



Medicare: Part B Premiums

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Summary

Medicare beneficiaries have out-of-pocket cost-sharing requirements that differ according to the services they receive. Physician and outpatient services provided under Part B are financed through a combination of beneficiary premiums, deductibles, and federal general revenues. In general, Part B beneficiary premiums equal 25% of estimated program costs for the aged, with federal general revenues accounting for the remaining 75%. The disabled pay the same premium as the aged. Beginning in 2007, higher-income enrollees paid a higher percentage of Part B costs. The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare) estimated that approximately 4% of beneficiaries would pay a higher premium in 2007, and 5% would pay a higher premium in 2008 and 2009.

The standard monthly Part B premium for 2009 will be \$96.40, the same as the standard 2008 premium. Although costs in the Medicare Part B program are expected to grow between 2008 and 2009, the standard premium will remain the same because steps taken by CMS in recent years have resulted in a contingency reserve in the Supplementary Medical Insurance (Part B) trust fund that is “more than adequate.”

Higher-income beneficiaries subject to a premium adjustment will pay larger premiums. In 2009, while the standard premium will be \$96.40, beneficiaries in the four income-related premium categories will pay premiums of \$134.90, \$192.70, \$250.50, or \$308.30 per month.

Beneficiaries who enroll in Part B after their initial enrollment period and/or reenroll after a termination of coverage are subject to a “delayed enrollment penalty.” The delayed enrollment penalty 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, some military retirees, and some international volunteers.

The basis for determining the Part B premium amount has changed several times since the inception of the Medicare program, reflecting different 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. While there have been many changes over the years, the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) permanently set the premium at 25% of program costs so that, generally speaking, premiums rise or fall with Part B program costs.

Current issues related to the Part B premium that may come before Congress include the recent requirement that higher-income beneficiaries pay a larger income-related premium, the programs that assist low-income beneficiaries with out-of-pocket Medicare costs including the Part B premium, the amount of the premium and the rate of increase in recent years (by 2080, projections by the Medicare trustees indicate that a medium earner will need 15% of his or her Social Security benefits to pay the Part B premium), and modifications to the late enrollment penalty. The report also discusses the comparative cost adjustment program, the Part B deductible, and the Part A premium. This report will be updated as needed.

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Introduction

Medicare is the nation's health insurance program for individuals aged 65 and over and certain disabled persons. Medicare consists of four distinct parts: Part A (Hospital Insurance [HI]); Part B (Supplementary Medical Insurance [SMI]); Part C (Medicare Advantage [MA]); and Part D (the outpatient prescription drug benefit added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [MMA]).

Medicare Premiums

Medicare beneficiaries have out-of-pocket cost-sharing requirements that differ according to the services they receive. Medicare Part A does not require a beneficiary premium (except in rare occasions¹) as Part A is primarily financed through payroll taxes, although beneficiaries still have deductibles and copayments for these services. In contrast, physician and outpatient services provided under Part B as well as outpatient prescription drug benefits under Part D are financed through a combination of beneficiary premiums, deductibles, and federal general revenues. Medicare beneficiaries who enroll in a Part C managed care plan (MA) receive both Part A and Part B benefits through the managed care plan, which may charge beneficiaries a premium. Beneficiaries who enroll in a Medicare Advantage plan that also offers the prescription drug benefit (MA-PD) might pay a combined premium for all their Part B and Part D benefits.

In general, Part B beneficiary premiums equal 25% of estimated program costs for the aged, with federal general revenues accounting for the remaining 75%. The disabled pay the same premium as the aged. Beginning in 2007, higher-income enrollees paid a higher percentage of Part B costs. The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare) estimated that approximately 4% of beneficiaries would pay a higher premium in 2007, and 5% would pay a higher premium in 2008 and 2009.²

The standard monthly Part B premium for 2009 will be \$96.40, the same as the 2008 premium.³ Although costs in the Medicare Part B program are expected to grow between 2008 and 2009, the standard premium will remain the same because steps taken by CMS in recent years have resulted in a contingency reserve in the Supplementary Medical Insurance (Part B) trust fund that is "more than adequate."⁴ However, the 2009 premiums for Medicare beneficiaries who fall in the higher income categories and are subject to the income-related premium calculation will increase over

¹ Approximately 99% of Medicare beneficiaries have (or are the spouse of widower of someone who had) at least 40 quarters of Medicare-covered employment and have contributed payroll taxes and as a result do not pay a premium for Part A services. Part A services are still available for beneficiaries who do not meet this condition but they must pay a Part A premium. The voluntary Part A premium is equal to the actuarial value of the Part A benefit, however, persons who have at least 30 quarters of covered employment have a reduced Part A premium. Persons who voluntarily purchase Part A must also purchase Part B.

² CMS, "Medicare Premiums and Deductibles for 2007," Fact Sheet, September 12, 2006, "CMS Announces Medicare, Premiums, Deductibles for 2008," Fact Sheet, October 1, 2007, and "CMS Announces Medicare Premiums, Deductibles for 2009," Fact Sheet, September 19, 2008.

³ Centers for Medicare and Medicaid Services, "Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2009," 73, No. 186 *Federal Register* 55089-11096, September 24, 2008.

⁴ See CMS Fact Sheet, September 19, 2008 and the discussion of contingency reserve below for details.

the 2008 premium amounts largely because 2009 is the last year of a three-year phase-in period that requires these beneficiaries to bear a greater percentage of the average cost of the Part B program.

Individuals receiving Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks. In general, their Social Security checks cannot go down from one year to the next as a result of the annual Part B premium increase.⁵ However, this protection does not apply to higher-income persons subject to higher income-related premiums. Social Security payments are subject to an annual cost-of-living adjustment, or COLA; the 2009 COLA increase will be 5.8%.⁶

Enrollment in Medicare Part B

Generally, elderly or disabled individuals are able to qualify for Medicare. An individual (or spouse of an individual) who has worked in covered employment and paid Medicare payroll taxes is entitled to Medicare Part A benefits upon turning 65. Persons who have applied for Social Security or railroad retirement benefits automatically receive a Medicare card when they turn 65. Persons who have not applied for Social Security or railroad retirement benefits must file an application for Medicare benefits. An individual who becomes entitled to Medicare Part A is automatically enrolled in Part B unless he or she specifically refuses this coverage, however, an aged person not entitled to Part A may still enroll in Part B.⁷ Disabled persons who have received cash payments for 24 months under the Social Security or railroad retirement disability programs automatically receive a Medicare card and are automatically enrolled in Part B unless they specifically decline such coverage.

