-year lapse in coverage.

Additionally, Part B does not have a “creditable” coverage exemption similar to that under the Part D outpatient prescription drug benefit.<sup>29</sup> Except for certain circumstances discussed below, having equivalent coverage does not entitle one to a SEP should one decide to enroll in Part B later. For example, an individual who has retiree coverage similar to Part B and therefore decides not to enroll in Part B when first eligible, could be subject to late enrollment penalties if he or she enrolls in Part B at a later time (for example, because the retiree coverage was discontinued).

## Calculation of Penalty

The delayed enrollment penalty is equal to a 10% premium surcharge for each full 12 months of delay in enrollment and/or reenrollment during which the beneficiary was eligible for Medicare.<sup>30</sup> The period of the delay is equal to (1) the number of months that elapse between the end of the initial enrollment period and the end of the enrollment period in which the individual actually enrolls; or (2) for a person who reenrolls, the months that elapse between the termination of coverage and the close of the enrollment period in which the individual enrolls.

Generally, individuals who do not enroll in Part B within a year of the end of their initial enrollment period would be subject to the premium penalty. For example, if an individual’s initial enrollment period ended in September 2012 and the individual subsequently enrolled during the 2013 general enrollment period (January 1<sup>st</sup> through March 31<sup>st</sup>), the delay would be less than 12

<sup>28</sup> By comparison, to be eligible for the outpatient prescription drug benefit under Part D, a Medicare beneficiary must reside in a geographic area where a Part D plan is available. Individuals who are incarcerated or who live outside the United States are therefore *not eligible* to enroll in (or continue enrollment in) Part D. Because the Part D penalty is based on periods when one is eligible but not enrolled, periods of incarceration or extended residence outside of the United States would not be included in that calculation. For example, an individual living outside of the country during his or her initial enrollment period would be given a special enrollment period (SEP) upon returning to the United States and would be able to sign up for Part D at that time without penalty. See Social Security Administration Program Operations Manual Section HI 03001.001 “Description of the Medicare Part D Prescription Drug Program,” at <https://secure.ssa.gov/poms.nsf/lnx/0603001001>, and CMS Publication, “Understanding Medicare Part C & D Enrollment Periods,” at <http://www.medicare.gov/Pubs/pdf/11219.pdf>.

<sup>29</sup> Under Part D, individuals who have maintained drug coverage equivalent to Medicare’s standard prescription drug coverage prior to enrolling in Part D are not subject to a late enrollment penalty. Examples of “creditable” Part D drug coverage include drug coverage from a former employer or union, TRICARE, the Department of Veteran Affairs (VA), the Federal Employees Health Benefits Program (FEHBP), or the Indian Health Service. As an illustration, if an individual did not sign up for Part D when first becoming eligible because he or she already had equivalent coverage through a former employer, the individual could sign up for Part D at any time without penalty during the time he or she maintained creditable coverage. Should that coverage end, the individual would be entitled to a special enrollment period and could enroll in Part D without penalty. Beneficiaries who have a break in creditable prescription drug coverage usually have 63 consecutive days to enroll in Part D during a SEP.

<sup>30</sup> Social Security Act §1839(b).

months and the individual would not be subject to a penalty. However, if that individual delayed enrolling until the 2015 general enrollment period, the premium penalty would be 20% of that year's standard premium. (Although the elapsed time covers a total of 30 months of delayed enrollment, the episode includes only two full 12-month periods.) An individual who waits more than 10 years to enroll in Part B would pay twice the standard premium amount.

The surcharge is calculated as a percentage of the monthly standard premium amount (e.g., in 2015, \$104.90), and that amount is added to the beneficiary's premium each month.<sup>31</sup> Using the example above, in which the individual is subject to a 20% premium penalty, the total monthly premium in 2015 would be calculated as follows:

<p>Premium Penalty = Standard Premium x Applicable Percentage</p> <p>Standard premium + Premium Penalty = Penalty Adjusted Premium</p> <p><u>Example of a 20% penalty in 2015:</u> \$104.90 + (\$104.90 x 20%) = \$125.88</p>
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For those subject to the high-income premium (see "Income-Related Premium"), the late enrollment surcharge applies only to the standard monthly premium amount and not to the higher income adjustment portion of their premiums. Using the example above, should the beneficiary have an income of between \$85,000 and \$107,000, the applicable income-related adjustment of \$42.00 would be added onto the penalty adjusted premium of \$125.88, for a total monthly premium of \$167.88.<sup>32</sup>

There is no upper limit on the amount of the surcharge that may apply, and the penalty continues to apply for the entire time the individual is enrolled in Part B. Each year, the surcharge is calculated using the standard premium amount for that particular year. Therefore, if premiums increase in a given year, the dollar value of the surcharge will increase as well.

## Exemptions to Penalty

Under certain conditions, select beneficiaries may be exempt from the delayed enrollment penalty. Beneficiaries who are exempt include working individuals (and their spouses) with group coverage, some military retirees, some international volunteers, and those who based their non-enrollment decision on incorrect information provided by a federal representative. Individuals who are permitted to delay enrollment have their own *special enrollment periods* (SEP).

### Current Workers

A working individual and/or the spouse of a working individual may be able to delay enrollment in Medicare Part B without being subject to the delayed enrollment penalty. Delayed enrollment is permitted when an individual aged 65 or over has group health insurance coverage based on the individual's or spouse's *current employment* (with an employer with 20 or more employees).

<sup>31</sup> A late premium calculator may be found on the Medicare.gov website at <http://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html>.

<sup>32</sup> For additional information, see Social Security Administration Programs Operation Manual Section HI 01101.031, "How IRMAA is Calculated and How IRMAA Affects the Total Medicare Premium," at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0601101031>.

About 1.9 million of the 2.6 million working aged population are enrolled in Part A only, with most of the rest enrolled in both Parts A and B.<sup>33</sup> Delayed enrollment is also permitted for certain disabled persons who have group health insurance coverage based on their own or a family member's *current employment* with a large group health plan. For the disabled, a large group health plan is defined as one which covers 100 or more employees.

Specifically, persons permitted to delay coverage without penalty are those persons whose Medicare benefits are determined under the Medicare Secondary Payer program.<sup>34</sup> Under the Medicare Secondary Payer rules, an employer (with 20 or more employees) is required to offer workers aged 65 and over (and workers' spouses aged 65 and over) the same group health insurance coverage that is made available to other employees.<sup>35</sup> The worker has the option of accepting or rejecting the employer's coverage. If he or she accepts the coverage, the employer plan is primary (i.e., pays benefits first) for the worker and/or spouse aged 65 or over, and Medicare becomes the secondary payer (i.e., fills in the gaps in the employer plan, up to the limits of Medicare's coverage). Similarly, a group health plan offered by an employer with 100 or more employees is the primary payer for its employees under 65 years of age, or their dependents, who are entitled to Medicare because of disability.<sup>36</sup>

Such individuals may sign up for Medicare Part B (or Part A) anytime that they (or their spouse) are still working, and they are covered by a group health plan through the employer or union based on that work. Additionally, those who qualify for Medicare based on age may sign up during the eight-month period after employment or group health plan coverage ends, *whichever happens first*. (If an individual's group health plan coverage, or the employment on which it is based, ends during the *initial enrollment period*, that individual would not qualify for a SEP.)<sup>37</sup> Disabled individuals whose group plan is involuntarily terminated have six months to enroll without penalty.<sup>38</sup>

Individuals who fail to enroll during this special enrollment period are considered to have delayed enrollment and thus could become subject to the penalty. For example, even though an individual

<sup>33</sup> 2014 *Medicare Working-Aged Beneficiary Counts* from CMS 100% Unloaded Enrollment Database.

<sup>34</sup> Social Security Act §1837(i) and 42 CFR §407.20. See Medicare Publication "Medicare and Other Health Benefits: Your Guide to Who Pays First," at <http://www.medicare.gov/publications/pubs/pdf/02179.pdf> and CMS Medicare Secondary Payer webpage at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html>. Also see CRS Report RL33587, *Medicare Secondary Payer: Coordination of Benefits*, by Suzanne M. Kirchoff.

<sup>35</sup> The requirement that large employers' coverage pays primary for Medicare-eligible employees was created by the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) and amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

<sup>36</sup> For Medicare-eligible beneficiaries employed by organizations with fewer than 20 employees (or fewer than 100 employees for the disabled), Medicare generally pays primary and the employer group health plan generally pays secondary. In such cases, employers may offer coverage that wraps around the Medicare benefit and beneficiaries may need to enroll in Medicare Part B when first eligible to avoid potential late enrollment penalties and/or gaps in coverage. Individuals who are turning 65 and still working should check with their employers' benefit administrator to learn how their employer health coverage works with Medicare.

<sup>37</sup> See "Special Enrollment Period" section of Social Security webpage: "Retirement Planner: Applying for Medicare Only" at <http://www.socialsecurity.gov/retire2/justmedicare.htm>.

<sup>38</sup> The Balanced Budget Act of 1997 (BBA, P.L. 105-33) added this exception to the penalty. This exception is for disabled persons who: (a) at the time they first become eligible for Part B are enrolled in a group health plan (regardless of size) by virtue of their current or former employment, and (b) whose continuous enrollment under the plan is involuntarily terminated at a time when their enrollment in the plan is by virtue of their or their spouse's former (i.e., not current) employment. These individuals have a special 6-month enrollment period beginning on the first day of the month in which the termination occurs.

may have continued health coverage through the former employer after retirement or have COBRA coverage,<sup>39</sup> he or she must sign up for Part B within eight months of retiring to avoid paying a Part B penalty if the individual eventually enrolls. Individuals who return to work and receive health care coverage through that employment may be able to drop Part B coverage, qualify for a new special enrollment period upon leaving that employment, and reenroll in Part B again without penalty as long as enrollment is completed within the specified timeframe.

### **Certain Military Retirees**

Some military retirees may also be exempt from the late enrollment penalty. Health care coverage for military retirees was expanded by the Floyd D. Spence National Defense Authorization Act for FY2001 (P.L. 106-398). This law established the TRICARE for Life (TFL) program, which acts as a secondary payer to Medicare and provides supplemental coverage to TRICARE-eligible beneficiaries who are entitled to Medicare Part A and have Medicare Part B, based on age, disability, or end-stage renal disease (ESRD). The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, Section 3110) established a 12-month special enrollment period (SEP) for certain individuals who are otherwise eligible for TRICARE and are entitled to Medicare Part A based on disability or ESRD, but have declined Part B. The Secretary of Defense is required to identify and notify individuals of their eligibility for this Special Enrollment Period. The SEP begins the first day of the month following the end of the individual's initial enrollment period, or if later, the month the individual is notified that s/he is entitled to Medicare Part A and Part B. The late enrollment surcharge is waived for those who enroll during the SEP. (If the individual does not enroll during the SEP, he or she may only enroll during the General Enrollment Period and the late enrollment surcharge could apply.)

### **International Volunteers**

Some international volunteers may also be exempt from the Part B late enrollment penalty. The Deficit Reduction Act of 2005 (P.L. 109-171) permits certain individuals to delay enrollment in Part B without a delayed enrollment penalty if they volunteered outside of the United States for at least 12 months through a program sponsored by a tax-exempt organization defined under Section 501(c)(3) of the Internal Revenue Code.<sup>40</sup> These individuals must demonstrate that they had health insurance coverage while serving in the international program. Individuals permitted to delay enrollment have a six-month special enrollment period, which begins on the first day of the first month they no longer qualify under this provision.

