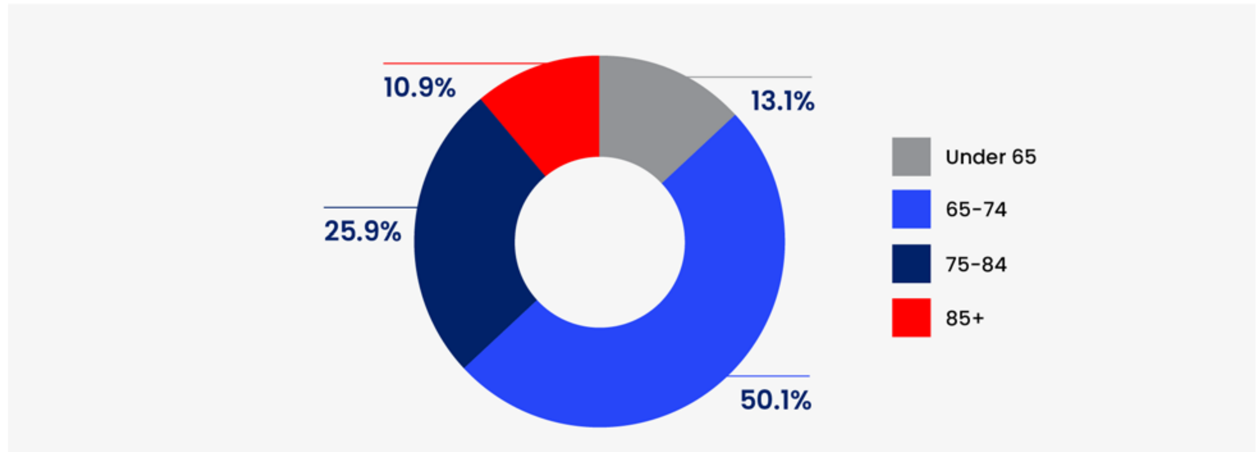
Medicare Program Basics

Medicare is a federal health program that provides health coverage for 65 million people, 57.1 million of whom qualify based on age (65 years and older) and work history (worked and paid payroll taxes for at least 40 quarters [10 years]) and 7.9 million of whom qualify based on a disability.[7] Almost 9 in 10 beneficiaries are ages 65 and older, and half of beneficiaries are between the ages of 65 and 74. The total number of people enrolled in the Medicare program is expected to increase to approximately 77 million people by 2030, due in part to the baby boom generation aging into the program.[8]

Figure 2: Share of Medicare Population by Age, 2020



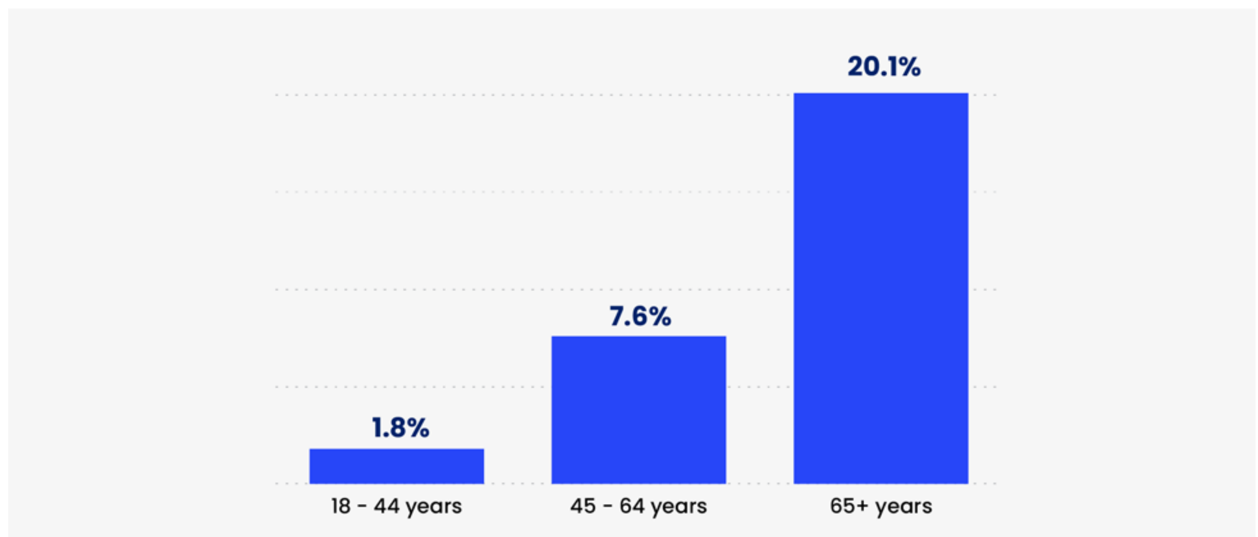
Source: MedPAC 2023 data book.

These demographic changes are particularly important for those interested in cancer policy because the risk of cancer increases with age.[9]

Cancer diagnoses

Most new cancers are diagnosed in individuals who are over the age of 65, and thus rely on Medicare as their primary source of coverage.

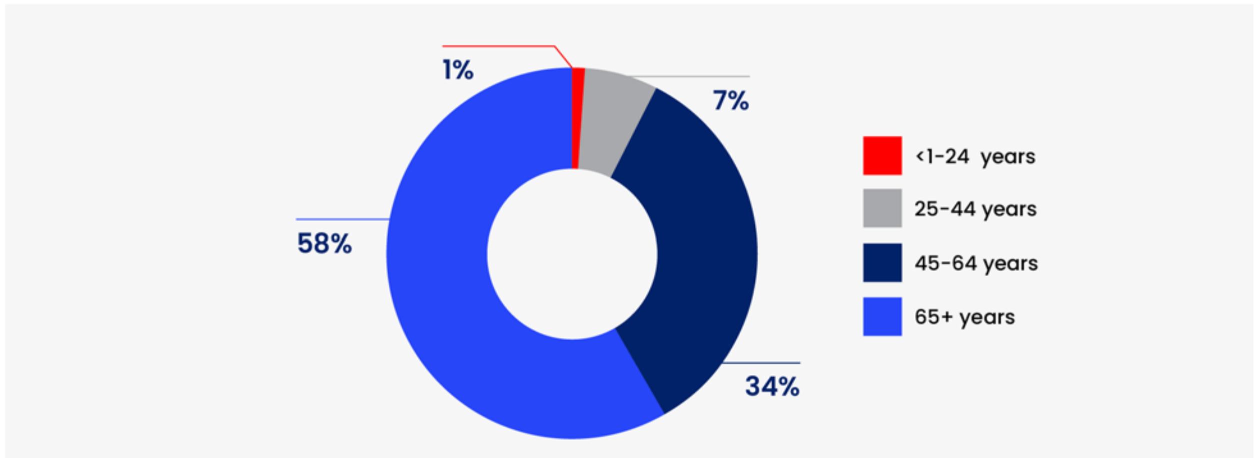
Figure 3: Reported History of Cancer in Adults by Age, 2019



Source: National Center for Health Statistics. Health, United States, 2020-2021: Table CanHst. Hyattsville, MD. 2023. Available from: cdc.gov/nchs/hus/data-finder.htm.