Initial Enrollment Periods

Some persons are required to file an application for Medicare benefits. These include persons who have not applied for Social Security or railroad retirement benefits because they are still working, and certain federal, state and local government workers who are not entitled to cash benefits under these programs, but who are still entitled to Medicare benefits. Further, aged persons not entitled to Part A must file an application if they wish to obtain Part B coverage.⁸

⁵ Specifically, the law provides that if the Part B premium increase is greater than the dollar increase in the annual Social Security cost-of living adjustment, the premium owed by the individual would be reduced to the amount needed to assure no reduction in the Social Security cash payment.

⁶ Social Security Administration, "Social Security Announces 5.8 Percent Benefit Increase for 2009," press release, October 16, 2008, <http://www.ssa.gov/pressoffice/pr/2009cola-pr.htm>.

⁷ An aged person not entitled to Part A may enroll in Part B if he or she is 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.

⁸ Since 1965, some changes have been made to the Part B enrollment provisions. The Social Security Amendments of 1972 (P.L. 92-603) removed the prior three-year limit for initial enrollment and reenrollment after an initial termination. Also in 1972, enrollment in Part B was made automatic for those entitled to Part A. Since most persons voluntarily enroll in Part B, there was now less likelihood that a person might inadvertently not obtain Part B protection; these persons still retained their right to reject Part B coverage. The Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) provided for continuous open enrollment; further, the provision preventing reenrollment more than twice was removed. The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) repealed the 1980 continuous open enrollment provision; the provision permitting unlimited reenrollment was retained. Other conforming changes have also been made over the period, reflecting such things as the coverage of the disabled population and the addition of (continued...)

A person's initial enrollment period is seven months long and begins three months before the month in which the individual first meets the eligibility requirements. 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 enrollment penalties discussion below).

General Enrollment Period

An individual who does not establish eligibility during the initial enrollment period must wait until the next general enrollment period. In addition, persons who specifically decline Part B coverage, or terminate Part B coverage, must also wait until the next general enrollment period to enroll or re-enroll. The general enrollment period lasts for three months from January 1 to March 31 of each year, with coverage beginning on July 1 of that year. A delayed enrollment penalty may apply.

Collection of the Part B Premium

When possible, the Medicare Part B premium is deducted from the monthly benefit, annuity, or pension check of Social Security or railroad retirement beneficiaries and civil service annuitants, except for those beneficiaries enrolled as state public assistance recipients. 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.⁹ 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.

Determining the Part B Premium

Each year, Medicare actuaries estimate total per capita incurred Part B costs for beneficiaries aged 65 and older over the following year and set the Part B premium to cover 25% of expenditures. However, because prospective estimates may differ from the actual spending for the year, program income for the year may not equal projected program costs. Since the trust fund assets must be maintained at a level to cover a moderate degree of variation between actual and projected costs, this flexibility is achieved through a contingency reserve adjustment.

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 were higher than expected.¹⁰ In some cases, legislation that has the effect of increasing expenditures for the year has been enacted after the premium for the year has been set. For example, with

(...continued)

special enrollment periods for persons with group health plans.

⁹ 42 C.F.R. § 408.60. Premiums For Supplementary Medical Insurance: Subpart D—Direct Remittance: Individual Payment.

¹⁰ CMS Fact Sheet, September 19, 2008.

physician payments, current law specifies a 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. 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 each year and passed 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.

In calculating the premium for 2008, CMS recognized the possibility that Congress would override the reduction for 2008 (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 2008 premium. Because of this action, the contingency reserve was sufficiently large that the 2009 premiums did not have to increase, despite increases in overall Part B expenditures.¹¹

Premium Calculation for 2009

The monthly Part B premium amount is calculated by estimating the total cost of covered Part B services, removing required beneficiary cost sharing contributions (deductibles and coinsurance), adjusting for administrative expenses and interest, and setting a contingency reserve margin.¹² For 2009, the total monthly benefit costs of \$463.92 were reduced by \$73.36 for required beneficiary cost-sharing (\$11.00 for the deductible and \$62.36 for coinsurance). The resulting amount of \$390.56 was increased by \$6.40 for administrative expenses and reduced by \$5.26 for interest earnings. An additional amount of \$6.28 was removed for the contingency margin adjustment. Twenty-five percent of the resulting net per capita amount yields a 2009 standard premium amount (when rounded to the nearest \$0.10) of \$96.40.¹³

Although the standard premium amount in 2009 is the same as the amount for 2008, the calculations had different underlying figures. The estimated total monthly benefit costs, beneficiary cost sharing, administrative expenses and interest earnings were all lower in calculating the 2008 premium than in the calculation for 2009. However, an amount equal to \$23.70 was *added* to increase the reserves for the contingency margin adjustment in 2008.¹⁴ This cushion allowed CMS to keep premiums from increasing in 2009.

Enrollment Penalty and Exceptions

Beneficiaries who enroll in Part B after their initial enrollment period and/or reenroll after a termination of coverage are subject to a “delayed enrollment penalty.” The penalty provision was included in the original Medicare legislation enacted in 1965 to help prevent adverse selection on

¹¹ CMS, *Federal Register*, September 24, 2008, op. cit.

¹² The actual calculation presented in the regulation shows the numbers for the “monthly actuarial rate” which equals 50% of costs.

¹³ See CMS *Federal Register*, September 24, 2008, op. cit., pp. 55092-4.

¹⁴ Centers for Medicare and Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible Beginning January 1, 2008,” 72, No. 193 *Federal Register* 57039, October 5, 2007.

the part of beneficiaries.¹⁵ The late enrollment penalty was put in place to create a strong incentive for all eligible beneficiaries to enroll in Part B. With most persons over 65 enrolled in Part B, the costs are spread over the majority of this population and per capita costs are less than would be the case if adverse selection had occurred.

The delayed enrollment penalty is equal to a 10% surcharge for each 12 months of delay in enrollment and/or reenrollment. Thus, the length of the period equals: (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 re-enrolls, the months that elapse between the termination of coverage and the close of the enrollment period in which the individual enrolls. For example, if an individual's first enrollment period ended in September 2005 and the individual subsequently enrolled during the 2008 general enrollment period, the surcharge would be 20%. (Although the elapsed time covers a total of 30 months of delayed enrollment, the episode includes only two full 12-month periods.) 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.

Under certain conditions, select beneficiaries are exempt from the delayed enrollment penalty. Beneficiaries who are exempt include working individuals (and their spouses) with group coverage, some military retirees, and some international volunteers.