### **Equitable Relief**

Under certain circumstances, a special enrollment period may be created and/or late enrollment penalties may be waived if a Medicare beneficiary can establish that an error, misrepresentation, or inaction of a federal worker or an agent of the federal government (such as an employee of the Social Security Administration, CMS, or a Medicare administrative contractor) resulted in late Part B enrollment.<sup>41</sup> In order to qualify for an exception under these conditions, the beneficiary must provide documentary evidence of the error, which “can be in the form of statements from

<sup>39</sup> For a description of COBRA, see Department of Labor, “COBRA Continuation Coverage,” at <http://www.dol.gov/ebsa/cobra.html>.

<sup>40</sup> Social Security Act §1837(k) and 42 CFR §407.21.

<sup>41</sup> Social Security Act §1837(h) and 42 CFR §407.32.

employees, agents, or persons in authority that the alleged misinformation, misadvice, misrepresentation, inaction, or erroneous action actually occurred.”<sup>42</sup>

## Collection of the Part B Premium

If a person is enrolled in both Medicare Part B and Social Security, the Part B premiums are deducted from the person’s Social Security benefit.<sup>43</sup> In addition, railroad retirees and civil service annuitants have their Part B premiums deducted from their monthly checks when possible. This withholding does not apply to those beneficiaries receiving state public assistance through a Medicare Savings Program as their premiums are paid by their state Medicaid program (see “Premium Assistance for Low-Income Beneficiaries”). Beneficiaries who are not entitled to a monthly cash benefit from Social Security, a railroad retirement annuity or pension, or a federal civil service annuity must pay the Part B premium directly to CMS.<sup>44</sup>

## Deduction of Part B Premiums from Social Security Checks

By law, a Social Security beneficiary who is enrolled in Medicare Part B must have the Part B premium automatically deducted from his or her Social Security benefits.<sup>45</sup> Automatic deduction from the Social Security benefit check also applies to Medicare Advantage participants who are enrolled in private health-care plans in lieu of traditional Medicare.<sup>46</sup> About 66% of Social Security beneficiaries (39 million persons) have Medicare Part B premiums deducted from their benefit checks.<sup>47</sup>

Social Security beneficiaries who do not pay Medicare Part B premiums include those who are under the age of 65 and don’t yet qualify for Medicare (e.g., began receiving Social Security benefits at the age of 62), receive low-income assistance from Medicaid to pay the Part B premium, have started to receive Social Security disability insurance (SSDI) but are not eligible for Medicare Part B because they have not received SSDI for 24 months, or chose not to enroll in Medicare Part B.

The amount of an individual’s Social Security benefits cannot go down one year to the next as a result of the annual Part B premium increase, except in the case of higher-income individuals subject to income-related premiums. (See “Protection of Social Security Benefits from Increases in Medicare Part B Premiums.”) For those beneficiaries “held harmless,” the dollar amount of their Part B premium increases would be held below or equal to the amount of the increase in their monthly Social Security benefits.

<sup>42</sup> For additional information, see Social Security Program Operations Manual Section HI 00805.170 *Conditions for Providing Equitable Relief*, at <https://secure.ssa.gov/poms.nsf/lnx/0600805170> and Section HI 00805.175 *Evidence of Government Error or Delay*, at <https://secure.ssa.gov/poms.nsf/lnx/0600805175>.

<sup>43</sup> Social Security Act §1840(a)(1).

<sup>44</sup> 42 C.F.R. §408.60.

<sup>45</sup> Social Security Act §1840(a)(1).

<sup>46</sup> Beneficiaries who receive their Parts A and B benefits through Medicare Advantage (MA, Part C), must still pay the monthly Part B premium, but may pay different amounts. For example, some MA plans may offer an additional benefit by reducing the amount one pays for the Part B premium. Alternatively, some MA plans may be more expensive than traditional Medicare, for example because they provide benefits beyond what is provided under traditional Medicare, and may charge a premium in addition to the Part B premium. The Social Security Administration has in place a “safety net” to prevent the deduction of more than \$300 of Part C and Part D plan premiums from a single Social Security check. For amounts over \$300, the enrollee may be billed directly.

<sup>47</sup> Number of people as of April 2015. Figures provided to CRS by the Social Security Administration.

## Part B Enrollees Who Do Not Receive Social Security Benefits

About 3% of Medicare Part B enrollees do not receive Social Security benefits.<sup>48</sup> For example, certain persons who spent their careers in employment that was not covered by Social Security, including certain federal, state, or local government workers, and certain other categories of workers, do not receive Social Security benefits, but may still qualify for Medicare. For those who receive benefit payments from the Railroad Retirement Board (RRB)<sup>49</sup> or the Civil Service Retirement System (CSRS),<sup>50</sup> Part B premiums are deducted from the enrollees' monthly benefit payments. While RRB retirement benefit amounts are protected by the hold-harmless provision, CSRS benefits are not held harmless from increases in the Part B premium. For those who do not receive these types of benefit payments, Medicare will bill directly for their premiums every three months.<sup>51</sup> Nonpayment of premiums results in termination of enrollment in the Part B program, although a grace period (through the last day of the third month following the month of the due date) is allowed for beneficiaries who are billed and pay directly.<sup>52</sup>

## Determining the Part B Premium

Each year, the CMS actuaries estimate total per capita Part B costs for beneficiaries aged 65 and older over for the following year and set the Part B premium to cover 25% of these expected expenditures.<sup>53</sup> However, because prospective estimates may differ from the actual spending for the year, contingency reserve adjustments are made to ensure sufficient income to accommodate potential variation in actual expenditures during the year. The Part B premium is a single national amount that does not vary with a beneficiary's age, health status, or place of residence. Premiums may be adjusted, however, for late enrollment (see "Late Enrollment Premium Penalty and Exemptions") and for beneficiaries with high incomes (see "Income-Related Premiums").

## Premium Calculation for 2015<sup>54</sup>

Monthly Part B premiums are based on the estimated amount that would be needed to finance Part B expenditures on an incurred basis during the year. In estimating needed income and to

<sup>48</sup> Figure provided to CRS by the Centers for Medicare & Medicaid Services, September 2015.

<sup>49</sup> Social Security Act §1840(b)(1).

<sup>50</sup> Generally, employees of the federal government hired before 1984 are covered by the Civil Service Retirement System (CSRS) and are not covered by Social Security. Most federal workers first hired into federal service on or after January 1984, participate in the Federal Employees' Retirement System (FERS) which includes Social Security coverage. However, the Tax Equity and Fiscal Responsibility Act (P.L. 97-248) enabled federal workers to be eligible for Medicare based on their federal employment. See CRS Report R42741, *Laws Affecting the Federal Employees Health Benefits (FEHB) Program*, by Kirstin B. Blom and Ada S. Cornell.

<sup>51</sup> Payment may be made by check, money order, or credit card; or one may schedule it to be automatically deducted from one's bank account. Premium billing form and information may be found at <http://www.medicare.gov/forms-help-and-resources/mail-about-medicare/notice-of-medicare-premium-payment-due.html>.

<sup>52</sup> This grace period may be extended for up to an additional three months if the enrollee can establish that non-payment was due to circumstances beyond his or her control, such as being physically or mentally incapable of making premium payments or due to an administrative error.

<sup>53</sup> Part B premium announcements are generally made in the fall prior to the effective year. For example, the 2015 Part B premium rate was announced in October of 2014.

<sup>54</sup> Centers for Medicare & Medicaid Services, "Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015," 79 *Federal Register* 61314, October 10, 2014, at <http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf>.

account for potential variation, CMS takes into consideration the difference in prior years of estimated and actual program costs, the likelihood and potential impact of potential legislation affecting Part B in the coming year, and the expected relationship between incurred and cash expenditures (e.g., payments for some services provided during a particular year may not be paid until the following year). Once the premium has been set for a year, it will not be changed during that year.

While both aged and disabled Medicare beneficiaries may enroll in Part B, the statute provides that Part B premiums are to be based only on the expected program costs, that is, the *monthly actuarial rate*, for the aged (those 65 and over). (See **Appendix A** for a discussion of the history of the premium methodology.) Part B costs not covered by premiums are paid for through transfers from the general fund of the Treasury. The monthly actuarial rates for *both* the aged and disabled enrollees are used to determine the needed amount of general revenue funding per beneficiary each month (one-half of the expected average monthly cost for each aged enrollee and one-half of the expected cost for each disabled enrollee).

To determine the 2015 monthly Part B premium amount, CMS first estimated the monthly actuarial rate for enrollees aged 65 and older using actual per-enrollee costs by type of service from program data through 2013 and projected these costs for subsequent years. For 2015, CMS estimated that the monthly amount needed to cover one-half of the total benefit and administration costs for the aged would be \$208.61. However, because of expected variations between projected and actual costs, a contingency adjustment of \$3.41 was added to this amount (see “Contingency Reserve” below). After a reduction of \$2.22 to account for expected interest on trust fund assets, the monthly actuarial rate for the aged was determined to be \$209.80. As premiums are only based on projections of expected costs of the aged, and the actuarial monthly amount for the aged accounts for one-half of projections of total costs (with the actuarial monthly amount for the disabled making up the other half), the 2015 Part B premium amount is one-half of \$209.80, or \$104.90 per month (25% of the monthly expected per capita costs of the aged).

## Contingency Reserve

The contingency reserve is the amount set aside to cover an appropriate degree of variation between actual and projected costs. In recent years, CMS has noted that Part B expenditures have been higher than expected under current law.<sup>55</sup> In some cases, legislation that resulted in increased Medicare Part B expenditures for the year was enacted after the premium for the year had been set. For example, at the time that the 2015 premiums were being determined, the law specified a physician payment formula called the sustainable growth rate system (SGR) for calculating the annual update to the conversion factor used to determine payments under the physician fee schedule.<sup>56</sup> The SGR formula has called for a reduction in the update factor (i.e., lower reimbursement rates) for each year since 2003. However, Congress has overridden the payment cut in every year except one, by passing legislation that has either frozen or slightly increased the reimbursement rates. These actions have often led to discrepancies between the actual and projected Part B costs.

<sup>55</sup> Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015,” 79 *Federal Register* 61314, October 10, 2014, at <http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf>.

<sup>56</sup> For additional information on the Medicare physician rate system, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.



In calculating the premium for 2015, CMS recognized the possibility that Congress would override the scheduled reduction of about 21.1% in physician fees beginning in April 2015 (thereby significantly increasing Part B expenses), and provided for the maintenance of a somewhat higher contingency reserve than would otherwise be necessary in calculating the 2015 premium.<sup>57</sup>

Additionally, starting in 2011, manufacturers and importers of brand-name drugs began paying a fee that is allocated to the SMI trust fund. The contingency reserve was thus reduced to account for this additional revenue. Further, certain payment incentives to encourage the development and use of health information technology (HIT) by Medicare physicians are excluded from premium determinations. (HIT bonuses or penalties will be directly offset through transfers of general funds from the Treasury.) The 2015 contingency margin adjustment of \$3.41 reflects the expected net effects of all of these factors.