Of the more than 1.7 million new cancer cases expected to be diagnosed in 2023, over 1 million of those cases are expected to be diagnosed in individuals over the age of 65.

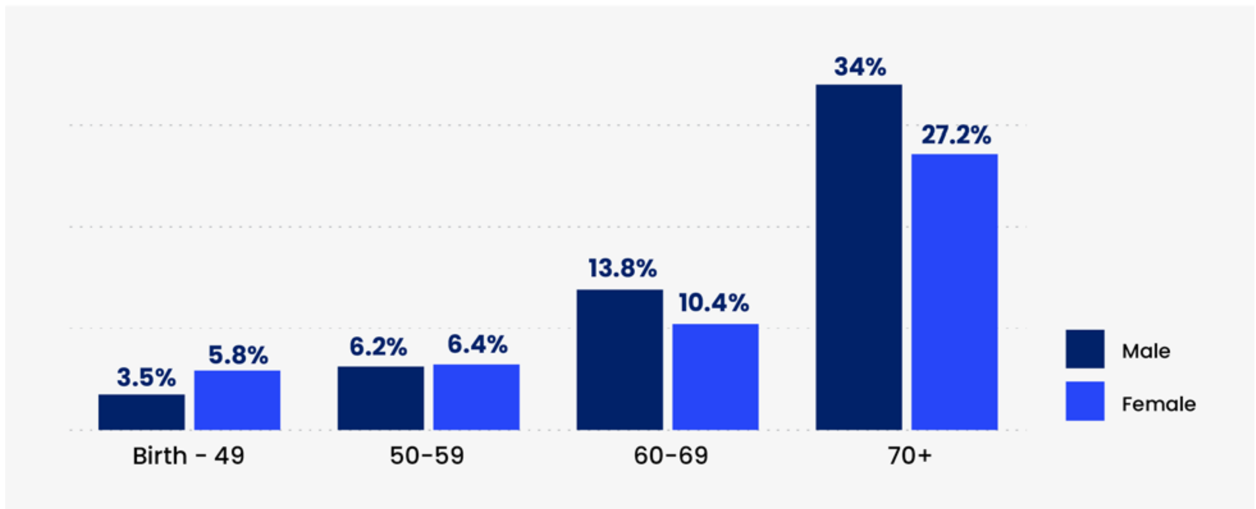
Figure 4: Incidence of New Cancer Cases, 2020



Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2023.

Not only does the incidence or risk of cancer increase with age, but the probability of developing an invasive form of cancer does as well. Invasive cancers occur when the cancer has spread beyond the area in which it initially develops and is growing into healthy tissue.[10]

Figure 5: Probability of Developing Invasive Cancer by Age Intervals and Gender, 2017-2019

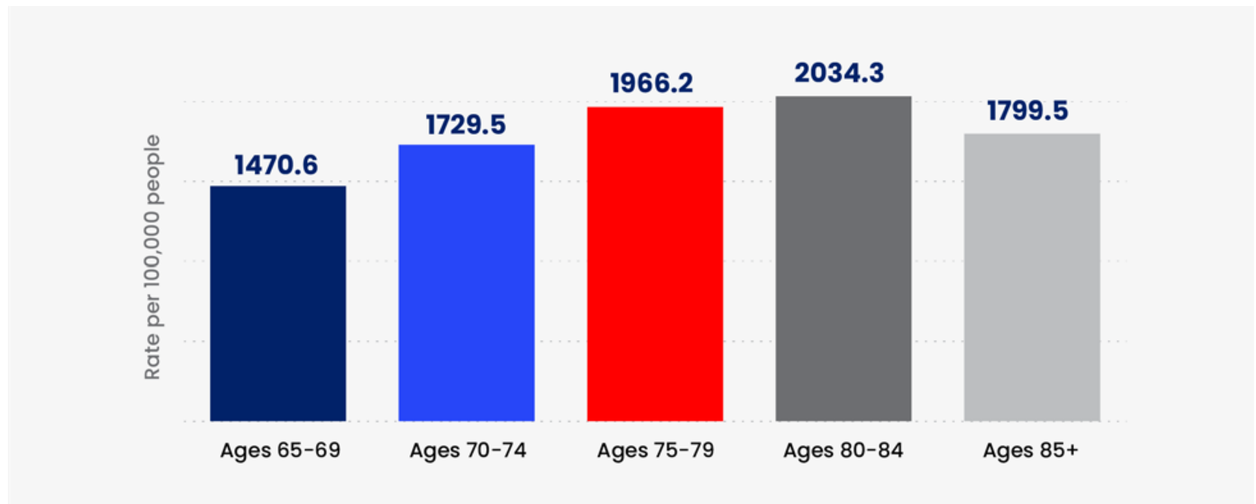


Source: Siegel, RL, Miller, KD, Wagle, NS, Jemal, A. Cancer statistics, 2023. *CA Cancer J Clin*. 2023; 73(1): 17- 48. doi:10.3322/caac.21763.

Distribution of cancers diagnosed among adults 65+

The incidence of cancer increases with age beyond age 65. Individuals between 80 and 84 years of age have the highest incidence of cancer diagnosis.

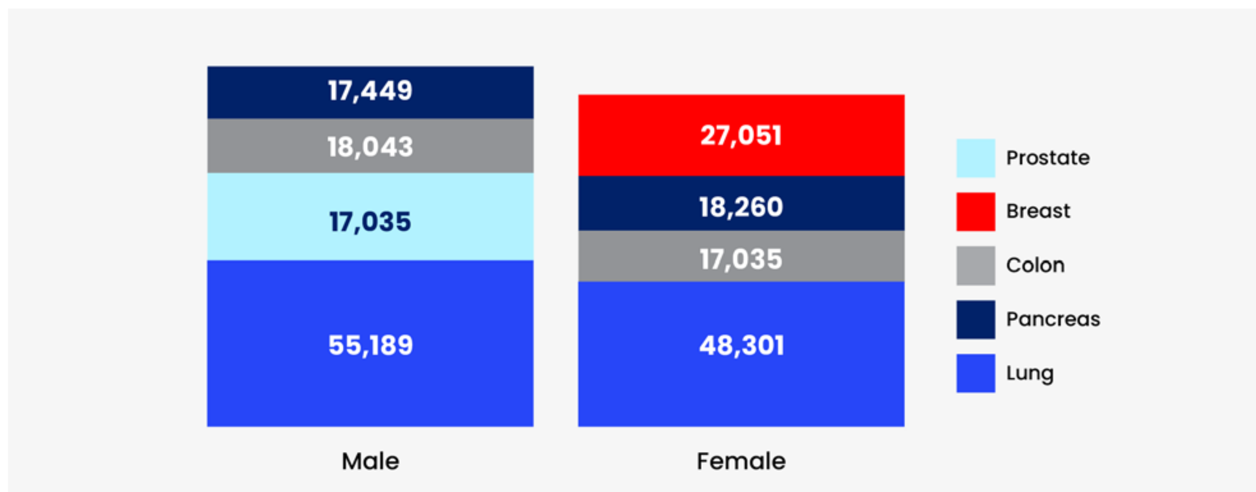
Figure 6: Incidence of Cancer Diagnosis by Age Group, 2020



Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2023.