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 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). 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. A large group health plan is one which covers 100 or more employees.^{16 17}

¹⁵ 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 turn out to be 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 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.

¹⁶ Persons permitted to delay coverage without penalty are those persons whose Medicare benefits are determined under the Medicare secondary payer (MSP) program. Under MSP, 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 as is made available to other employees. 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 over age 65. 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 employees or their dependents who are on the Medicare disability program.

¹⁷ The Balanced Budget Act of 1997 (BBA, P.L. 105-33) added an additional 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 six-month enrollment period beginning on the first day of the month in which the termination occurs. Individuals who fail to enroll during this period would be considered to have delayed enrollment.

Individuals who are permitted to delay enrollment have their own *special enrollment periods*. A special enrollment period begins when current employment (or coverage under the employer-sponsored plan) ends and lasts for eight months. Individuals who fail to enroll in this period are considered to have delayed enrollment and then could become subject to the penalty.

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), which authorized a permanent comprehensive health care benefit for Medicare-eligible retirees who are enrolled in Part B. These military retirees were made eligible for health care within TRICARE, the military health care system, effective October 1, 2001. TRICARE for Life serves as a second payer to Medicare, paying cost sharing amounts for services covered under Medicare. Eligibility for TRICARE for Life is contingent on enrollment in Part B and, once enrolled, beneficiaries are eligible for any TRICARE for Life benefits not covered by Medicare. Section 625 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) waived the Part B enrollment penalty for military retirees, age 65 and over, who enrolled in the TRICARE for Life program from 2001-2004. A special enrollment period applied for these persons, which ended December 31, 2004. The waiver applied to premiums for months beginning January 1, 2004.¹⁸

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. The individuals must demonstrate 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.

Approximately 5% of Medicare enrollees are subject to higher premiums based on their higher incomes (see discussion of income-related premiums below). However, the delayed enrollment surcharge applies only to the standard monthly premium amount and not to the total income-related premium amount including the higher income adjustment.

History of the Part B Premium

Statutory Evolution of the Premium

The basis for determining the Part B premium amount has changed several times since the inception of the Medicare program, reflecting different 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

¹⁸ The Secretary of the Health and Human Services was required to rebate any penalties paid for months on or after January 2004, which were no longer applicable as a result of this provision.

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. (See **Appendix** for year-by-year details.)

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. (See **Figure 1**.)

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 Congressional Budget Office (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.¹⁹

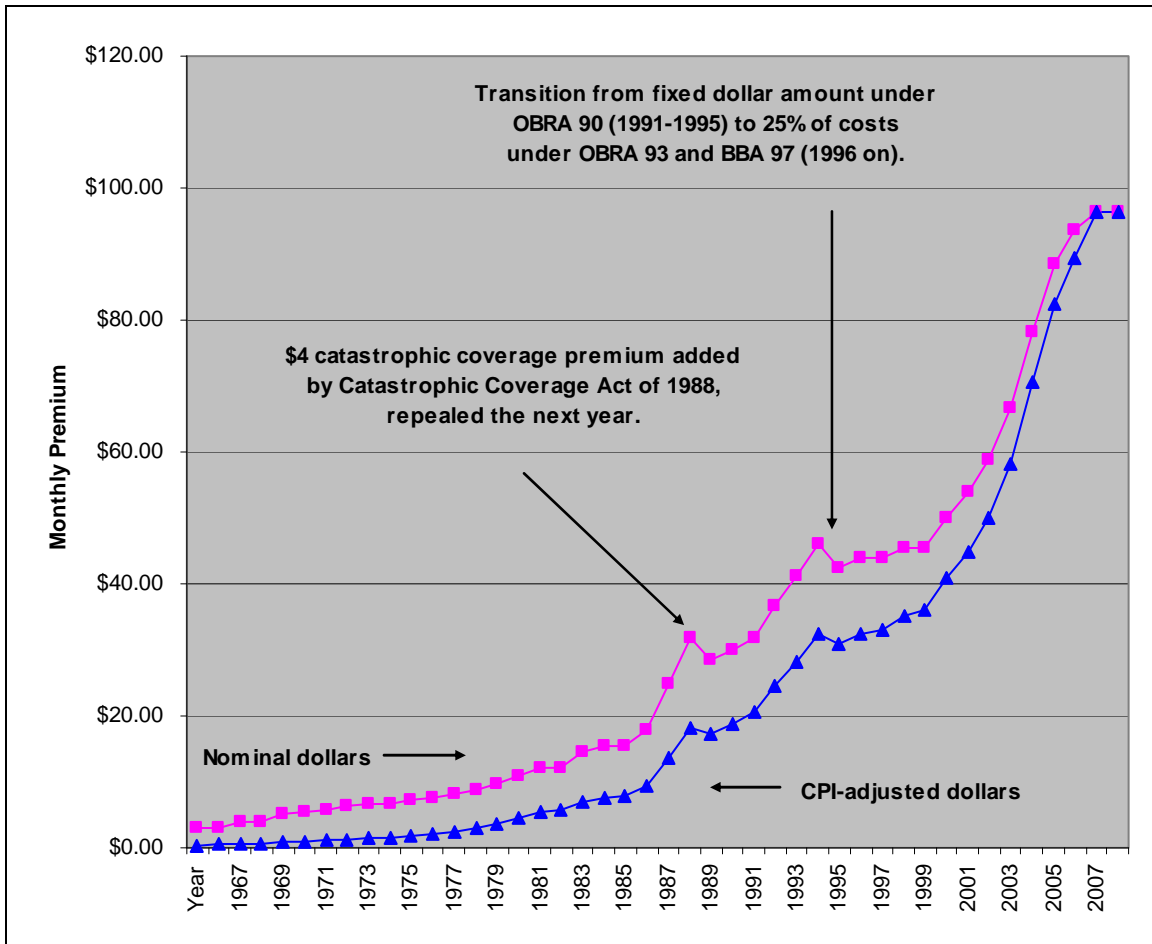
Part B Premium Amount over Time

The Part B premium has increased over the years along with total Part B expenditures as the two are linked, although the precise relationship has changed with modifications to the statute. There are instances when the premium has declined or has not changed from year to year, and many of the policies discussed above were in response to the impact of Part B program expenditure increases on beneficiary premiums.

In nominal dollar terms (not adjusted for inflation), the Part B premium has risen from \$3.00 in 1966 to \$96.40 for 2009 (see **Figure 1**). Over that period, the premium has decreased from year to year twice: once from 1989 (\$31.90) to 1990 (\$28.60) as a result of the repeal of the Catastrophic Coverage Act, as mentioned above, 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 OBRA 90 to 25% of costs as directed under OBRA 93. The premium has more than doubled in recent years, increasing from \$45.50 in 2000 to \$96.40 in 2008 and 2009.