## Income-Related Premiums

For the first 41 years of the Medicare program, all Part B enrollees paid the same Part B premium regardless of their income. However, the Medicare Modernization Act of 2003 (MMA; P.L. 108-173)<sup>58</sup> required that, beginning in 2007, high-income enrollees pay higher premiums.<sup>59</sup> About 5.6% of Medicare beneficiaries pay these higher premiums in 2015.<sup>60</sup>

Adjustments are made to the Part B premiums for high-income beneficiaries with the share of expenditures paid by beneficiaries increasing with income. This share ranges from 35% to 80% of the value of Part B coverage. In 2015, individuals whose income exceeds \$85,000, and couples whose combined income exceeds \$170,000, are subject to higher premium amounts. Income thresholds used in determining high-income Part B premiums for 2011 through 2017 are frozen at the 2010 levels.<sup>61</sup> The current law provision that prevents a beneficiary's Social Security benefits

<sup>57</sup> The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) was enacted on April 16, 2015. MACRA froze physician payment rates for three months, increased them by 0.5 percent for services furnished during the last six months of CY2015, and will then increase them by 0.5 percent a year for services furnished during calendar years 2016 through 2019. Over the next several years, the bill replaces the SGR formula with new payment systems. For additional information, see CRS Report R43962, *H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015*, coordinated by Jim Hahn and Kirstin B. Blom.

<sup>58</sup> The MMA would have phased in the increase over five years; however, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) shortened the phase-in period to three years.

<sup>59</sup> At the time of enactment of the MMA, the Congressional Budget Office (CBO) estimated that 1.2 million persons (3% of beneficiaries) would pay higher premiums in 2007; and 2.8 million persons (6% of beneficiaries) would pay higher premiums in 2013. CBO further estimated that the MMA provision would reduce federal outlays by \$13.3 billion over the 2007-2013 period. CBO estimated that the DRA provision accelerating the phase-in would increase premium collections by \$1.6 billion over the 2007-2010 period. The MMA estimate and the DRA estimate were each made by CBO at the time of enactment of each law. Both estimates were based on the CBO budget baseline in effect at the time. As is the case for all CBO estimates, the earlier estimates are incorporated into subsequent CBO baselines. Therefore the two savings estimates cannot be added together.

<sup>60</sup> Calculation based on "2015 Social Security/SSI/Medicare Information," at <http://www.ssa.gov/legislation/2015%20Fact%20Sheet.pdf>.

<sup>61</sup> Section 3402 of the Patient Protection and Affordable Care Act (P.L. 111-148) froze the thresholds used to determine high-income premiums at the 2010 level. These levels will be maintained through 2017. In 2018 and 2019, Section 402 of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) maintains the freeze on the income thresholds for the lower two high-income premium tiers but reduces the threshold levels for the two highest income tiers so that more beneficiaries will fall into the higher percentage categories. Beginning in 2020, the thresholds will be adjusted annually for inflation. See CRS Report R43962, *H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015*, coordinated by Jim Hahn and Kirstin B. Blom.

from decreasing from one year to the next as a result of the Part B premium increase does not apply to those subject to an income-related increase in their Part B premiums. (See “Protection of Social Security Benefits from Increases in Medicare Part B Premiums.”)

## Determination of Income

To determine those subject to the high-income premium, Social Security uses the most recent Federal tax return provided by IRS. In general, the taxable year used in determining the premium is the second calendar year preceding the applicable year. For example, the 2014 tax return (2013 income) was used to determine who would pay the 2015 high-income premiums.<sup>62</sup>

High-income adjustments to Part B premiums are referred to as the *income-related monthly adjustment amount* (IRMAA). The income definition on which these premiums are based is modified adjusted gross income (MAGI)<sup>63</sup> which is different from gross income. Specifically, gross income is all income from all sources, minus certain statutory exclusions (e.g., nontaxable Social Security benefits).<sup>64</sup> From gross income, adjusted gross income (AGI)<sup>65</sup> is calculated to reflect a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments. MAGI is defined as AGI plus certain foreign earned income and tax-exempt interest.<sup>66</sup>

If a person had a one-time increase in taxable income in a particular year (such as from the sale of income producing property), that increase would be considered in determining the individual’s total income for that year and thus liability for the income-related premium two years ahead. It would not be considered in the calculations for future years.

In the case of certain major life-changing events that result in a significant reduction in MAGI, an individual may request to have the determination made for a more recent year than the second preceding year.<sup>67</sup> Major life-changing events include (1) death of a spouse; (2) marriage; (3) divorce or annulment; (4) partial or full work stoppage for the individual or spouse; (5) loss by individual or spouse of income from income-producing property when the loss is not at the individual’s direction (such as in the case of a natural disaster); or (6) reduction or loss for individual or spouse of pension income due to termination or reorganization of the plan or scheduled cessation of the pension.<sup>68</sup> Certain types of events, such as those that affect expenses but not income, or result in the loss of dividend income because of the ordinary risk of investment, are not considered major life-changing events.<sup>69</sup>

<sup>62</sup> If an enrollee amended his or her tax return and it changed the income used to determine the high-income adjustments, the updated information may be provided to the Social Security Administration so that it may correct or remove the income-related monthly adjustment amounts.

<sup>63</sup> Defined at Social Security Act §1839(i)(4). See also Social Security Program Operations Manual, HI 01101.010, “Modified Adjusted Gross Income (MAGI),” at <https://secure.ssa.gov/poms.nsf/lnx/0601101010>.

<sup>64</sup> Internal Revenue Code §61.

<sup>65</sup> Internal Revenue Code §62.

<sup>66</sup> The definition of MAGI for IRMAA in Medicare is different from the MAGI definition in certain ACA Medicaid provisions. See CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, coordinated by Evelyne P. Baumrucker.

<sup>67</sup> Social Security Form SSA-44, at <http://www.ssa.gov/online/ssa-44.pdf>.

<sup>68</sup> 20 CFR §418.1205.

<sup>69</sup> 20 CFR §418.1210.

If Medicare enrollees disagree with decisions regarding their income-related monthly adjustment amounts, they may file an appeal with Social Security. Enrollees may either submit a “Request for Reconsideration”<sup>70</sup> or contact their local Social Security office to file an appeal. (An enrollee does not need to file an appeal if he or she is requesting a new decision based on a life-changing event described above, or if the enrollee has shown that Social Security used the wrong information to make the original decision.)

## Income Thresholds and Premium Adjustments

Depending on their level of income, beneficiaries may be classified into one of five income categories.<sup>71</sup> In 2015, individuals with incomes less than \$85,000 a year (\$170,000 for a couple) pay the standard premium which is based on 25% of the average Part B per capita cost. Individuals with incomes over \$85,000 per year and couples with combined income over \$170,000 per year pay a higher percentage of Part B costs. Depending on one’s level of income over these threshold amounts, premiums may be adjusted to cover 35%, 50%, 65%, or 80% of the value of Part B coverage (with the rest being subsidized through federal general revenues). The five income categories and associated premiums for 2015 are shown below in **Table 2**. When both members of a couple are enrolled in Part B, each pays the applicable premium amount.

**Table 2. Monthly Medicare Part B Premiums for 2015**

Levels of Premium Adjustment and Percentage of Costs Covered by Premiums	Beneficiaries Who File an Individual Tax Return with Income:	Beneficiaries Who File a Joint Tax return with Income:	Income-Related Monthly Adjustment Amount (IRMAA)	Total Monthly Premium (standard premium + adjustment)
<b>Standard = 25%</b>	Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$104.90
<b>Level 1 = 35%</b>	Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$42.00	\$146.90
<b>Level 2 = 50%</b>	Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$104.90	\$209.80
<b>Level 3 = 65%</b>	Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$167.80	\$272.70
<b>Level 4 = 80%</b>	Greater than \$214,000	Greater than \$428,000	\$230.80	\$335.70

**Source:** Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015,” 79 *Federal Register* 61314, October 10, 2014, at <http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf>.

**Note:** The above income thresholds will remain the same through 2017.

Married persons who lived with their spouse at some point during the year, but who filed separate returns, are subject to different premium amounts. There are two higher income categories that determine the additional monthly premium adjustment for these beneficiaries. The income levels and premium amounts are shown in **Table 3**.

<sup>70</sup> Social Security Form SSA-561-U2, at <http://www.ssa.gov/online/ssa-561.pdf>.

<sup>71</sup> Social Security Act §1839(i).

**Table 3. Part B Premium Adjustment for Married Beneficiaries Filing Separately for 2015**

<b>Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:</b>	<b>Income-Related Monthly Adjustment Amount (IRMAA)</b>	<b>Total Monthly Premium (standard premium +adjustment)</b>
Less than or equal to \$85,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$129,000	\$167.80	\$272.70
Greater than \$129,000	\$230.80	\$335.70

**Source:** Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015,” 79 *Federal Register* 61314, October 10, 2014, at <http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf>.

**Note:** The above income thresholds will remain the same through 2017.

The original provision establishing the Part B income-related premiums set the initial income threshold and high-income-level ranges. Prior to 2010, annual adjustments to these levels were based on annual changes in the consumer price index for urban consumers (CPI-U), rounded to the nearest \$1,000. However, the ACA froze the income thresholds and ranges at the 2010 level through 2019, rather than allowing them to rise with inflation.<sup>72</sup> This has meant that over time, as incomes have increased with inflation, a greater share of Medicare enrollees are reaching the high-income thresholds and paying the high-income premiums than would have been the case without this freeze.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)<sup>73</sup> makes changes to the income thresholds in the top two income categories beginning in 2018, as shown in **Table 4** below. Individuals with incomes between \$133,500 and \$160,000 per year will be in the 65% applicable percentage group (instead of those with incomes between \$160,000 and \$214,000), and the income threshold for the highest group (80%) will be \$160,000 (instead of \$214,000). The thresholds for the lower two income groups will remain unchanged. In 2019, the thresholds will remain the same as in 2018. For the years 2020 and after, the thresholds will be adjusted annually for inflation based on the new (2018 and 2019) threshold levels.<sup>74</sup>

<sup>72</sup> Section 3402 of the ACA (P.L. 111-148). Because more beneficiaries are expected to pay this higher premium over time and therefore reduce the amount of general revenues needed to fund Part B, CBO scored this provision as saving the federal government \$25 billion over 10 years (FY2010-FY2019), at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>.

<sup>73</sup> CRS Report R43962, *H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015*, coordinated by Jim Hahn and Kirstin B. Blom.

<sup>74</sup> Under prior law (ACA §3402), in 2020 and subsequent years, the income thresholds were to be indexed to inflation as if they had not been frozen between 2011 and 2019. In other words, the income thresholds would have reverted to the levels they would have reached had they been indexed for inflation since 2007, thereby reducing the proportion of beneficiaries who would be subject to higher premiums.

**Table 4. Income Thresholds for High-Income Premiums in 2018 and 2019**

<b>Beneficiaries Who File Individual Tax Returns with Income:</b>	<b>Percentage of Costs Covered by Premiums</b>
Less Than or Equal to \$85,000	25%
More Than \$85,000 but Not More Than \$107,000	35%
More Than \$107,000 but Not More Than \$133,500	50%
More Than \$133,500 but Not More Than \$160,000	65%
More Than \$160,000	80%

**Source:** Section 402 of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

## Premium Assistance for Low-Income Beneficiaries

Medicare beneficiaries with limited income and resources may be able to qualify for assistance with their premiums and other out-of-pocket expenses.<sup>75</sup> About one in five Medicare beneficiaries receives Part B premium subsidies.