The leading cause of cancer deaths in individuals ages 65 and over varies slightly by gender.

Figure 7: Leading Causes of Cancer Deaths Ages 65+ by Gender, 2020

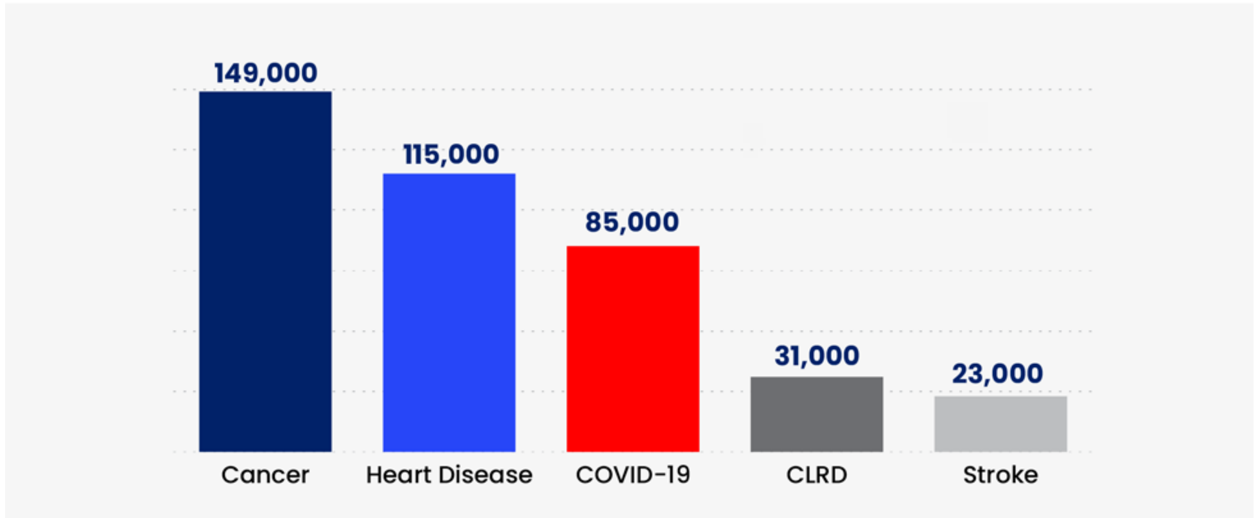


Source: Siegel RL, Miller KD, Sandeep Wagle N, Jemal A. Cancer Statistics, 2023. *Cancer*. Jan. 2023. doi.org.10.3322/caac.21763.

Cancer deaths

Cancer is the leading cause of death in adults ages 65-74.

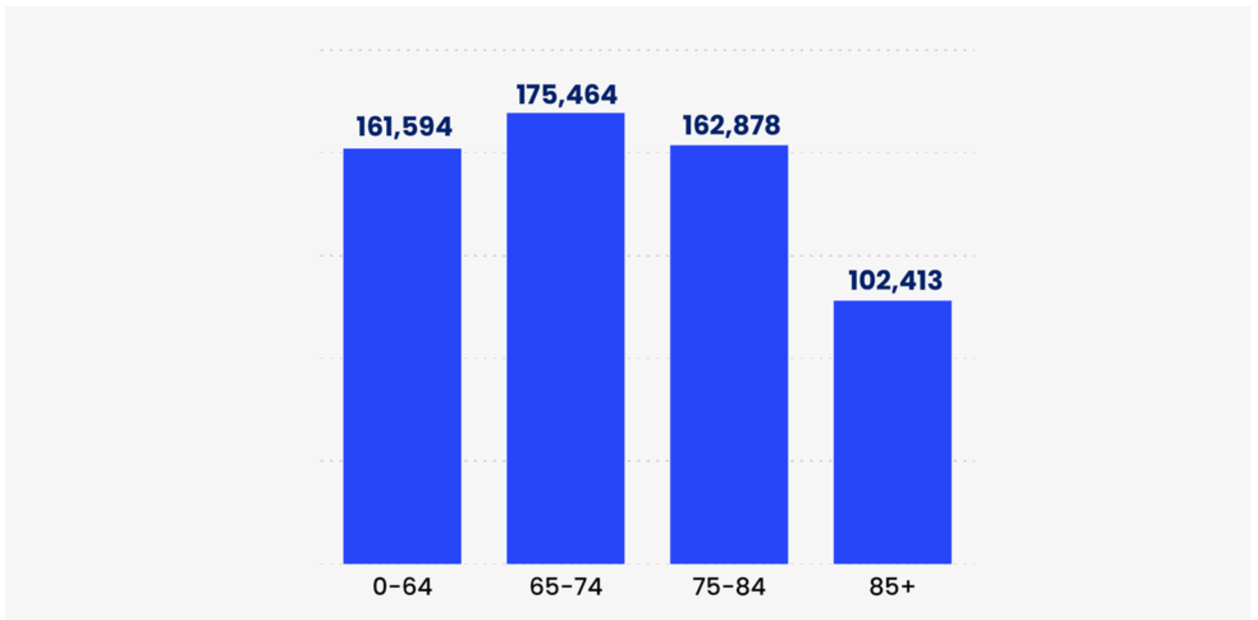
Figure 8: Leading Causes of Death for Individuals 65-74, January to October 2021



Note: CLRD refers to chronic lower respiratory disease.
Source: Shiels MS, Haque AT, Berrington de González A, Freedman ND. Leading Causes of Death in the US During the COVID-19 Pandemic, March 2020 to October 2021. *JAMA Intern Med.* 2022;182(8):883–886. doi:10.1001/jamainternmed.2022.2476.

About 7 in 10 cancer deaths occur in the Medicare population.