¹⁹ 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.

Figure 1. Monthly Medicare Part B Premiums
 Nominal and CPI-adjusted dollars, 1966-2009



Source: CRS figure, based on the **2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds**, Table V.C2. – SMI Cost Sharing and Premium Amounts, and U.S. Department Of Labor, Bureau of Labor Statistics, “History of CPI-U U.S. All Items Indexes and Annual Percent Changes From 1913 to Present,” <ftp://ftp.bls.gov/pub/special.requests/cpi/cpiat.txt>.

Notes: See **Appendix** for yearly details.

Because prices have increased every year since the inception of the Medicare program (as measured by the consumer price index, or CPI),²⁰ inflation-adjusted premiums show an even more pronounced increase over time. The original premium in 1966, adjusted for inflation, would be \$0.45 in 2008 dollars. (See **Figure 1**.)

The proportion of the Social Security benefit required to pay for the Part B premium depends on the earnings history of the beneficiary (and thus the amount of the Social Security benefit), however, this share has been growing in recent years. A Social Security (and Medicare) beneficiary who earned the average wage throughout his or her career (called a medium earner)

²⁰ See U.S. Department of Labor, Bureau of Labor Statistics table, “History of CPI-U U.S. All Items Indexes and Annual Percent Changes From 1913 to Present,” <ftp://ftp.bls.gov/pub/special.requests/cpi/cpiat.txt>.

would have needed about 5% of the retiree's benefits in 1999 and about 8% in 2008 to pay the standard Part B premium. By 2080, projections by the Medicare trustees indicate that a medium earner will need 15% of his or her Social Security benefits to pay the Part B premium.²¹

The premium increase in recent years is attributable to a number of factors that have increased Part B expenditures. CMS cites the growth in a number of service categories, including home health, physician-administered drugs, ambulatory surgical centers, durable medical equipment, independent labs, and physician office labs, as well as the growth in the Medicare Advantage (MA) program.²² Increases attributed to the MA program reflect the increase in the average risk of enrolled beneficiaries (which increases average per capita payments), as well as the impact of fee-for-service cost growth on MA county benchmarks.

Current Issues

Current issues related to the Part B premium that may come before the Congress include the recent requirement that higher-income beneficiaries pay a larger income-related premium, the programs that assist low-income beneficiaries with out-of-pocket Medicare costs including the Part B premium, the amount of the premium and the rate of increase in recent years (and the potential impact on net Social Security benefits), and modifications to the late enrollment penalty.

Income-Related Premium

For the first forty-one years of the Medicare program, all Part B enrollees paid the same Part B premium, regardless of their income. Over time, a number of proposals have been offered that would increase the share of Part B costs borne by higher-income individuals. Some observers suggested that it might be inappropriate for taxpayers to pay (through general revenue financing) three-quarters of Part B costs for these persons, as this could result in low income and middle income working persons subsidizing higher-income elderly persons. However, others have argued that relating premiums to income would relieve some of the financial pressure on the program even though the transition might represent a first step in moving away from the entitlement nature of the Medicare program. Further, some individuals have suggested that higher-income enrollees might be tempted to drop Medicare Part B coverage as a result of the higher premium although, as a practical matter, the number of beneficiaries who have this as an option might be few as there are few alternatives available for the Medicare-eligible population in the private insurance market.²³

The Medicare Modernization Act of 2003 (MMA) increased the Part B premium percentage for high-income enrollees beginning in 2007. The MMA would have phased in the increase over five years, however, the Deficit Reduction Act of 2005 (DRA) shortened the phase-in period to three years. At the time of enactment of the MMA, the Congressional Budget Office (CBO) estimated

²¹ See CRS Report RL33364, *The Impact of Medicare Premiums on Social Security Beneficiaries*, by Kathleen Romig for details.

²² Payments to Medicare Advantage plans are made in appropriate part from the Medicare Part A Hospital Insurance Trust Fund and from the Medicare Part B Supplementary Insurance Trust Fund.

²³ Medicare beneficiaries who have coverage through a group plan offered by their spouse's employer might also be able to consider dropping Part B, however, this is a small subset of the Medicare Part B population.

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.²⁴

In announcing the premium levels for 2007 through 2009, the Centers for Medicare and Medicaid Services (CMS) estimated that 4% of enrollees would be subject to the higher premium amounts in 2007 and 5% in 2008 and 2009. While some have intimated that an income-related premium incrementally moves Medicare away from an entitlement program and gives Medicare a characteristic of a means tested program, the same Part B benefits are available to all enrollees, regardless of income.

The Part B premiums for high-income beneficiaries are based on a greater beneficiary share of total expenditures that increases with income. Beginning in 2007, individuals whose modified adjusted gross income (AGI) exceeded \$80,000, and couples whose modified AGI exceeded \$160,000, were subject to higher premium amounts. When both members of a couple are enrolled in Part B, each pays the applicable premium amount.

The income level categories are indexed to change with the consumer price index for urban consumers (CPI-U), rounded to the nearest \$1,000. Thus, the 2008 income levels for the lowest of the four higher-income categories were \$82,000 - \$102,000 for an individual and \$164,000 - \$204,000 for a couple. CMS estimates that approximately 4% of Part B enrollees paid a premium greater than the standard amount in 2007, with less than 1% of beneficiaries falling in the highest premium category. Income levels for all categories and years from 2007-2009 are shown in **Table 1**.