Medicare beneficiaries who qualify for full Medicaid benefits (full dual-eligibles) have most of their health care expenses paid for by either Medicare or Medicaid. For these individuals, Medicaid covers the majority of Medicare premium and cost-sharing expenses, and supplements Medicare by providing coverage for services not covered under Medicare, such as dental services and long-term services and supports (LTSS). In cases where services are covered by both Medicare and Medicaid, Medicare pays first and Medicaid picks up most of the remaining costs. Each state has different rules about eligibility and applying for Medicaid.<sup>76</sup>

Beneficiaries who do not meet their respective state's eligibility criteria for Medicaid may still qualify for assistance with Part B premiums if they have incomes of less than 135% of the federal poverty level (FPL) and assets of less than \$7,280 for an individual or \$10,930 for a couple in 2015.<sup>77</sup> These assistance programs are commonly referred to as *Medicare Savings Programs* (MSP).<sup>78</sup> Three of these programs provide assistance with Part B premiums.

<sup>75</sup> See Medicare.gov, "Medicare Savings Programs" at <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html> and Medicare Publication, "Get Help with Your Medicare Costs," at <https://www.medicare.gov/Pubs/pdf/10126.pdf>. Subsidies are also available for low-income beneficiaries enrolled in Part D, the outpatient prescription drug benefit. Those who are eligible for assistance with Part B premiums through their Medicaid programs are automatically eligible to receive the Part D low-income subsidy. Other low-income beneficiaries with incomes below 150% of the federal poverty level, and who meet the resource tests, may also be eligible for the drug subsidy.

<sup>76</sup> See CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell. In those states that have extended Medicaid coverage to individuals 64 years of age and under with incomes of up to 138% of FPL, it is possible that certain individuals at the higher income levels may no longer qualify for Medicaid when they turn 65. In other words, traditional Medicaid categorical and income eligibility (i.e., income and asset) rules will apply when an individual becomes eligible for Medicare.

<sup>77</sup> Income and asset requirements may vary by state and change each year. These amounts do not include a burial fund allowance of \$1,500 per person.

<sup>78</sup> For additional information about these programs and to learn whether a beneficiary might qualify for Medicare premium assistance, one should contact one's State Medical Assistance (Medicaid) office. (As the names of these programs may vary by state, one should specifically inquire about Medicare Savings Programs.) The contact information for state Medicaid offices may be obtained by calling 1-800-MEDICARE (1-800-633-4227) or by visiting the following Medicare website: <http://www.medicare.gov/contacts>.

## Qualified Medicare Beneficiaries

Aged or disabled persons with incomes at or below FPL may qualify for the Qualified Medicare Beneficiary (QMB) program.<sup>79</sup> In 2015, the QMB monthly qualifying income levels are \$1,001 for individuals and \$1,348 for a couple (annual income of \$12,012 and \$16,176, respectively).<sup>80</sup> QMBs are entitled to have their Medicare Parts A and B cost-sharing charges, including the Part B premium and all deductibles and coinsurance, paid for by Medicaid.<sup>81</sup> (See **Table 5**.) For QMBs, Medicaid coverage is limited to the payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services, unless the individual is otherwise entitled to Medicaid).

## Specified Low-Income Medicare Beneficiaries

Individuals whose income is more than 100% but less than 120% of FPL may qualify for assistance as a Specified Low-Income Medicare Beneficiary (SLMB). In 2015, the monthly income limits are \$1,197 for an individual and \$1,613 for a couple (annual income of \$14,364 and \$19,356, respectively).<sup>82</sup> Medicaid pays the Medicare Part B premiums for SLMBs, but not other cost sharing.

**Table 5. 2015 Medicare Savings Program Eligibility Standards**

	Monthly Income <sup>a</sup>	Resources <sup>b</sup>	Benefits
Qualified Medicare Beneficiary (QMB)	At or below 100% FPL <sup>c</sup> \$1,001 (single) \$1,348 (couple)	\$7,280 (single) \$10,930 (couple)	Part B premium <sup>d</sup> Coverage of Parts A and B deductibles and coinsurance
Specified Low-Income Medicare Beneficiary (SLMB)	Above 100% but less than 120% FPL <sup>c</sup> \$1,001–\$1,197 (single) \$1,348–\$1,613 (couple)	\$7,280 (single) \$10,930 (couple)	Part B premium
Qualifying Individual (QI)	At or above 120% but less than 135% FPL <sup>c</sup> \$1,197–\$1,345 (single) \$1,613–\$1,813 (couple)	\$7,280 (single) \$10,930 (couple)	Part B premium

**Source:** Social Security Program Operations Manual Section HI 00815.023 (Income Limits), at <https://secure.ssa.gov/poms.nsf/lnx/0600815023>, and “Medicare Savings Programs” at <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html>.

<sup>79</sup> The federal poverty levels for 2015 are \$11,770 per year for an individual and \$ 15,930 for a couple. (These levels are slightly higher in Alaska and Hawaii.) See *The 2015 HHS Poverty Guidelines* at <http://aspe.hhs.gov/2015-poverty-guidelines>.

<sup>80</sup> The qualifying levels are slightly higher than the monthly federal poverty level because, by law, \$20 per month of unearned income is disregarded in the calculation. See Social Security Administration Program Operations Manual HI 00815.023 Medicare Savings Programs Income Limits at <https://secure.ssa.gov/poms.nsf/lnx/0600815023>.

<sup>81</sup> The QMB program does not provide assistance with drug costs. Low-income beneficiaries who qualify for a Medicare Savings Program are automatically enrolled in Medicare Part D; their premiums and most cost sharing are paid for by the Part D low-income subsidy which is financed through Medicare. States pay some of the costs for Part D low-income assistance through state transfer payments.

<sup>82</sup> The qualifying levels are calculated the same way as for the QMB program.

**Notes:**

- a. These amounts include a \$20 general income exclusion, under which \$20 from any income is not counted toward the income limits.
- b. Resources include money in checking and savings accounts, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources do not include one's primary residence, a life insurance policy worth up to \$1,500, one car, burial plots, up to \$1,500 per person for burial expenses, and household items. Some states have no limits on resources.
- c. Federal Poverty Levels (FPLs) are updated each year, usually in January or February. Income levels are higher for Hawaii and Alaska and for those living with dependents.
- d. Most people do not pay a premium for Part A because they have worked 40 or more quarters in covered employment. For those without sufficient work history to qualify for premium-free Part A, Medicaid will also pay Part A premiums for QMBs.

## Qualifying Individuals

Individuals whose income is between 120% and 135% of the federal poverty level may qualify for assistance as Qualifying Individuals (QIs). In 2015, the monthly income limit for a QI is \$1,345, and for a couple, \$1,813 (annual income of \$16,140 and \$21,756, respectively). Medicaid protection for these individuals is limited to payment of the monthly Medicare Part B premium. Expenditures under the QI program are, however, paid for (100%) by the federal government from the Medicare SMI trust fund up to the state's allocation level.<sup>83</sup> A state is only required to cover the number of people who would bring its spending on these population groups in a year up to its allocation level. Any expenditures beyond that level are voluntary and paid entirely by the state.

Funding for the QI program was first made available by the Balanced Budget Act of 1997 (BBA97; P.L. 105-33).<sup>84</sup> Subsequent legislation extended the program and the amounts available through allocation.<sup>85</sup> MACRA permanently extended the QI program and appropriated \$535 million for the remainder of CY2015 (April 1, 2015, through December 31, 2015) and \$980 million for CY2016.<sup>86</sup>

## Protection of Social Security Benefits from Increases in Medicare Part B Premiums

After a person becomes eligible to receive Social Security benefits, his or her monthly benefit amount is increased annually to maintain purchasing power over time. Near the end of each year, the Social Security Administration announces the cost-of-living adjustment (COLA) payable in January of the following year. The amount of the COLA is based on inflation as measured by the Consumer Price Index-Urban Wage Earners and Clerical Workers (CPI-W).<sup>87</sup> If the CPI-W

<sup>83</sup> In general, Medicaid payments are normally shared between the federal government and the states according to matching formulas.

<sup>84</sup> Section 4732(c) of BBA97 added §1933(c) of the Social Security Act.

<sup>85</sup> See archived CRS Report R43958, *Health Care-Related Expiring Provisions, First Session of the 114th Congress*, coordinated by Jim Hahn.

<sup>86</sup> The amount of funding for CY2017 and subsequent calendar years will be based on the product of the following: (1) the previous year's QI allocation; (2) the increase from the previous year in Medicare Part B premium; and (3) the estimated increase from the previous year in Part B enrollment.

<sup>87</sup> The CPI-W tracks the prices of a fixed market basket of goods and services over time. Social Security's COLA is calculated as the change in the CPI-W from the third quarter of the prior calendar year to the third quarter of the current (continued...)

decreases, Social Security benefits stay the same—benefits are not reduced during periods of deflation.

In instances when the annual Social Security COLA is not sufficient to cover the standard Medicare Part B premium increase, most beneficiaries are protected by a *hold-harmless* provision in the Social Security Act.<sup>88</sup> Specifically, if in a given year, the increase in the standard Part B premium would cause a beneficiary’s Social Security check to be less, in dollar terms, than it was the year before, then the Part B premium is reduced to ensure that the amount of the individual’s Social Security check does not decline.<sup>89</sup> To be held harmless in a given year, a Social Security beneficiary must have received Social Security benefit checks in both December of the previous year and January of the current year, and must also have had Part B premiums deducted from both checks.<sup>90</sup> The hold-harmless provision operates by comparing the net dollar amounts of the two monthly benefit payments—if the net Social Security benefit for January of the current year is lower than in December of the previous year, then the hold-harmless provision takes effect for most individuals.<sup>91</sup> This determination is made by the Social Security Administration.

Several groups are *not* covered by the hold-harmless provision.

- **Lower-Income Beneficiaries.** Lower-income beneficiaries who receive premium subsidies are not held harmless for premium increases; however, the Medicaid program pays the full amount of any increase in their Part B premiums. (See “Premium Assistance for Low-Income Beneficiaries.”)
- **Higher-Income Beneficiaries.** Higher-income beneficiaries who are required to pay income-related Part B premiums are not held harmless for premium increases. They are required to pay the full amount of any increase in their Part B premiums. (See “Income-Related Premiums.”)
- **Beneficiaries with no history of Social Security benefit checks with deductions to cover the Medicare Part B premium.** This includes new enrollees in either Social Security or Medicare Part B, and Part B enrollees who do not receive Social Security benefits. As noted above, in order to be held harmless in a given year, a Social Security beneficiary must have received Social Security benefit payments in both December of the previous year and January of the current year, and must have had Part B premiums deducted from both checks. (See “Part B Enrollees Who Do Not Receive Social Security Benefits.”)

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(...continued)

calendar year. If the CPI-W increases during this period, Social Security benefits for the next year increase proportionately. See CRS Report 94-803, *Social Security: Cost-of-Living Adjustments*, by Gary Sidor.

<sup>88</sup> Social Security Act §1839(f). This provision was originally created by the Deficit Reduction Act of 1984 (P.L. 98-369, Section 2302), extended by subsequent legislation, and made permanent by the Catastrophic Coverage Act of 1988 (P.L. 100-360, Section 211(b)) (this provision was not repealed when that law was repealed in 1989). Those who receive RRB benefits are also protected by this provision. The hold-harmless provision was first implemented in January 1987.

<sup>89</sup> For more information on the hold-harmless provision, see archived CRS Report R40561, *Interactions Between the Social Security COLA and Medicare Part B Premiums*, by Jim Hahn.

<sup>90</sup> Note that Social Security benefit checks reflect benefit entitlements for the previous month while Part B premiums are deducted in advance. For example, a November Social Security benefit check is not received until December, but has December’s Part B premium deducted from it.