Figure 9: Cancer Deaths by Age, 2020

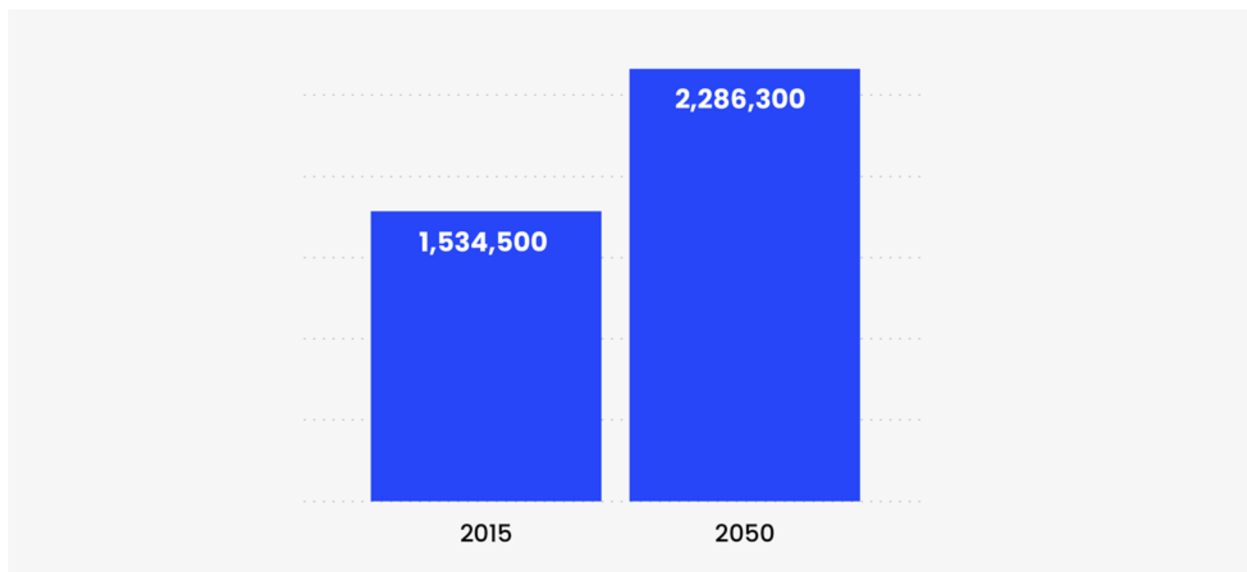


Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2023.

Cancer survivors

Due to advances in cancer treatments and earlier diagnoses for some cancers, individuals are surviving cancer and living longer. As a result, the number of individuals with a reported history of cancer is increasing, particularly among individuals over the age of 65. Individuals with a prior history of cancer often have long-term effects from their cancer experiences and tend to utilize more health care services relative to those without a cancer history.

Figure 10: Estimated and Projected Average Annual Cancer Cases



Source: Weir HK, Thompson TD, Stewart SL, White MC. Cancer Incidence Projections in the United States Between 2015 and 2050. Prev Chronic Dis 2021;18:210006. DOI: http://dx.doi.org/10.5888/pcd18.210006.

Components of Medicare

The Medicare program is comprised of several parts:

Medicare Part A covers inpatient hospital stays (including any cancer treatments provided as an inpatient in a hospital), skilled nursing facility stays, home health care and hospice care. Part A also covers costs of surgically implanted breast prosthesis following a mastectomy if the surgery takes place on an inpatient basis.

Medicare Part B covers physician visits, outpatient services, a limited number of preventive services, diagnostic tests, laboratory visits, durable medical equipment, some drugs (such as chemotherapy drugs administered in an outpatient clinic or physician's office and some oral chemotherapy treatments), radiation treatments for cancer, breast prosthesis following a mastectomy if the surgery takes place in an outpatient setting and principal illness navigation services, among other services.

Medicare Part A and B are together considered to be Original Medicare (otherwise known as Original, Traditional or fee-for-service Medicare).

In **Medicare Part C** (also known as Medicare Advantage), beneficiaries enroll in a private health plan where they receive Part A and B benefits, usually Part D benefits and sometimes other benefits not covered under Parts A or B, such as vision and hearing services.

Part D covers outpatient prescription drugs that patients obtain at pharmacies, including some oral chemotherapy drugs, anti-nausea drugs and pain medication. The Part D program is administered through private plans contracted with Medicare.

As discussed in more detail below, beneficiaries face cost sharing for utilizing most Medicare services. As a result, many beneficiaries opt to have supplemental coverage. Beneficiaries who don't have access to supplemental coverage through a current or former employer are often faced with the task of choosing supplemental coverage options – the outcome of which has long-term consequences – when they are first eligible for the program.[11] At the initial enrollment period, beneficiaries can choose to enroll in traditional Medicare (Parts A and B), purchase prescription drug coverage (Part D) and, possibly, supplemental coverage (Medigap), or they choose to enroll in a Medicare Advantage plan. Beneficiaries with lower incomes may qualify for additional assistance that helps pay Medicare premiums and cost sharing.

Parts of Medicare

Part A

What's covered: In general, Medicare Part A pays for medically necessary inpatient hospital services. This includes inpatient hospitalization services related to cancer treatments and/or medically necessary inpatient hospitalization related to side effects related to cancer treatments, some skilled nursing facility stays, home health care for homebound patients[12] and hospice care. Part A also covers the costs of surgically implanted breast prosthesis following a mastectomy only if the surgery was provided on an inpatient basis.

How many people are covered: As of 2022, there were 34.9 million beneficiaries enrolled in Part A.[13]

What beneficiaries pay — premiums: Approximately 99% of Medicare beneficiaries do not pay premiums for Medicare Part A, but rather qualify for the program based on their (or their spouse's) work history and having reached the age of 65. To obtain coverage, beneficiaries must have worked – and paid payroll taxes – for at least 40 quarters (10 years). Some beneficiaries who fail to meet these qualifications may be eligible to purchase Part A coverage.[14] Premiums for those who have to pay for Part A coverage increase each year.[15] While technically individuals can choose to enroll in Medicare Part B (see below) and not also enroll in Part A, most people enroll in Part A when they are first eligible because they face no premiums.[16]

Cost-sharing: Beneficiary cost sharing will vary depending on the service being provided. In 2023, beneficiary cost sharing for various services included:

Inpatient hospitalization:[17] Beneficiaries admitted as inpatients to a hospital will pay a deductible for each benefit period (defined as a spell of illness or an episode of care). In addition to the deductible, beneficiaries may also pay coinsurance (depending on how many days they have spent in the hospital):

Period	Beneficiary Cost-Sharing, 2024[18]
Deductible	$1,632
Daily coinsurance 0-60 days	$0
Daily coinsurance 61-90 days	$408 per day for each benefit period
Daily coinsurance for lifetime reserve days[19]	$816

Home Health: Beneficiaries do not have a copayment for Medicare-covered home health benefits. However, if a beneficiary utilizes durable medical equipment as part of the home health services, their cost-sharing obligation would amount to 20% of the Medicare-approved amount.

Hospice: Beneficiaries generally do not have cost sharing associated with hospice care itself, most of which is delivered in the home. However, beneficiaries in hospice may incur cost sharing for related care. For example, beneficiaries may pay up to $5 per prescription for pain and symptom relief for care at home. If a beneficiary receives inpatient respite care, they will pay 5% of the Medicare-approved amount for that care.