Table 1. Income Levels for Determining Medicare Part B Premium Adjustment
2007-2009 (in nominal dollars \$)

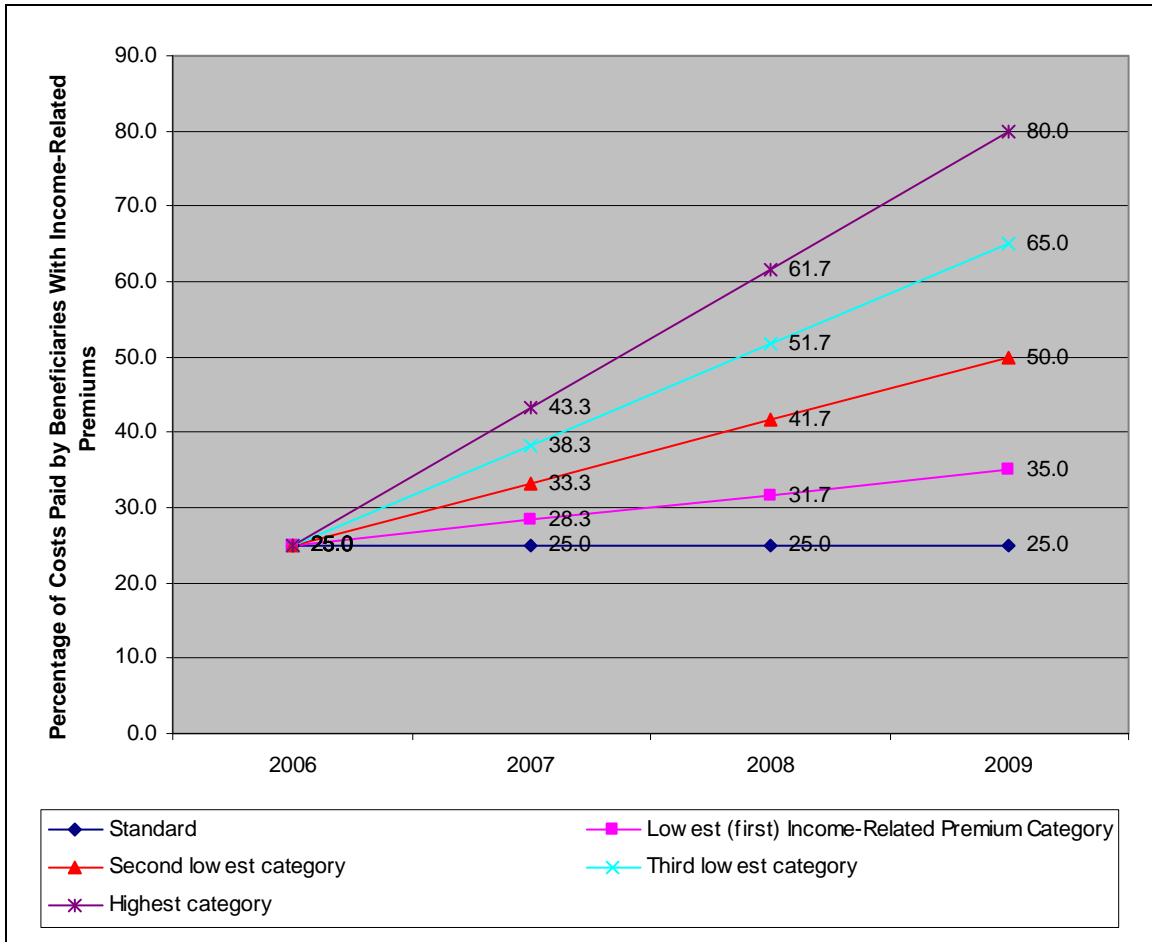
Income Level	2007	2008	2009
Standard	Less than 80,000 individual	Less than 82,000 individual	Less than 85,000 individual
	Less than 160,000 couple	Less than 164,000 couple	Less than 170,000 couple
Lowest (first) Category	80,000-100,000 individual	82,000-102,000 individual	85,000-107,000 individual
	160,000-200,000 couple	164,000-204,000 couple	170,000-214,000 couple
Second lowest Category	100,001-150,000 individual	102,001-153,000 individual	107,000-160,000 individual
	200,001-300,000 couple	204,001-306,000 couple	214,000-320,000 couple
Third lowest Category	150,001-200,000 individual	153,001-205,000 individual	160,001-213,000 individual
	300,001-400,000 couple	306,001-410,000 couple	320,000-426,000 couple
Highest Category	200,001+ individual	205,000+ individual	213,000+ individual
	400,000+ couple	410,000+ couple	426,000+ couple

²⁴ 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.

Source: Centers for Medicare and Medicaid Services, “Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2009,” 73, No. 286 *Federal Register* 55089-55096, September 24, 2008.

In 2009, the income-related premiums are to be fully phased in with higher-income individuals paying total premiums ranging from 35% to 80% of the value of Part B. See **Figure 3** for the percentages by income category as phased in over the three years, 2007-2009.

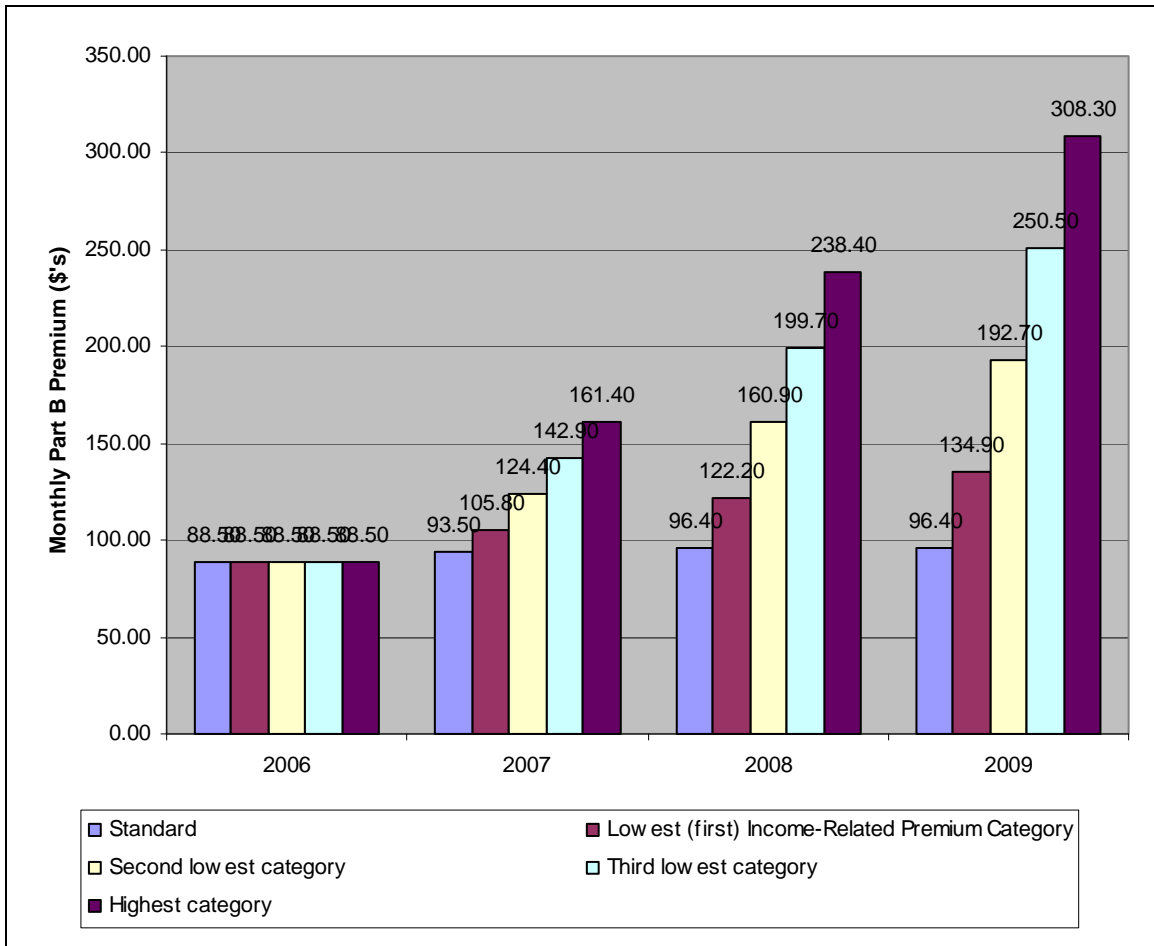
Figure 2. Percentage of Costs Paid by Beneficiaries with Income-Related Premiums 2006-2009