<sup>91</sup> Part D premiums are not covered by the hold-harmless provision; therefore, some people protected by the Part B hold-harmless provision may still see a decrease in their Social Security checks due to an increase in Medicare Part D premiums. Beneficiaries who qualify for the Part D low-income subsidies, however, would not be affected.



As described earlier, an individual's Social Security COLA is determined by multiplying his or her benefit amount by the inflation rate, the CPI-W. Part B premiums are determined by projected Part B program costs. Thus, the number of people held harmless can vary widely from year to year, depending on inflation rates and projected Part B costs. For most years, the hold-harmless provision has affected a relatively small number of beneficiaries.<sup>92</sup> However, due to low inflation, no COLA adjustments were made to Social Security benefits in 2010 and 2011. Most Medicare beneficiaries (about 73%) were protected by the hold-harmless provision and continued to pay the 2009 standard monthly premium of \$96.40 in both 2010 and 2011.<sup>93</sup> Because Part B expenditures were still expected to increase in those years, and beneficiary premiums are required to cover 25% of those costs, the premiums for those not held harmless (27% of beneficiaries) were higher than they would have been had the rest of the beneficiaries not been held harmless. The standard monthly premiums paid by those not held harmless were \$110.50 in 2010 and \$115.40 in 2011.<sup>94</sup> In 2011, of the 27% who were not eligible to be held harmless, about 3% were new enrollees, about 5% were high-income, about 17% had their premiums paid for by Medicaid, and the remaining 2% did not have their premiums withheld from Social Security benefit payments.

In 2012 and 2013, Social Security beneficiaries received a 3.6% and a 1.7% COLA, respectively, which more than covered the Part B premium increases in those years; therefore, the hold-harmless provision was not applicable for most beneficiaries. Similarly, in 2014 and 2015, with a Social Security COLA increase of 1.5% and 1.7% and no increase in Part B premiums, the hold-harmless provision also was not applicable in those years.<sup>95</sup>

In 2016, however, the Medicare Trustees project that there will be no Social Security COLA increase but that there will be an increase in Medicare Part B premiums. Therefore, the Medicare Trustees expect that the hold-harmless provision will again go into effect for most beneficiaries in 2016.<sup>96</sup> Those held harmless (an estimated 70% of Part B enrollees) would pay the 2015 monthly premium of \$104.90, while those not held harmless (the remaining 30%)<sup>97</sup> could pay an estimated

<sup>92</sup> The hold-harmless provision is applied on a case-by-case basis. For example, in a given year a Social Security COLA applied to most benefit levels may be sufficient to cover the dollar amount of a Part B premium increase for most beneficiaries; however, it may not be sufficient to fully cover the increase for someone who receives a smaller benefit amount, i.e., the COLA percentage is applied to a smaller number, and the resulting dollar increase may not be sufficient to fully cover the Part B premium increase. In such a case, the hold-harmless provision would apply to that individual and his/her Part B premiums may be lower than that paid by most beneficiaries in a given year. Thus, the hold-harmless provision may apply to a small number of beneficiaries each year.

<sup>93</sup> The standard Part B premium in 2009 was also the same as that in 2008, \$96.40; however, the lack of change in those years was not a result of the "hold-harmless" provision. At the end of 2008, it was determined that Part B premiums and general revenue financing in recent years had been set at somewhat higher levels than would otherwise be required to maintain an adequate contingency reserve, and that the level of assets in the Part B account of the SMI trust fund were more than adequate. Therefore, it was estimated that an adequate level of assets could be maintained throughout the next year, 2009, without an increase in premiums.

<sup>94</sup> Most new enrollees in 2010 were eligible to be held harmless in the second year of no COLA, i.e., 2011; these individuals continued to pay the 2010 standard premium of \$110.50 in 2011.

<sup>95</sup> Social Security Administration, "Cost-of-Living Adjustment (COLA) Information for 2015," at <http://www.socialsecurity.gov/cola/> and Social Security Administration Fact Sheet, "2015 Social Security Changes," at <http://www.ssa.gov/news/press/factsheets/colafacts2015.html>.

<sup>96</sup> *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 22, 2015, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>.

<sup>97</sup> Those expected *not to be* held harmless include those eligible for premium assistance through their state Medicaid programs (about 19%); those who pay the high-income premiums (about 6%); those who do not receive Social Security benefits (3%), and new enrollees in 2016 (5%). (As there is some overlap in categories, for example some individuals may pay the high-income premiums and not yet receive Social Security benefits, these figures sum to more than 30%.) (continued...)

\$159.30 per month, a 52% increase. Projections of future premiums may be found in **Appendix C**.

## Part B Premiums Over Time

Part B premium changes through time generally reflect the growth in total Part B expenditures, although the exact relationship between Part B expenditures covered by the Part B premium has been changed by statute at various points. (See **Appendix A**.) The monthly Part B premium has risen from \$3.00 in 1966 to \$104.90 in 2015. (See **Figure 1**.) For comparison, during a similar time period, average annual Part B benefit costs per beneficiary have increased from about \$101 in 1970 (about \$8.42 per month) to a projected \$5,310 per beneficiary (about \$442.50 per month) in 2015.<sup>98</sup>

Prior to 2000, the Part B premium decreased from year to year twice: once from 1989 (\$31.90) to 1990 (\$28.60) as a result of the repeal of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), and once from 1995 (\$46.10) to 1996 (\$42.50) as a result of the transition from a premium as determined by a fixed dollar amount under the Omnibus Reconciliation Act of 1990 (P.L. 101-508) to 25% of costs as directed under the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

More recently, because of the absence of a Social Security COLA in 2010 and 2011, most beneficiaries were “held-harmless” and paid the 2009 premium of \$96.40 per month during those years. The standard 2010 and 2011 premiums, paid by those who were not held harmless, were thus higher than they would have been had the hold-harmless provision not been in effect. (See prior section “Protection of Social Security Benefits from Increases in Medicare Part B Premiums” for additional detail.)

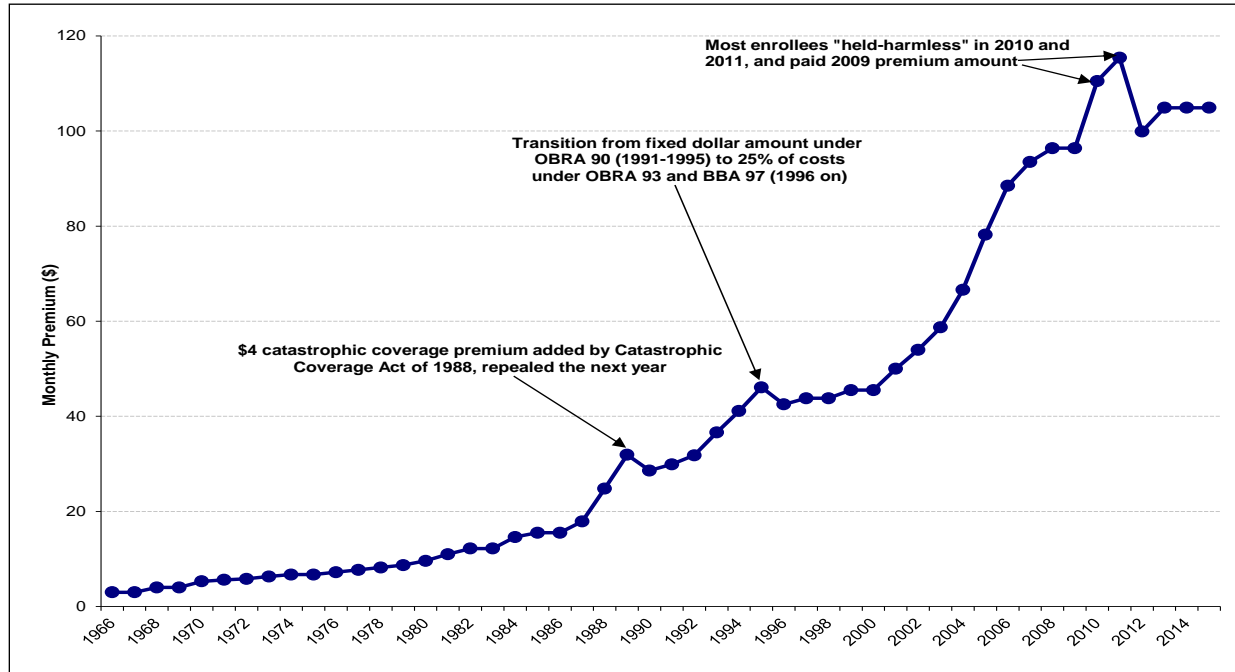
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(...continued)

Estimates provided to CRS by the Centers for Medicare & Medicaid Services, September 2015.

<sup>98</sup> For data on recent growth in specific Part B services, see the 2015 Report of the Medicare Trustees, pp. 125-139, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>.

**Figure I. Monthly Medicare Part B Premiums**  
(1966-2015)



**Source:** CRS figure, based on the 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, Table V.E2.

Since 2000, the Medicare Part B premium has more than doubled from \$45.50 in 2000 to the current premium of \$104.90 in 2015. Increases have been due to a number of factors that have raised per capita Part B expenditures during that time, including rising prices of health care services and equipment, new technologies, and increased utilization of Medicare Part B services. While Part B expenditure growth has slowed in recent years and premiums have remained level for the past three years, the Medicare Trustees project faster benefit spending growth over the next five years (a 6.7% Part B average annual growth rate compared with a 5.3% growth rate over the last five years).

Additionally, the Medicare Trustees project that 2015 Part B expenditures will be higher than they originally projected in 2014. Their 2015 report noted that “(l)egislation enacted at the end of 2014 and the beginning of 2015 raised Part B physician expenditures substantially compared to the law in effect in the fall of 2014 when the 2015 financing was established.”<sup>99</sup> Higher-than-expected utilization of Part B services also contributed to this increase. While the Medicare Trustees note that the financing established for calendar year 2015 should be adequate to cover expected expenditures, it “would need to be increased in future years in order to restore the financial status of the Part B account for a satisfactory level.”<sup>100</sup>

<sup>99</sup> 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, July 22, 2015, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>, p. 87.

<sup>100</sup> 2015 Medicare Trustees Report, pp 96-97.

Because of the projected Part B spending increases and the need to build up an adequate level of contingency reserves,<sup>101</sup> the Medicare Trustees estimate that beneficiary premiums would need to increase to about \$120.70 per month in 2016. However, as previously noted, the Trustees also expect that there will be no Social Security COLA in 2016 and that the hold-harmless provision will apply to most beneficiaries. Because about 70% of beneficiaries would be held harmless and their premiums would remain at the 2015 amount (\$104.90 per month), the premiums of the remaining 30% of beneficiaries would need to cover *all* of the expected increased costs so that 25% of Part B costs are still covered by beneficiary premiums. In other words, if the hold-harmless provision is not in effect in 2016, everyone who pays the standard premium will pay about \$120.70 per month; however, if it goes into effect, those not held harmless will be expected to pay standard premiums of close to \$160 per month (\$159.30), while those who are held harmless will continue to pay \$104.90 per month. The Trustees project that in 2017, the hold-harmless provision will no longer be in effect and the standard premium will decrease to about \$120.70. Estimates of premiums in future years through 2024 may be found in **Appendix C**.