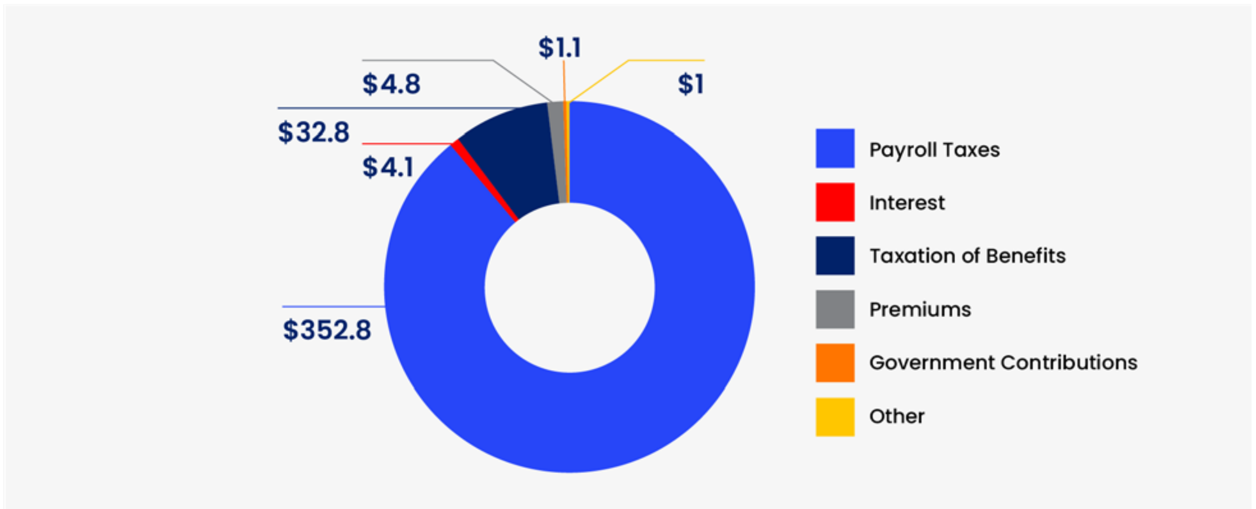
Skilled Nursing Facilities: Medicare will only cover a beneficiary's stay at a skilled nursing facility if the beneficiary was discharged from an inpatient hospital with a minimum stay of three days.[20] The beneficiary's cost sharing for such services would be as follows:

Period	Beneficiary Cost-Sharing, 2024[21]
Deductible	$0
Cost-sharing 1-20 days	$0
Cost-sharing 21-100 days	Up to $204 per day
Cost-sharing 101 days and beyond	Beneficiary pays all charges

Cap on beneficiary out-of-pocket costs: There is no cap on beneficiaries' total out-of-pocket costs.[22]

Source of financing: Medicare Part A is financed through the Hospital Insurance (HI) Trust Fund, which is financed primarily through payroll taxes. Employers and employees each pay 1.45% of a worker's wages, and self-employed individuals pay 2.9% of their net earnings. Starting in January 2023, high-income workers began paying an additional 0.9% tax on their earnings above a certain amount ($200,000 for single tax filers and $250,000 for married couples).

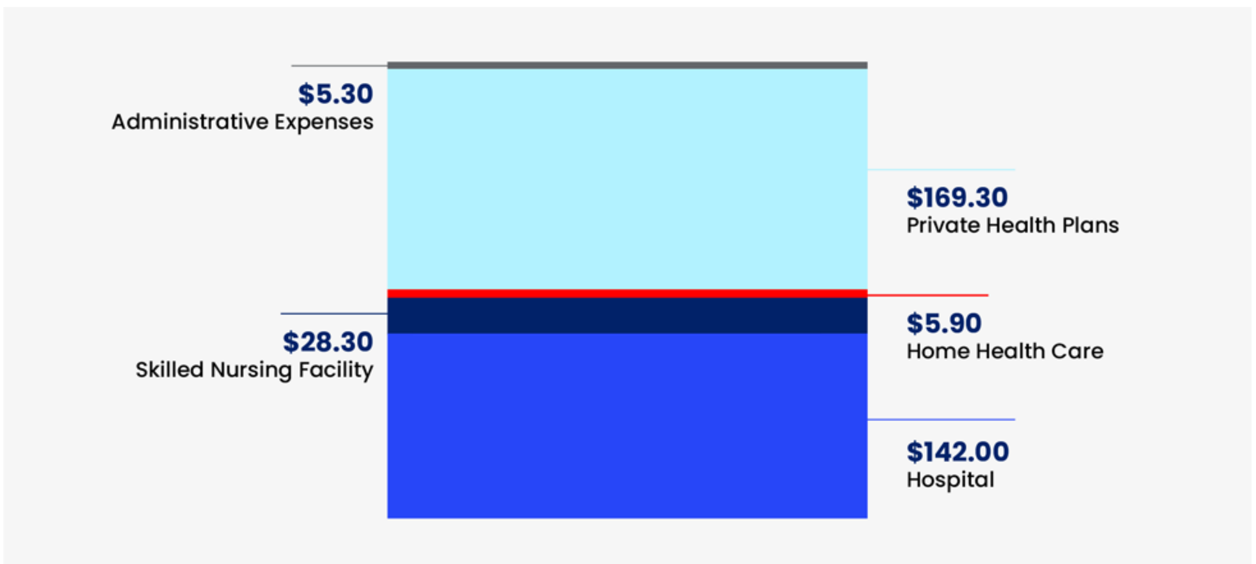
Figure 11: Part A Finances, 2022 (in billions)



Source: The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2023 Medicare Trustees Report. 2023. Available from: https://www.cms.gov/oact/tr/2023.

Part A Expenditures: Medicare Part A pays for inpatient hospital services, some skilled nursing facility stays, home health care and hospice care. By far the largest Part A expenditure among Original Medicare is for inpatient hospital services.

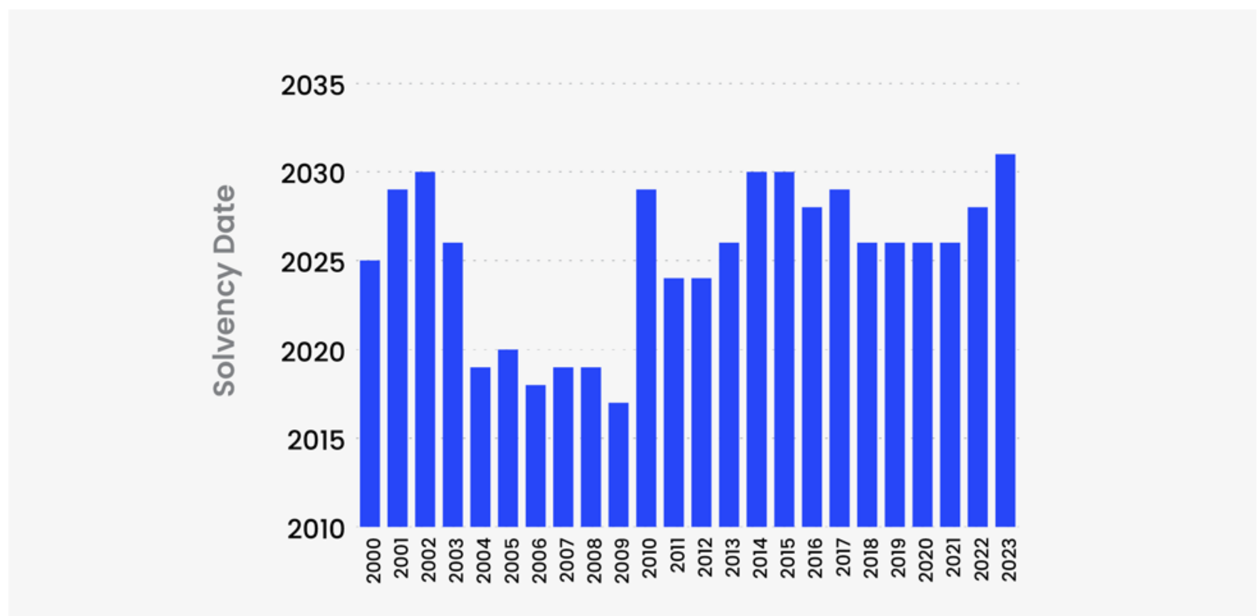
Figure 12: Part A Expenditures, 2022 (in billions)



Note: Private health plans include all categories of costs and are not separately detailed in the 2023 Medicare Trustees Report.
Source: 2023 Medicare Trustees Report.