Source: CRS figure based on data from CMS.

As a result of the income-related adjustment and the phase-in of the increased share of program costs paid by higher income beneficiaries, the variation in premiums increases from no difference in 2006 to a three-fold difference between the standard premium and the premium paid by beneficiaries in the highest premium-adjustment income category in 2009. In 2006, the year before the income-related adjustment, all premiums were \$88.50. In 2009, premiums will range from \$96.40 for the standard premium to \$308.30 for beneficiaries in the highest income-related premium category. (See **Figure 3**.)

Figure 3. Part B Premiums by Beneficiary Income Category
2006-2009



Source: CRS figure based on CMS data.

Notes: Numbers above the bars are the premium amounts for that year for that beneficiary income category,

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 show in **Table 2**.

Table 2. Income Levels for Determining Part B Premium Adjustment for Married Beneficiaries Filing Separately
2007-2009

Income Level	2007	2008	2009
Standard	\$93.50	\$96.40	\$96.40
Lower adjustment category	143.40	199.70	250.50
Higher adjustment category	162.10	238.40	308.30

Source: Centers for Medicare and Medicaid Services, "Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2009," 73, No. 286 *Federal Register* 55089-55096, September 24, 2008.

Notes: The actual income levels are indexed and increase year to year. Thus, the thresholds were (i) less than \$80,000/\$82,000/\$85,000 for 2007/2008/2009 respectively for beneficiaries who had no additional adjustment and paid the standard premium (second row of the table); (ii) from \$80,000 to \$120,000/\$82,000 to \$123,000/\$85,000 to \$128,000 for 2007/2008/2009 (third row of the table); and, (iii) greater than \$120,000/greater than \$123,000/greater than \$128,000 for 2007/2008/2009 (fourth row of the table).

The term "modified AGI" means adjusted gross income as defined under the Internal Revenue Code plus the following:

- tax-exempt interest income;
- income from U.S. savings bonds used to pay higher education tuition and fees;
- foreign-earned income;
- income derived from sources within Guam, American Samoa, or the Northern Mariana Islands; and
- income from sources within Puerto Rico.²⁵

In general, the taxable year used in determining the premium is the second calendar year preceding the relevant year. For example, 2007 income is used to calculate the 2009 premium amount. If a person had a one-time increase in income in a particular year (such as from the sale of income producing property), that increase will be considered in determining the individual's total income for that year and liability for the income-related premium two years ahead, when the premium calculation is based on the year in question. It will 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 modified AGI, an individual may request to have the determination made for a more recent year than the second preceding year. Major life-changing events are defined as:

- death of a spouse;
- marriage;
- divorce or annulment;
- partial or full work stoppage for the individual or spouse;
- 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);
- reduction or loss for individual or spouse of pension income due to termination or reorganization of the plan or scheduled cessation of the pension.²⁶

²⁵ Social Security Administration, Medicare Part B Income-Related Monthly Adjustment Amount, vol.71n no.208, October 27, 2006, 62923.

²⁶ *Ibid.*, 62937.

The current law provision that prevents a beneficiary's check from decreasing from one year to the next as a result of the Part B premium increase does not apply to persons subject to an income-related increase in their Part B premiums.

Some proposals have sought to modify the calculation of the income levels. Currently, the income levels are indexed to changes in the consumer price index (CPI) for urban consumers. President George W. Bush proposed eliminating the annual CPI adjustments in his proposed 2008 budget.²⁷ Such a modification would result in more beneficiaries being subject to the higher premium each year as incomes increased (in part due to inflation) while the thresholds remained stagnant. While this change in policy would yield cost savings to the government because more and more beneficiaries would pay higher premiums, it could lead to problems in the future when future average and lower income levels (which will be subject to inflation) approach the nominal and unchanging "higher income" thresholds of today.²⁸

Assistance for Low Income Beneficiaries

Certain low-income beneficiaries are entitled to assistance in paying their Part B premiums. Eligible persons fall into one of the following three coverage groups:

Qualified Medicare Beneficiaries (QMBs)

QMBs are aged or disabled persons with incomes at or below the federal poverty level. In 2008, the monthly federal poverty level is \$867 for an individual and \$1,167 for a couple²⁹ and assets below \$4,000 for an individual and \$6,000 for a couple and the QMB monthly qualifying levels are \$887 and \$1,187 respectively.³⁰ The monthly QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the federal-state Medicaid program. Medicaid protection is limited to 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 (SLIMBs)

These are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLIMB limit is 120% of the federal poverty level. In 2008, the monthly income limits are \$1,060 for an individual and \$1,420 for a couple.³¹ Medicaid protection is limited to payment of

²⁷ President Bush also proposed that the Part D premium be income-related using the same income levels and categories.

²⁸ This scenario would mirror the current alternative minimum tax (AMT) situation where the "millionaire's tax" affects more and more individuals each year who are not as far in the higher end of income distribution as those individuals affected by the AMT when it was initially enacted.

²⁹ The annual HHS poverty guidelines for 2008 are \$10,400 for an individual and \$14,000 for a couple. See Health and Human Services, "Annual Update of the HHS Poverty Guidelines," 73, No. 15 *Federal Register* 3971-3972, January 23, 2008.