## Current Issues

### Premium Amount and Annual Increases

The Medicare Trustees estimate that over the next decade, Medicare Part B premiums will increase, on average, by about 6% each year. (See **Appendix C**.) Rising Medicare premiums could have a large effect on Social Security beneficiaries, particularly on those who rely on Social Security as their primary source of income.<sup>102</sup> In 2014, for example, among Americans aged 65 and older, 52% of married couples and 74% of unmarried persons receive more than half of their income from Social Security, and 22% of married couples and 47% of unmarried persons receive more than 90% of their income from Social Security.<sup>103</sup> Some of these beneficiaries may see a decline in their standard of living as their Medicare premiums rise.

Once a person receives Social Security, his or her benefit is indexed to inflation and thereafter grows with annual Social Security COLAs.<sup>104</sup> However, Medicare premiums are based on the per capita cost growth of Part B benefits which reflect the growth in the cost of medical care, and in the utilization and intensity of services used by beneficiaries, factors that have historically grown faster than CPI-W. Additionally, as there has been a continuing shift from providing care in inpatient (Part A) to outpatient settings (Part B), a greater portion of Medicare spending is expected to be covered by beneficiary premiums.<sup>105</sup> This means that, over time, Medicare

<sup>101</sup> The Trustees try to maintain an adequate reserve fund (about 17% of expected costs for the year) in the Supplementary Medical Insurance Trust fund to cover potential variations in projected and actual costs. Unexpected expenditures in 2015 are expected to draw down on this reserve so that by the end of the year, reserves are projected to represent about 12% of expected 2016 costs. Financing for 2016 (premiums and general revenue) will need to be adjusted to build the reserves back up to 17% of expected costs.

<sup>102</sup> Other sources of income may include earnings from employment employer-sponsored pension benefits and investment earnings. In addition, retirees may draw down on their accumulated assets to supplement their income.

<sup>103</sup> Social Security Basic Facts, as of April 2014, at <http://www.ssa.gov/pressoffice/basicfact.htm>.

<sup>104</sup> The COLA increases the benefits paid to *current* beneficiaries. In contrast, average Social Security benefits (those paid to new and current beneficiaries) have risen at a faster rate than the annual COLA, because the formula for calculating initial Social Security benefits is linked to *wage* growth, whereas the COLA is based on *price* growth. Generally, wages rise faster than prices.

<sup>105</sup> In 2000, the ratio of Part A expenditures to Part B expenditures was 59:41. This ratio decreased to 50:50 in 2014, and is expected to drop to 46:54 in 2024. This means that over time the proportion of Medicare expenditures covered (continued...)

premiums are expected to represent a growing proportion of most beneficiaries' Social Security income.<sup>106</sup> Since 2000, Social Security's annual COLA has resulted in a cumulative benefit increase of about 39%, significantly less than the Part B premium growth of close to 120%. The Medicare Trustees estimated that average Part B plus Part D premiums in 2015 would represent close to 11% of the average Social Security benefit, and increase to an estimated 18% in 2089.<sup>107</sup>

Should the hold-harmless provision go into effect in 2016 (see "Protection of Social Security Benefits from Increases in Medicare Part B Premiums"), then about 30% of Medicare Part B enrollees could see an increase in premiums from \$104.90 per month to approximately \$159.30 per month. Those who pay the high-income premiums could see premiums of up to \$509.80. (See **Appendix B** and **Appendix C** for historical, current, and projected Part B premiums.) In addition, the late-enrollment penalty is determined as a percentage of the standard premium. Therefore, even if protected by the hold-harmless provision for their standard premiums, those who pay the late enrollment penalty could see a large increase in their penalty payments in 2016. (The penalties are considered nonstandard premiums and are not protected by the hold-harmless provision.) For example, an individual with a 30% penalty currently pays an additional \$31.35 per month on top of the standard premium of \$104.90. In 2016, a 30% penalty could increase to close to \$48.00. This amount would be in addition to whatever premium that person pays (\$104.90 for those held harmless and an estimated \$159.30 for those not held harmless). The increased premiums for those not held harmless and those subject to enrollment penalties could cause sufficient financial hardship for some beneficiaries that they may not be able to maintain their enrollment in Part B.

## Proposals to Modify the Late Enrollment Penalty

Periodically, proposals have been offered to modify or eliminate the Part B premium penalty either for all enrollees or alternatively for a selected population group. As an increasing number of new Medicare-eligibles must actively sign up for Medicare because they are not yet receiving Social Security benefits (e.g., their full retirement Social Security age exceeds the Medicare age of eligibility), there is concern that more people could become subject to late enrollment penalties. For example, the Medicare Rights Center reported a large number of calls to its hotline related to transitioning to Medicare. Their report noted that "(t)housands of callers to the Medicare Rights Center's helpline report challenges, misunderstandings and misinformation related to Medicare enrollment and benefits coordination" and that "such confusion leads to beneficiaries facing gaps in coverage and premium penalties that many have difficulty affording."<sup>108</sup>

(...continued)

under Part B is expected to increase. While providing more services on an outpatient basis may be more cost effective for the program as a whole, it also means that beneficiaries will be expected to bear a larger portion of program costs over time. See CRS Report R43122, *Medicare Financial Status: In Brief*, by Patricia A. Davis.

<sup>106</sup> A "hold-harmless" provision, described earlier, caps the annual Part B premium increase (but not the Part D increase) at the dollar amount of a beneficiary's COLA.

<sup>107</sup> Similarly, average Medicare cost sharing is estimated to be about 12% of the Social Security benefit in 2015, and expected to increase to approximately 18% in 2089. *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, July 22, 2015, p. 38, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>.

<sup>108</sup> Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline," January 2014, at <http://www.medicarerights.org/policy/priorities/2012-medicare-trends/>. The Medicare Rights Center also recently issued a related summary of findings from its helpline (continued...)

Some proposals have suggested modifying the penalty provision to limit both the amount and the duration of the surcharge, such as is the case for delayed Part A enrollment which has a maximum 10% surcharge, and a duration of twice the number of years that enrollment was delayed. (See **Appendix D** for information on the Part A premium and late enrollment penalty.)

Some have also suggested that Medicare Part B have a creditable coverage exemption, similar to that under Part D, that would allow Medicare beneficiaries with equivalent coverage to postpone enrollment in Part B without being subject to a penalty. For example, under the Part D prescription drug benefit, individuals are not subject to a late enrollment penalty if they have maintained “creditable” prescription drug coverage prior to enrollment, that is, coverage that is expected to pay at least as much as Medicare’s standard prescription drug coverage.<sup>109</sup> Creditable prescription drug coverage includes such things as employer-based prescription drug coverage; qualified State Pharmaceutical Assistance Programs (SPAPs); and military-related coverage (e.g., VA and TRICARE).<sup>110</sup>

Other suggestions include formally training employers about Medicare coverage and interaction with other insurance; improving education on Medicare, including late enrollment penalties, for those nearing Medicare eligibility age; and expanding equitable relief to include remedies for actions based on misinformation provided by entities in addition to an agent of the federal government, such as an agent of state or local government, and/or an employer or insurer.

In recent Congresses, several bills have been introduced to address the Part B late enrollment penalty. For example, H.R. 2476 introduced in the 114<sup>th</sup> Congress, would establish a special Medicare Part B enrollment period for individuals enrolled in COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage who elected not to enroll in Part B during their initial enrollment period. Similar legislation introduced in the 112<sup>th</sup> Congress, H.R. 1654, would have also created a continuous enrollment period that would allow Medicare eligible beneficiaries to sign up for Part B outside of the general enrollment period, and receive health coverage the following month. Additionally, H.R. 1654 would have expanded eligibility for equitable relief to those who based enrollment decisions on incorrect information provided by group health plans and plan sponsors, and directed the Government Accountability Office to study problems with Part B enrollment. Also introduced in the 112<sup>th</sup> Congress, H.R. 103 would have, among other changes, eliminated late enrollment penalties for those between the ages of 65 and 70. In the 111<sup>th</sup> Congress, H.R. 2235 would have limited the penalty for late Part B enrollment to 10% and twice the period of no enrollment, similar to the Part A late enrollment penalty. It would also have excluded periods of COBRA and retiree coverage from the penalty.

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(...continued)

entitled “A Costly Mistake: Missing Part B Enrollment,” April 2015, at <http://www.medicarerights.org/pdf/medicare-snapshot-040915.pdf>.

<sup>109</sup> See Medicare publication “Your Guide to Medicare Prescription Drug Coverage,” p.19, at <http://www.medicare.gov/Publications/Pubs/pdf/11109.pdf>.

<sup>110</sup> Employers or unions may also qualify for a federal subsidy to maintain prescription drug coverage for their retirees. Such subsidies are generally less expensive to the federal government than providing full coverage to such enrollees under Part D. *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, July 22, 2015, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>, Table IV.B9.

## Deficit Reduction Proposals

As Medicare currently represents about 15% of federal spending,<sup>111</sup> many proposals to reduce federal deficits include suggestions to reduce Medicare program spending and/or increase program income. For example, some recent proposals would increase Medicare premiums as a portion of total program funding, while others would limit the amount of federal contributions.

### Increasing Medicare Premiums

Certain proposals would limit premium increases to high-income beneficiaries. For example, the President's FY2016 budget proposal would increase the percentage of per capita expenditures paid by high-income enrollees from the current range of 35% to 80% of expenditures to a range of between 40% and 90%, and it would increase the number of high-income brackets from four to five.<sup>112</sup> The proposal would also continue the freeze on income thresholds until 25% of beneficiaries were subject to the high-income premiums.<sup>113</sup>

Other proposals would increase premiums paid by all beneficiaries. For example, a proposal introduced by then Senators Lieberman and Coburn<sup>114</sup> suggested raising the standard Part B premium from the current 25% of program costs to 35% over five years.

### Impose a Part B Premium Surcharge for Beneficiaries in Medigap Plans with Near First-Dollar Coverage

About 23% of beneficiaries enrolled in traditional Medicare buy Medigap policies from private insurance companies which cover some or all of Medicare's cost sharing.<sup>115</sup> Individuals who purchase Medigap must pay a monthly premium which is set by, and paid to, the insurance company selling the policy. There are 10 standardized Medigap plans with varying levels of coverage. Two of the 10 standardized plans cover Parts A and B deductibles and coinsurance in full (i.e., offer "first-dollar" coverage). In 2013, 66% of all beneficiaries who purchased Medigap insurance were covered by one of these two plans.

There is some concern that beneficiaries enrolled in Medigap plans with low-cost sharing requirements may have less incentive to consider the cost of health care services, and may thus increase costs to the Medicare program. To address this, Section 401 of MACRA prohibits the sale of Medigap policies that cover Part B deductibles to newly eligible Medicare beneficiaries beginning in 2020. Some have also proposed imposing a Part B premium surcharge for Medicare beneficiaries who purchase certain types of Medigap plans. For example, the President's FY2016 budget proposal<sup>116</sup> suggests imposing a Part B premium surcharge of approximately 15% of the average Medigap premium (about 30% of the Part B premium) for new Medicare beneficiaries who enroll in a near first-dollar Medigap plan.

<sup>111</sup> The federal spending amount is net of beneficiary premiums.

<sup>112</sup> See CRS Report R43934, *President's FY2016 Budget: Centers for Medicare & Medicaid Services (CMS) Legislative Proposals*, coordinated by Alison Mitchell, Kirstin B. Blom, and Patricia A. Davis.