Solvency: The Medicare Part A program is financed primarily by payroll taxes (89% of program inlays were from payroll taxes in 2023).[23] The Medicare Board of Trustees annually reports on the solvency of the Medicare Part A program. Because Part A program expenditures exceed income, the overall solvency of the program is reduced. When assets are fully depleted, Medicare Part A will have insufficient resources with which to pay benefits, a situation that has never existed in the program's history. In the 2023 Medicare Trustees Report, actuaries projected that the Part A trust fund will be depleted in 2031.

Figure 13: Medicare Trustees' Estimated Year of Part A Insolvency, 2000-2023



Source: Authors' analysis of Medicare Trustees' reports 2000-2023.

Part B

What's covered: In general, Medicare Part B covers physician services (like oncologist services) and outpatient services (such as care provided in hospital emergency room departments, ambulatory surgical centers, durable medical equipment, clinical laboratory services, physical therapy and some home health care). Part B also covers chemotherapy drugs administered in an outpatient clinic or physician's office and some oral chemotherapy treatments. Medicare Part B will also cover FDA-approved drugs and biologics in an anticancer chemotherapeutic regimen for off-label use if the off-label medically accepted indications are supported in one or more compendia or in peer-reviewed medical literature.[24] In addition, Part B covers radiation treatments and breast prosthesis following a mastectomy if the surgery took place in an outpatient setting. Most preventive services (including cancer screenings) are covered under Medicare Part B.

How many people are covered: As of 2022, total enrollment for Original Medicare Part B was 29.7 million.[25]

What beneficiaries pay — premiums: Beneficiaries pay a monthly premium of 25% of projected Part B costs per beneficiary. Part B premiums vary depending on the enrollee's income.[26, 27] In 2024, beneficiaries whose annual modified adjusted gross income is less than or equal to $103,000 ($206,000 for couples filing joint returns), will pay the base monthly premium of $174.70. Beneficiaries whose income exceeds that threshold will pay higher monthly premiums.[28]

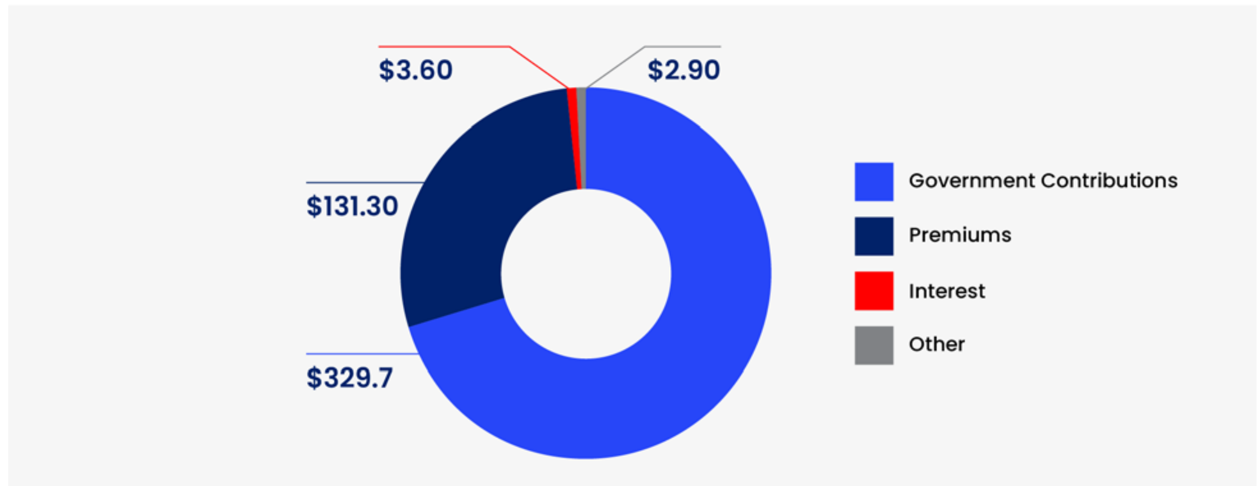
Late-enrollment penalty: Beneficiaries who failed to enroll in Part B when first eligible may face a late enrollment penalty of 10% per year for each year they failed to sign up for Part B.[29] This penalty is permanent for as long as the beneficiary is covered under Medicare.

Cost-sharing: Beneficiaries pay an annual deductible ($240 in 2024),[30] which is modified each year. After the deductible, beneficiaries who lack supplemental coverage generally pay 20% coinsurance for each service (though some services, like certain cancer screenings and other preventive care, are covered at no additional cost to the beneficiary).

Cap on beneficiary out-of-pocket costs: There is no cap on beneficiaries' out-of-pocket costs.[31]

Source of financing: Medicare Part B is financed through the Supplementary Medical Insurance (SMI) Trust Fund, which is funded largely through beneficiary premiums (approximately 25%) and general tax revenue.

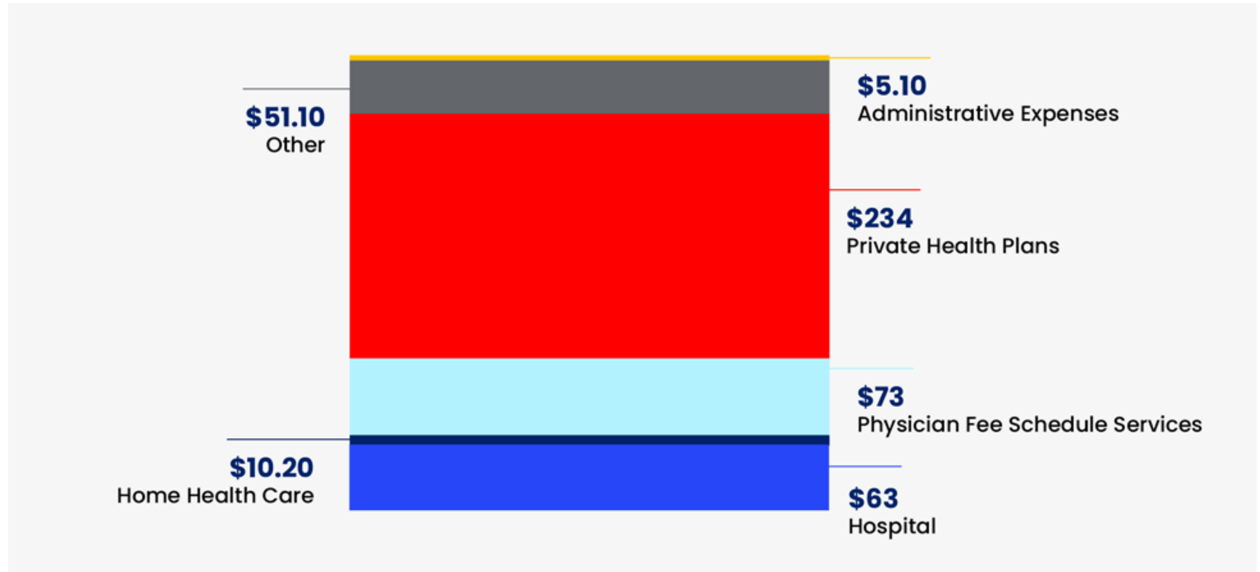
Figure 14: Part B Finances, 2022 (in billions)



Source: 2023 Medicare Trustees Report.