³⁰ The qualifying levels are higher because, by law, \$20 per month of unearned income is disregarded in the calculation. Centers for Medicare and Medicaid Services, , CMS Publication No. 10126, March 2008, <http://www.medicare.gov/publications/pubs/pdf/10126.pdf>.

³¹ The qualifying levels are calculated the same way as for the QMB program.

the Medicare Part B premium (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.

Qualifying Individuals (QI-1)

These are persons who meet the QMB criteria, except that their income is between 120% and 135% of poverty. Further, they are *not* otherwise eligible for Medicaid. In 2008 the monthly income limit for QI-1 for an individual is \$1,190 and for a couple \$1,595. Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium.³² The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) extended the program through June 2008 and provided \$200 million for the six-month period from January 1, 2008 through June 30, 2008.³³ The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the program through December 31, 2009 and added another \$700 million.³⁴

Premium Amount and Annual Increases

The amount and the rate of growth of Part B premiums has received considerable attention in recent years. Since beneficiary premiums are currently required to cover 25% of total expenditures, the Part B premium will increase as total Medicare Part B expenditures increase. Thus, recent growth in expenditures for physician services, led by the increase in imaging and diagnostic services, produces pressure for beneficiary premiums to increase proportionately to cover the 25% share of total expenditures. The Medicare trustees project that premiums for Parts B (and D) will grow at a faster rate than Social Security benefits and consume a greater proportion of benefits over time.³⁵ In 2080, under conservative assumptions, a medium earner is projected to need 15% of his or her benefits to pay the Part B premium and 23% of his or her benefits to pay combined Parts B and D premiums.³⁶

As noted, an individual's Social Security payment cannot decrease from one year to the next as a result of an increase in the Part B premium (except for those subject to the income-related premium). However, some observers have suggested that beneficiaries should not face the prospect of losing a large portion of their cost-of-living (COLA) increase. Further, the hold harmless provision does not apply to the premiums for the Part D prescription drug program. Individuals enrolled in a Part D plan with a higher premium or newly enrolling in a plan in 2009 might see a reduction in their social security checks.³⁷

³² In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 program are paid for (100%) by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons who would bring its spending on these population groups in a year up to its allocation level. Any expenditures beyond that level are paid by the state.

³³ P.L. 110-173, Section 203.

³⁴ P.L. 110-275, Section 111.

³⁵ The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2008 Annual Report of the Boards of Trustees*, Washington, DC, March 25, 2008, pp. 77-84.

³⁶ In their 2008 Annual Report, the trustees note that "projected SMI expenditures are substantially understated because future reductions in physician payment rates, required under current law, are unrealistic and very likely to be overridden by Congress." (p. 77) See also Romig, op. cit.

³⁷ MMA added a new Medicare Part D drug benefit, effective January 1, 2006. The cost of this drug benefit is (continued...)

The tension between current law, which prescriptively determines physician payment updates, and the recent history of Congressional actions to override the statutory formula creates an ongoing dynamic that affects the Part B premium. Typically, the premium calculations are based on current law provisions that include a formula for calculating the annual update to the physician fee schedule. This formula has stipulated a reduction in the fee schedule conversion factor for every year since 2003.³⁸ Under current law, a significant reduction (21%) is slated to occur in 2010 and for a number of subsequent years.³⁹

Each change made to avert the scheduled reductions had and continues to have the effect of increasing overall Part B costs beyond the current law baseline and, by extension, the Part B premium. Some proposals before Congress have attempted to shield Medicare beneficiaries from premium increases by including hold-harmless provisions, however, these approaches would in turn place additional pressure on the Treasury and the general revenues that are needed to cover the expenses not offset by premiums.

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. For example, a number of persons suggested that the penalty should not apply to certain military retirees who declined Part B coverage. As noted above, these persons now have access to TRICARE for Life, provided they enroll in Part B. MMA waived the Part B penalty for persons enrolling in both programs by the end of 2004.

Some have suggested further 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. While some of the reasons for limiting the Part A penalties could also be offered for Part B, there are some significant differences. First, since almost all aged persons are automatically entitled to Part A, the Part A delayed enrollment penalty could affect only a small number of persons compared to the potential number under Part B. Second, persons who voluntarily enroll in Part A pay the full actuarial cost of Part A coverage while Part B enrollees currently pay only 25% of the actuarial cost with federal general revenues picking up the remainder. Third, the amount of the maximum

(...continued)

accounted for separately and has no effect on the Part B premium. However, beneficiaries enrolled in MA-PD plans that provide Part B and Part D services (as well as Part A services) may face a single premium that could increase at a rate different than the stand-alone Part B premium.

³⁸ Congress overrode the reductions that were slated to occur in 2003-2009 under the Consolidated Appropriations Resolution (CAR, P.L. 108-7, enacted in February 2003), the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), the Deficit Reduction Act of 2005 (DRA, P.L. 109-171, enacted February 8, 2006) the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432, enacted December 20, 2006), the Medicare, Medicaid and SCHIP Extensions Act (MMSEA, P.L. 110-173, enacted December 29, 2007), and the Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275, enacted July 15, 2008). CAR increased physician payments for 2003; MMA increased physician payments for 2004 and 2005; DRA froze 2006 physician payments at the 2005 level (thereby overriding a scheduled reduction); TRHCA continued the freeze for an additional year; MMSEA gave physicians an increase for the first six-month of 2008, which MIPPA extended through the end of 2008; and MIPPA also provided an additional increase for 2009. For a discussion of these payment issues, see CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O'Sullivan.

³⁹ CBO Cost Estimate, "H.R. 6331: Medicare Improvements for Patients and Providers Act of 2008," July 23, 2008, <http://www.cbo.gov/ftpdocs/95xx/doc9595/hr6331pgo.pdf>.

10% Part A surcharge is considerably larger than what a maximum 10% Part B surcharge would be and thus is more likely to serve as a disincentive to delayed enrollment.