<sup>113</sup> MACRA, enacted subsequent to the issuance of the President's FY2016 budget, changes the threshold for the top two income categories beginning in 2018; a larger number of people are therefore expected to pay premiums that cover 65% and 80% of spending (see "Income Thresholds and Premium Adjustments").

<sup>114</sup> *A Bipartisan Plan to Save Medicare and Reduce Debt*, June 28, 2011.

<sup>115</sup> See CRS Report R42745, *Medigap: A Primer*, by Carol Rapaport.

<sup>116</sup> See CRS Report R43934, *President's FY2016 Budget: Centers for Medicare & Medicaid Services (CMS) Legislative Proposals*, coordinated by Alison Mitchell, Kirstin B. Blom, and Patricia A. Davis.

## Limit Federal Subsidies

Finally, other proposals, such as that put forth in the FY2016 House Budget,<sup>117</sup> would place limits on the amount of the federal subsidy, and premiums would vary depending on the plan in which the beneficiary enrolled. In general, such “premium support” proposals would limit federal spending by changing the current Medicare program from a defined benefit to a defined contribution system.<sup>118</sup> Most such proposals would limit the growth in the annual federal premium subsidy. Depending on how such a proposal is designed, and should Medicare costs grow more quickly than the limit, beneficiary premiums could increase more rapidly than the amount of the premium subsidy.

## Considerations

Some of the issues that would need to be addressed when evaluating these types of deficit reduction proposals include (1) the ability of Medicare beneficiaries to absorb increased costs given their current levels of income and assets, as well as their other out-of-pocket expenditures (both health and non-health related); (2) the willingness of high-income beneficiaries to continue participating in Medicare Part B should their premiums continue to increase; and (3) the capacity of the Medicaid program to continue providing premium assistance to low-income beneficiaries should premiums increase.

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<sup>117</sup> H.Con.Res. 27. A similar proposal was included in the FY2015 House Budget. See CRS Report R43479, *Overview of Health Care Changes in the FY2015 House Budget*, by Patricia A. Davis, Alison Mitchell, and Bernadette Fernandez.

<sup>118</sup> Most premium support models combine Parts A and B benefits; the premium subsidy and beneficiary premiums would apply to both of these parts of Medicare.



## Appendix A. History of the Part B Premium

### Statutory Policy and Legislative Authority

The basis for determining the Part B premium amount has changed several times since the inception of the Medicare program, reflecting different legislative views of what share beneficiaries should bear as expenditures increased. When the Medicare program first went into effect in July 1966, the Part B monthly premium was set at a level to cover 50% of Part B program costs. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which Social Security benefits were adjusted for changes in the cost-of-living (i.e., COLAs). Under this formula, revenues from premiums soon dropped from 50% to below 25% of program costs because Part B program costs increased much faster than inflation as measured by the Consumer Price Index on which the Social Security COLA is based (**Table A-1**).

From the early 1980s, Congress regularly voted to set Part B premiums at a level to cover 25% of program costs, in effect overriding the COLA limitation. The 25% provisions first became effective January 1, 1984, with general revenues covering the remaining 75% of Part B program costs. Premiums increased in 1989 as a result of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), which added a catastrophic coverage premium to the Part B premium. The act was repealed in November 1989, and the Part B premium for 1990 fell as a result.

Congress returned to the general approach of having premiums cover 25% of program costs in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90; P.L. 101-508). However, OBRA 90 set specific dollar figures, rather than a percentage, in law for Part B premiums for the years 1991-1995. These dollar figures reflected CBO estimates of what 25% of program costs would be over the five-year period. However, program costs grew more slowly than anticipated, in part due to subsequent legislative changes and as a result, the 1995 premium of \$46.10 actually represented 31.5% of Medicare Part B program costs.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93; P.L. 103-66) extended the policy of setting the Part B premium at a level to cover 25% of program costs for the years 1996-1998. As was the case prior to 1991, a percentage rather than a fixed dollar figure was used, which meant that the 1996 premium (\$42.50) and the 1997 premium (\$43.80) were lower than the 1995 premium (\$46.10). BBA 97 permanently set the premium at 25% of program costs so that, generally speaking, premiums rise or fall with Part B program costs.<sup>119</sup>

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173), as modified by the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), required that beginning in 2007, higher-income beneficiaries pay higher Part B premiums.<sup>120</sup> The income thresholds used to determine eligibility for the high-income premium are to be adjusted each year by the growth in the Consumer Price Index.<sup>121</sup> The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, Section 3402), however, froze these thresholds for the period of 2011

<sup>119</sup> BBA 97 made a change that had the effect of increasing the Part B premium over time. Prior to BBA 97, both Parts A and B of Medicare covered home health services. Payments were made under Part A, except for those few persons who had no Part A coverage. In order to extend the solvency of the Part A (hospital insurance) trust fund, BBA 97 gradually transferred coverage of some home health visits from Part A to Part B. Beginning January 1, 2003, Part A covers only post-institutional home health services for up to 100 visits, except for those persons with Part A coverage only who are covered without regard to the post-institutional limitation. Part B covers other home health services.

<sup>120</sup> MMA increased the Part B premium percentage for high-income enrollees; DRA accelerated the phase-in period for such premiums.

<sup>121</sup> Social Security Act §1839(i)(5).

through 2019 at the 2010 levels. In 2020, the thresholds were to return to the levels they would have been had they been adjusted for inflation each year during the freeze, and again indexed to inflation each year. As this would have resulted in higher income thresholds, it would have had the effect of reducing the number of beneficiaries who pay the high-income premiums in 2020.

Section 402 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) maintains the freeze on the income thresholds for all income categories through 2017 and on the lower two high-income premium tiers through 2019. Beginning in 2018, MACRA reduces the threshold levels for the two highest income tiers so that more beneficiaries will fall into the higher percentage categories. (See **Table 4.**) Additionally, starting in 2020, the income thresholds for all income categories will be adjusted annually for inflation based on the 2019 income thresholds. This will, in effect, maintain the proportion of beneficiaries who pay the high-income premium.

**Table A-I. Monthly Part B Premiums, 1966-2015**

Year	Monthly Premium	Effective Date	Governing Policy; Legislative Authority
1966	\$3.00	7/66	Fixed dollar amount; Social Security Amendments (SSA) of 1965
1967	\$3.00		Fixed dollar amount; SSA of 1965
1968	\$4.00	4/68	Fixed dollar amount through March; Medicare Enrollment Act of 1967. Beginning April: 50% of costs; SSA of 1965
1969	\$4.00		50% of costs; SSA of 1967
1970	\$5.30	7/70	50% of costs; SSA of 1967
1971	\$5.60	7/71	50% of costs; SSA of 1967
1972	\$5.80	7/72	50% of costs; SSA of 1967
1973	\$6.30	9/73	50% of costs; SSA of 1967 (COLA limit, added by SSA of 1972, could have applied, but was not needed). Limitations imposed by Economic Stabilization program set 7/73 amount at \$5.80 and 8/73 amount at \$6.10.
1974	\$6.70	7/74	50% of costs; SSA of 1967 (COLA limit, added by SSA of 1972, could have applied, but was not needed)
1975	\$6.70		Technical error in law prevented updating
1976	\$7.20	7/76	COLA limit; SSA of 1972
1977	\$7.70	7/77	COLA limit; SSA of 1972
1978	\$8.20	7/78	COLA limit; SSA of 1972
1979	\$8.70	7/79	COLA limit; SSA of 1972
1980	\$9.60	7/80	COLA limit; SSA of 1972
1981	\$11.00	7/81	COLA limit; SSA of 1972
1982	\$12.20	7/82	COLA limit; SSA of 1972
1983	\$12.20		Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) had set 25% rule for updates in 7/83 and 7/84. However, SSA of 1983 froze premiums 7/83-12/83 and changed future updates to January.
1984	\$14.60	1/84	25% of costs; TEFRA, as amended by SSA of 1983
1985	\$15.50	1/85	25% of costs; TEFRA, as amended by SSA of 1983
1986	\$15.50	1/86	25% of costs; Deficit Reduction Act (DEFRA) of 1984
1987	\$17.90	1/87	25% of costs; DEFRA of 1984
1988	\$24.80	1/88	25% of costs, Consolidated Omnibus Budget Reconciliation Act of 1985

Year	Monthly Premium	Effective Date	Governing Policy; Legislative Authority
1989	\$31.90	1/89	25% of costs, OBRA 87, plus \$4 catastrophic coverage premium added by Medicare Catastrophic Coverage Act of 1988
1990	\$28.60	1/90	25% of costs; OBRA 89. Medicare Catastrophic Coverage Repeal Act of 1989 repealed additional catastrophic coverage premium, effective 1/90
1991	\$29.90	1/91	Fixed dollar amount; OBRA 90
1992	\$31.80	1/92	Fixed dollar amount; OBRA 90
1993	\$36.60	1/93	Fixed dollar amount; OBRA 90
1994	\$41.10	1/94	Fixed dollar amount; OBRA 90
1995	\$46.10	1/95	Fixed dollar amount; OBRA 90
1996	\$42.50	1/96	25% of costs; OBRA 93
1997	\$43.80	1/97	25% of costs; OBRA 93
1998	\$43.80	1/98	25% of costs; OBRA 93 and BBA 97
1999	\$45.50	1/99	25% of costs; BBA 97
2000	\$45.50	1/00	25% of costs; BBA 97
2001	\$50.00	1/01	25% of costs; BBA 97
2002	\$54.00	1/02	25% of costs; BBA 97
2003	\$58.70	1/03	25% of costs; BBA 97
2004	\$66.60	1/04	25% of costs; BBA 97
2005	\$78.20	1/05	25% of costs; BBA 97
2006	\$88.50	1/06	25% of costs; BBA 97
2007	\$93.50	1/07	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees: 1 <sup>st</sup> year of 3-year phase-in)
2008	\$96.40	1/08	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees: 2 <sup>nd</sup> year of 3-year phase-in)
2009	\$96.40	1/09	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees: 3 <sup>rd</sup> year of 3-year phase-in)
2010	\$110.50	1/10	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees, fully phased-in; hold-harmless provision applied to most enrollees who paid the 2009 rate of \$96.40)
2011	\$115.40	1/11	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees, fully phased-in; ACA freezes income thresholds at 2010 levels from 2011 through 2019); hold-harmless provision applied to most enrollees who paid the 2009 rate of \$96.40
2012	\$99.90	1/12	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees, fully phased-in; ACA freezes income thresholds at 2010 levels from 2011 through 2019)
2013	\$104.90	1/13	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees, fully phased-in; ACA freezes income thresholds at 2010 levels from 2011 through 2019)
2014	\$104.90	1/14	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees, fully phased-in; ACA freezes income thresholds at 2010 levels from 2011 through 2019)
2015	\$104.90	1/14	25% of costs; BBA 97 (MMA and DRA authorize higher premiums for high-income enrollees, fully phased-in; ACA as modified by MACRA freezes income thresholds at 2010 levels from 2011 through 2017)

**Source:** Various Annual Medicare Trustees Reports, including the *2015 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*, July 22, 2015; and Centers for Medicare & Medicaid Services, "Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015," *79 Federal Register* 61314, October 10, 2014.