Part B expenditures: Medicare Part B covers physician services and outpatient services (including outpatient services that occur in a hospital setting), home health services and other services (including laboratory services).

Figure 15: Part B Expenditures, 2022 (in billions)



Note: The term Private Health Plans includes all categories of costs and is not separately detailed in the 2023 Medicare Trustees Report.
Source: 2023 Medicare Trustees Report.

Solvency: Unlike Part A, which is financed primarily through payroll taxes that finance the HI trust fund, the Part B program is financed primarily through government contributions and premiums. Each year the government authorizes funds to be appropriated and transferred from the general fund of the Treasury. The contributions need to cover expected Part B costs, as well as provide a reserve for Part B contingencies.

Part C

What's covered: Medicare Part C is administered through private managed care plans (also known as Medicare Advantage plans or MA plans) that contract with Medicare to provide the same benefits offered under Medicare Part A and Part B. Under contract requirements, MA plans may also offer additional benefits, known as supplemental benefits, beyond those covered under Original Medicare, such as fitness benefits, enhanced disease management and health education, among others.

How many people are covered: As of August 2023, 32.3 million beneficiaries (48% of eligible beneficiaries) were enrolled in Medicare Advantage plans.[32] Participation in the Medicare Advantage program has increased almost three-fold since 2010.[33] Medicare Advantage plans can offer benefits that are not offered in traditional Medicare, and unlike Original Medicare, MA plans have a cap on beneficiaries' out-of-pocket costs. These additional benefits are one of the common reasons why Medicare beneficiaries choose to enroll in MA plans.[34] But these plans may also require beneficiaries to seek care through their network, which could be a concern for people with cancer who want access to a wide range of providers.

What beneficiaries pay — premiums: Beneficiaries who are enrolled in Medicare Advantage plans pay their Part B premium, as well as a monthly premium to their Medicare Advantage plan. Monthly premiums for Medicare Advantage plans will vary depending on geography, the plan choice and what, if any, supplemental benefits are provided under the plan. In 2023, the average Medicare Advantage monthly premium was $18,[35] though individuals enrolled in Medicare Advantage plans also have to pay their Part B premium. Almost 70% of individuals enrolled in Medicare Advantage plans paid no premiums other than their Part B premium.[36]

Late-enrollment penalty: There is no late enrollment penalty for enrolling in Medicare Advantage plans. However, beneficiaries who are assessed a late enrollment penalty under Part B or D will continue to pay the penalty even if they are enrolled in a Medicare Advantage plan.

Beneficiary cost-sharing: Beneficiary cost sharing will differ depending on the plan chosen. However, Medicare Advantage plans are prohibited from charging beneficiaries more cost sharing than beneficiaries would incur in traditional Medicare. Medicare Advantage plans are permitted to reduce beneficiary cost sharing for services and to offer coverage of benefits not covered under Parts A or B, and a majority of Medicare Advantage plans also cover Part D benefits.

Cap on beneficiary out-of-pocket costs: Unlike Original Medicare, for which there is no cap on beneficiaries' out-of-pocket costs, Medicare Advantage plans are required to cap beneficiaries' out-of-pocket costs for Part A and B services. In 2023, the annual cap on in-network services was $8,300 and $12,450 for in-network and out-of-network services combined.[37]

Types of coverage: Beneficiaries who elect to enroll in Medicare Advantage plans can choose from various types of health plans, including health maintenance organization (HMO) plans, preferred provider organization (PPO) plans, private fee-for-service (PFFS) plans and special needs plans (SNPs). A majority of Medicare Advantage plans control costs by utilizing a network of plan providers (including physicians such as those who specialize in specific types of cancer and facilities, like cancer centers). Depending on the type of plan, beneficiaries may be limited in their choice of provider and may have to file a request with their Medicare Advantage plan to obtain care from an out-of-network provider or face other limitations in coverage. Medicare Advantage plans are rated on 38 unique quality and performance measures, which include breast and colorectal cancer screening measures.

In general, most Medicare Advantage plans also cover the cost of out-patient prescription drugs. Beneficiaries who are enrolled in Medicare Advantage plans without drug coverage can enroll in a Medicare Part D plan.

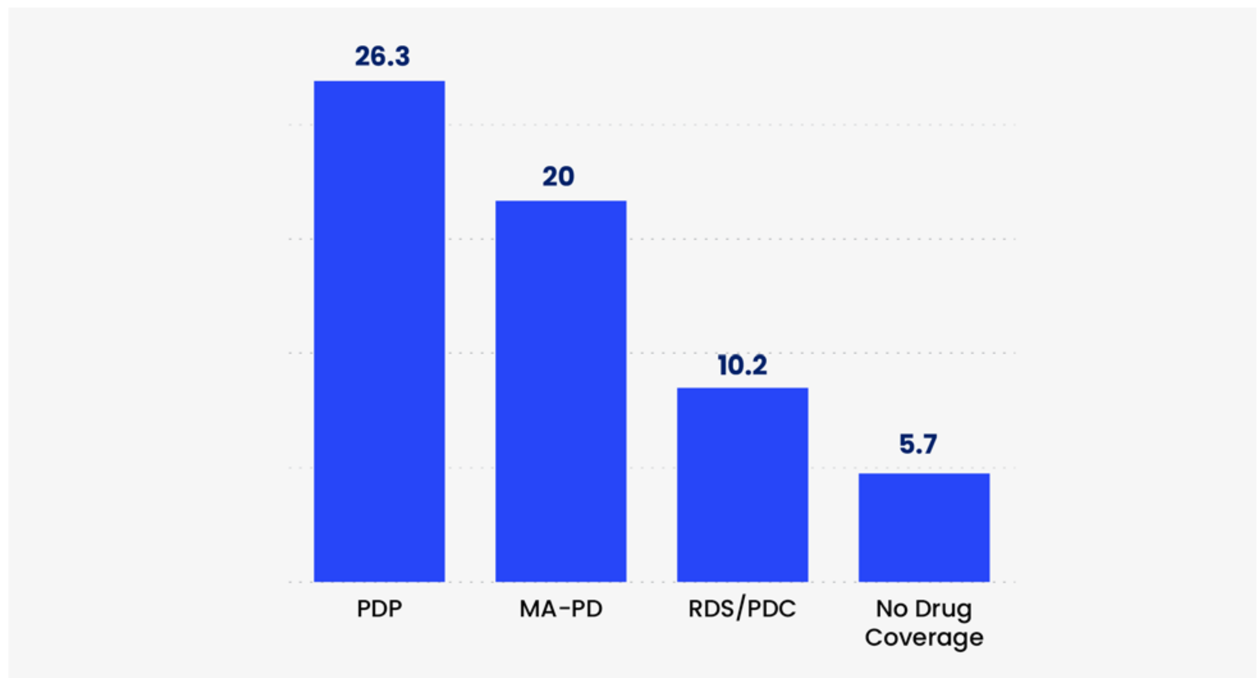
Source of financing: Part C is financed through the HI and SMI trust funds.