Comparative Cost Adjustment Program

MMA requires the Secretary to establish a six-year comparative cost adjustment (CCA) program beginning in 2010. The CCA program will introduce competition between traditional fee-for-service (FFS) Medicare and local private plans. As a result, an individual residing in a CCA area who is enrolled in Part B of Medicare, but not enrolled in a managed care plan, could have an adjustment to his or her Part B premium, either as an increase or a decrease. No premium adjustment will be made for certain low-income persons. The annual adjustment for a year cannot exceed 5% of the amount of the basic monthly Part B premium, as otherwise determined. Skeptics doubt that the program will be implemented on time if at all, citing the repeal of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program as an example of the political climate for competitive bidding programs.⁴⁰

Related Issues

Part B Deductible

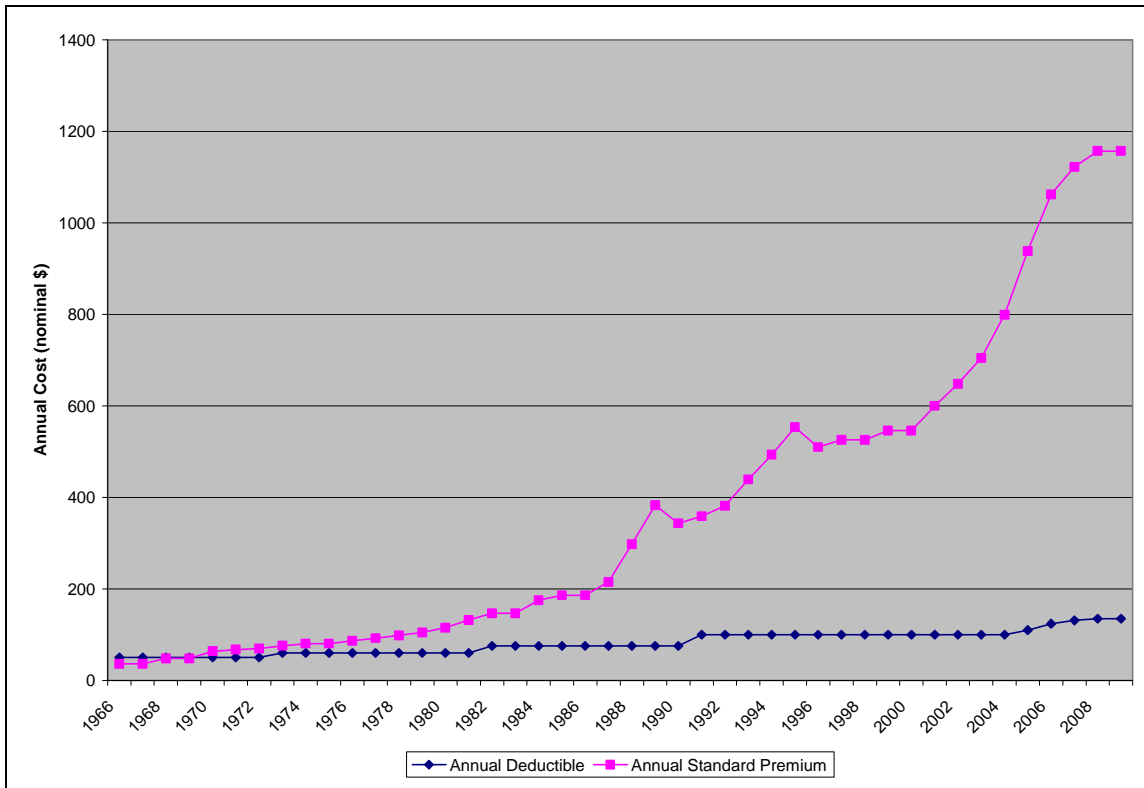
Prior to 2003, the Part B deductible was set in statute. MMA set the 2005 deductible level at \$110 and required that the deductible be indexed to the annual percentage increase in the Part B actuarial rate for aged beneficiaries beginning with 2006 (rounded to the nearest \$1).⁴¹ The Part B annual deductible for 2009 is \$135 for all beneficiaries.⁴² Initially, the annual deductible amount was greater than the annual cost of the premium (\$50 vs. \$36 in 1967) but this relationship switched in 1970 and now the annual cost of the Part B premium is nearly an order of magnitude greater than the annual deductible (\$1,156.80 vs. \$135 in 2009). See **Figure 4**.

⁴⁰ MMA required that CMS implement competitive bidding for DME with the first round to be initiated in 10 MSAs in 2008 and an additional 70 MSAs covered in the second round (2009). MIPPA, enacted into law over a veto on July 15, 2008, cancelled contracts that had taken effect only a few days before on July 1, 2008 and delayed the implementation of the DMEPOS National Competitive Bidding Program; the first round is to begin in 2009 and the second in 2011. For more information see <http://www.cms.hhs.gov/center/dme.asp>.

⁴¹ Section 629 of the MMA.

⁴² CMS Federal Register, Sept. 24, 2008, op. cit.

Figure 4. Annual Part B Deductible and Premium Amounts
1966-2009



Source: CRS figure, based on the **2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds**, Table V.C2. – SMI Cost Sharing and Premium Amounts.

Part A Premium

The vast majority of persons turning age 65 are automatically entitled to Medicare Part A based on their own or their spouse’s work in covered employment. Most persons not automatically covered under Part A have health insurance coverage through a former government employer. However, some persons may need Part A protection. These persons may voluntarily purchase Part A coverage.⁴³ The Part A premium is equal to the actuarial value of the Part A benefit (\$423 in 2008). Persons who have at least 30 quarters of covered employment have a reduced Part A premium (\$233 in 2008).⁴⁴ Persons who voluntarily purchase Part A must also purchase Part B.

⁴³ 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.

⁴⁴ On December 21, 2000, the President signed into law P.L. 106-554, the Consolidated Appropriations Act, 2001. This law 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.

A penalty is imposed for persons who delay Part A enrollment beyond their initial enrollment period (which is the same seven-month period applicable for enrollment in Part B). 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.⁴⁵ 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. A person who delays enrollment for the same three-year period under Part B would be subject to a permanent 30% penalty.⁴⁶

⁴⁵ An individual enrolled in a health maintenance organization (HMO) can sign up for Part A at any time while in the HMO and up to eight months after HMO coverage has ended. Any time the individual is enrolled with the HMO does not count toward determining whether the individual has delayed enrollment.

⁴⁶ Prior to enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 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.

Appendix. History of the Part B Premium Governing Policy and Legislative Authority

Table A-1. Monthly Part B Premiums, 1966-2009

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
1989	\$31.90	1/89	25% of costs, OBRA 87, plus \$4 catastrophic coverage premium added by Medicare Catastrophic Coverage Act of 1988

Year	Monthly premium	Effective date	Governing policy; legislative authority
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 st 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 nd 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 rd year of 3-year phase-in)

Source: Various Annual Trustee Reports, including the 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund, March 2008, and Centers for Medicare and Medicaid Services, "Medicare Program: Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2009," 73 *Federal Register* 55089-55096, September 24, 2008.

Note: CMS estimates that approximately 4% of high-income enrollees paid higher premiums in 2007 and 5% paid or will pay higher premiums in 2008 and 2009.

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