## Appendix B. Standard and High-Income Part B Premiums and Income Thresholds: 2007-2015

**Table B-1. Income Levels for Determining Medicare Part B Premium Adjustment and Per Person Premium Amounts**

2007-2015 (in nominal dollars)

	2007	2008	2009	2010	2011	2012	2013-2015
<b>Standard Premium</b>	Less than or equal to \$80,000 individual	Less than or equal to \$82,000 individual	Less than or equal to \$85,000 individual	Less than or equal to \$85,000 individual	Less than or equal to \$85,000 individual	Less than or equal to \$85,000 individual	Less than or equal to \$85,000 individual
	Less than or equal to \$160,000 couple	Less than or equal to \$164,000 couple	Less than or equal to \$170,000 couple	Less than or equal to \$170,000 couple	Less than or equal to \$170,000 couple	Less than or equal to \$170,000 couple	Less than or equal to \$170,000 couple
	<b>\$93.50</b>	<b>\$96.40</b>	<b>\$96.40<sup>a</sup></b>	<b>\$110.50<sup>b</sup></b>	<b>\$115.40<sup>b</sup></b>	<b>\$99.90</b>	<b>\$104.90</b>
<b>Level 1</b>	\$80,001-\$100,000 individual	\$82,001-\$102,000 individual	\$85,001-\$107,000 individual	\$85,001-\$107,000 individual	\$85,001-\$107,000 individual	\$85,001-\$107,000 individual	\$85,001-\$107,000 individual
	\$160,001-\$200,000 couple	\$164,001-\$204,000 couple	\$170,001-\$214,000 couple	\$170,001-\$214,000 couple	\$170,001-\$214,000 couple	\$170,001-\$214,000 couple	\$170,001-\$214,000 couple
	<b>\$105.80</b>	<b>\$122.20</b>	<b>\$134.90</b>	<b>\$154.70</b>	<b>\$161.50</b>	<b>\$139.90</b>	<b>\$146.90</b>
<b>Level 2</b>	\$100,001-\$150,000 individual	\$102,001-\$153,000 individual	\$107,001-\$160,000 individual	\$107,001-\$160,000 individual	\$107,001-\$160,000 individual	\$107,001-\$160,000 individual	\$107,001-\$160,000 individual
	\$200,001-\$300,000 couple	\$204,001-\$306,000 couple	\$214,001-\$320,000 couple	\$214,001-\$320,000 couple	\$214,001-\$320,000 couple	\$214,001-\$320,000 couple	\$214,001-\$320,000 couple
	<b>\$124.40</b>	<b>\$160.90</b>	<b>\$192.70</b>	<b>\$221.00</b>	<b>\$230.70</b>	<b>\$199.80</b>	<b>\$209.80</b>
<b>Level 3</b>	\$150,001-\$200,000 individual	\$153,001-\$205,000 individual	\$160,001-\$213,000 individual	\$160,001-\$214,000 individual	\$160,001-\$214,000 individual	\$160,001-\$214,000 individual	\$160,001-\$214,000 individual
	\$300,001-\$400,000 couple	\$306,001-\$410,000 couple	\$320,001-\$426,000 couple	\$320,001-\$428,000 couple	\$320,001-\$428,000 couple	\$320,001-\$428,000 couple	\$320,001-\$428,000 couple
	<b>\$142.90</b>	<b>\$199.70</b>	<b>\$250.50</b>	<b>\$287.30</b>	<b>\$299.90</b>	<b>\$259.70</b>	<b>\$272.70</b>
<b>Level 4</b>	\$200,000+ individual	\$205,000+ individual	\$213,000+ individual	\$214,000+ individual	\$214,000+ individual	\$214,000+ individual	\$214,000+ individual
	\$400,000+ couple	\$410,000+ couple	\$426,000+ couple	\$428,000+ couple	\$428,000+ couple	\$428,000+ couple	\$428,000+ couple
	<b>\$161.40</b>	<b>\$238.40</b>	<b>\$308.30</b>	<b>\$353.60</b>	<b>\$369.10</b>	<b>\$319.70</b>	<b>\$335.70</b>

**Source:** Centers for Medicare & Medicaid Services, Annual Notices, “Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible,” 2007 through 2014, and Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015,” 79 *Federal Register* 61314, October 10, 2014.

**Note:** When both are enrolled in Part B, each person in a couple pays the same individual premium amount.

- a. The standard Part B premium in 2009 was the same as that in 2008; however, the lack of change was not due to the “hold-harmless” provision. CMS determined that 2008 premiums and revenues were slightly

- higher than needed to cover costs in that year, and that 2009 financing would be adequate at the same premium level.
- b. Due to no Social Security COLA in 2010 and 2011, most Part B enrollees were “held harmless” and paid the 2009 standard monthly premium of \$96.40.

**Table B-2. Income Levels for Determining Part B Premium Adjustment for Married Beneficiaries Filing Separately and Associated Premiums**  
2007-2015 (in nominal dollars)

Income Level	2007	2008	2009	2010	2011	2012	2013-2015
Standard	Less than or equal to \$80,000 <b>\$93.50</b>	Less than or equal to \$82,000 <b>\$96.40</b>	Less than or equal to \$85,000 <b>\$96.40</b>	Less than or equal to \$85,000 <b>\$110.50</b>	Less than or equal to \$85,000 <b>\$115.40</b>	Less than or equal to \$85,000 <b>\$99.90</b>	Less than or equal to \$85,000 <b>\$104.90</b>
Lower adjustment category	Greater than \$80,000 and less than or equal to \$120,000 <b>\$142.90</b>	Greater than \$82,000 and less than or equal to \$123,000 <b>\$199.70</b>	Greater than \$85,000 and less than or equal to \$128,000 <b>\$250.50</b>	Greater than \$85,000 and less than or equal to \$129,000 <b>\$287.30</b>	Greater than \$85,000 and less than or equal to \$129,000 <b>\$299.90</b>	Greater than \$85,000 and less than or equal to \$129,000 <b>\$259.70</b>	Greater than \$85,000 and less than or equal to \$129,000 <b>\$272.70</b>
Higher adjustment category	Greater than \$120,000 <b>\$161.40</b>	Greater than \$123,000 <b>\$238.40</b>	Greater than \$128,000 <b>\$308.30</b>	Greater than \$129,000 <b>\$353.60</b>	Greater than \$129,000 <b>\$369.10</b>	Greater than \$129,000 <b>\$319.70</b>	Greater than \$129,000 <b>\$335.70</b>

**Source:** Centers for Medicare & Medicaid Services, Annual Notices, “Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible,” 2007 through 2014, and Centers for Medicare & Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015,” 79 *Federal Register* 61314, October 10, 2014.

## Appendix C. Estimated Future Part B Premiums

**Table C-1. Projected Part B Premiums**

	Percentage of Program Costs Represented by Premium				
	25% (Standard)	35%	50%	65%	80%
<b>2016<sup>a</sup></b>	\$159.30	\$223.00	\$318.60	\$414.20	\$509.80
<b>2017</b>	120.70	168.90	241.30	313.70	386.10
<b>2018</b>	122.30	171.20	244.50	317.90	391.20
<b>2019</b>	132.20	185.00	264.30	343.60	422.90
<b>2020</b>	140.00	195.90	279.90	363.90	447.80
<b>2021</b>	147.60	206.60	295.20	383.80	472.30
<b>2022</b>	155.80	218.10	311.50	405.00	498.40
<b>2023</b>	164.50	230.20	328.90	427.60	526.20
<b>2024</b>	173.90	243.50	347.80	452.10	556.50

**Source:** 2015 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, July 22, 2015, Tables V.E2 and V.E3.

**Notes:** These figures only represent estimates of future premiums. Actual premiums are determined each year in the fall prior to the actual year the premium will be in effect.

- a. In their 2015 report, the Medicare Trustees estimate that the *hold-harmless* provision will go into effect for most beneficiaries due to an expectation that there will be a 0% cost-of-living increase (COLA) for Social Security benefits. Should this occur, beneficiaries who have their premiums deducted from their Social Security checks at the end of 2015 and the beginning of 2016 will pay the same premium as they did in 2015, \$104.90. Those who pay the high-income premiums, who receive premium assistance through Medicaid, who do not receive Social Security, or who are new to Medicare in 2016 are not protected by the hold-harmless rule and are thus expected to pay the estimated premium amounts shown in this table for 2016. If there is a Social Security COLA in 2017, then it is expected that the premiums of those not held harmless in 2016 would drop in 2017, while the premiums of those held harmless in 2016 would increase.

## Appendix D. Part A Premiums

The vast majority of persons turning the age of 65 are automatically entitled to Medicare Part A based on their own or their spouse's work in covered employment. However, individuals aged 65 and older who are not otherwise eligible for Medicare Part A benefits and certain disabled individuals who have exhausted other entitlement may voluntarily purchase Part A coverage.<sup>122</sup> In most cases, persons who voluntarily purchase Part A must also purchase Part B. The periods during which one can enroll are the same as those for Part B (see "Medicare Part B Eligibility and Enrollment").

The monthly Part A premium is equal to the full average per capita value of the Part A benefit (\$407 per month in 2015). Persons who have at least 30 quarters of covered employment (or married to someone who has such coverage) pay a premium that is 45% less than the full Part A premium (\$224 per month in 2015). CMS estimates that in 2015, about 644,000 individuals will voluntarily enroll in Part A by paying the full premium and about 58,000 will pay the reduced premium.<sup>123</sup>

Similar to Part B, a penalty is imposed for persons who delay Part A enrollment beyond their initial enrollment period (which is the same 7-month period applicable for enrollment in Part B).<sup>124</sup> However, both the amount of the penalty and the duration of the penalty are different than under Part B. Persons who delay Part A enrollment for at least 12 months beyond their initial enrollment period are subject to a 10% premium surcharge.<sup>125</sup> The surcharge is 10% regardless of the length of the delay. Further the surcharge only applies for a period equal to twice the number of years (i.e., 12-month periods) during which an individual delays enrollment. Thus, an individual who delays enrollment for three years under Part A would be subject to a 10% penalty for six years, whereas a person who delays enrollment for the same three-year period under Part B would be subject to a permanent 30% penalty.<sup>126</sup>

<sup>122</sup> An individual eligible to enroll must be a resident of the United States. Further, the individual must either be a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for the immediately preceding five years. Section 1818A of the Social Security Act provides for voluntary enrollment in Medicare Part A for certain disabled individuals who were entitled to coverage due to their receipt of disability benefits, but who have lost those benefits because they have returned to work and their incomes exceed the level of "substantial gainful activity." For additional information on Part A benefits for the disabled returning to work, see Social Security website "Working While Disabled," at <http://www.socialsecurity.gov/pubs/10095.html>.

<sup>123</sup> "Medicare Program; CY 2015 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement," 79 *Federal Register* 61312, October 10, 2014, at <http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24250.pdf>.

<sup>124</sup> The Consolidated Appropriations Act of 2001 (P.L. 106-554) exempts certain state and local retirees, retiring prior to January 1, 2002, from the Part A delayed enrollment penalty. These are groups of persons for whom the state or local government elects to pay the Part A delayed enrollment penalty for life. The amount of the penalty which would otherwise be assessed is to be reduced by an amount equal to the total amount of Medicare payroll taxes paid by the employee and the employer on behalf of the employee. The provision applies to premiums beginning January 2002.

<sup>125</sup> Similar to Part B, if one qualifies for and signs up during a special enrollment period, e.g., within 8 months of retiring, one may not be subject to a penalty.

<sup>126</sup> Prior to enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272), there was no upper limit on the amount of the Part A surcharge or duration of the surcharge. COBRA limited the amount of the Part A surcharge to 10% and the duration to twice the period of delayed enrollment.



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