Solvency: Because of the way Part C is financed, the overall solvency of the plan is tied to the solvency of the Medicare Part A and B programs. As discussed above, due to the financing mechanism, absent legislative change, the solvency of Part B (and thus, Part B-covered services provided by Part C plans) are not at risk of insolvency. Conversely, as noted above, the solvency of the Part A program fluctuates. If Part A were ever to become insolvent, then Part A-covered services provided by Part C plans could also be at risk.

Part D

What's covered: Medicare Part D covers outpatient prescription drugs. It is administered through private plans that contract with Medicare. As of 2022, approximately 51.4 million beneficiaries were enrolled in Part D plans,[38] an estimate that does not account for beneficiaries who may have another source of drug coverage such as through a retiree benefit.

Figure 16: Medicare Drug Coverage by Type, 2019 (in millions)



Note: The term PDP refers to Prescription Drug Plans. MA-PD refers to Medicare Advantage plans that also offer a Part D benefit. RDS/PDC refers to those who are not enrolled in the Part D program but who have retiree drug coverage through a former employer that receives the retiree drug subsidy (RDS) or those who have private drug coverage (PDC).
Source: Tarazi, W., Welch, WP., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., and Sommers, BD. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. (Issue Brief No. HP2022-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2022.

Private plans that administer the Part D program (PDPs) are not required to cover every outpatient prescription drug, but they must cover at least two drugs per therapeutic category or class. Since the inception of the Part D program, the Centers for Medicare & Medicaid Services (CMS) has acknowledged that in some cases Medicare beneficiaries may need access to more than two drugs within a therapeutic class, so CMS identified six categories and classes of clinical concern (commonly known as the six protected classes) and requires Part D plans to cover all or substantially all drugs within each of the classes.[39] Antineoplastics, which include many oral chemotherapy drugs, is one of the six protected classes.[40] As with Part B, Medicare Part D will also cover FDA-approved drugs and biologics in an anticancer chemotherapeutic regimen for off-label use if the off-label medically accepted indications are supported in one or more compendia or in peer-reviewed medical literature.[41]

Part D plans are permitted to create their own plan formularies (list of covered drugs) and place drugs into certain formulary tiers with beneficiary cost sharing increasing on higher tiers. All PDPs also have a specialty tier for drugs whose costs exceed a certain amount.[42] Most cancer drugs are placed on the specialty tier due to their cost. CMS sets a maximum allowable cost sharing for drugs on the specialty tier at 25% cost sharing for plans that use a standard deductible and 33% cost sharing for plans that do not use a deductible.[43] PDPs are also permitted to impose utilization management tools (such as prior authorization, step therapy or quantity limits) to control access to prescription drugs.

How many people are covered: As of August 2023, 52 million beneficiaries were enrolled in a prescription drug plan.[44] Of those, 22.5 million beneficiaries were enrolled in a stand-alone prescription drug plan and 29.6 million beneficiaries were enrolled in an MA plan that also provides Part D coverage.[45]

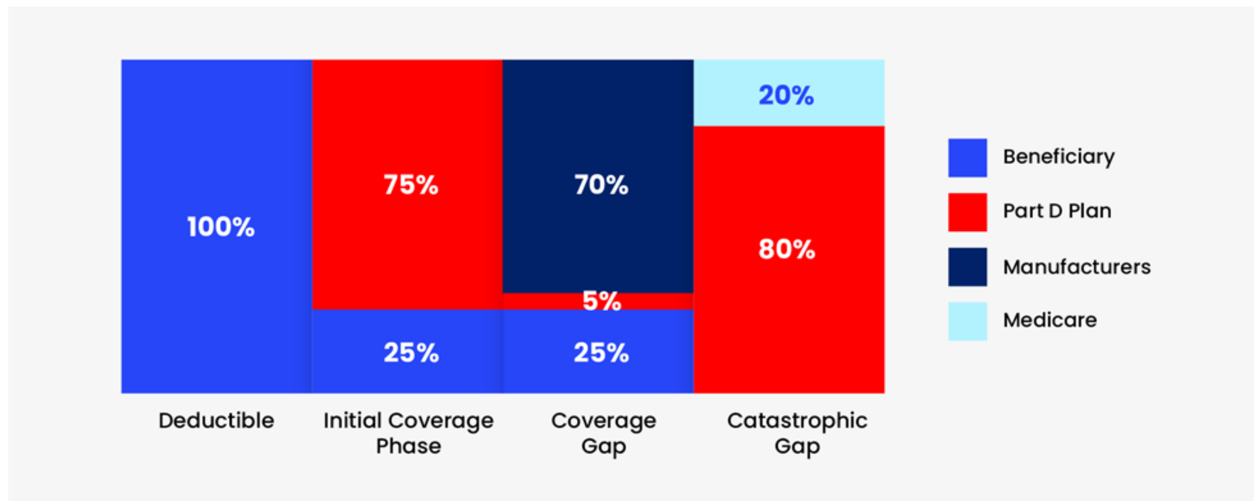
What beneficiaries pay — premiums: Like Part C, premiums for Part D plans vary depending on geography[46] and the type of plan offered. In 2024, the average total Part D monthly premium is estimated to be $55.50.[47] Beneficiaries whose annual modified adjusted gross income is less than or equal to $103,000 ($206,000 for couples filing joint returns) will not face an income-related monthly adjusted amount. Beneficiaries whose income exceeds that threshold will pay higher monthly premiums.[48]

Late enrollment penalty: Beneficiaries who failed to enroll in Part D when first eligible may face a late enrollment penalty of 12% per year for each year they failed to sign up for Part D.[49] This penalty is permanent for as long as the beneficiary is covered under Medicare.

Cost-sharing: Beneficiary cost sharing on outpatient prescription drugs will vary depending on whether the drug is included on the plan's formulary and, if so, the tiering of the prescription drug. In addition, beneficiary cost sharing will also vary depending on the Part D plan's benefit design. Beneficiaries with low incomes may qualify for the Low-Income Subsidy (LIS) program, under which they incur less cost sharing (see below) provided they enroll in a benchmark plan.[50] Beneficiaries who qualify for the LIS program and choose not to enroll in a benchmark plan may be required to pay some portion of their plan's monthly premium.

In 2024, under the standard Part D benefit, the beneficiary will have an annual deductible of no more than $545, after which they enter the initial coverage phase, where the plan pays 75% of the cost of the drugs and the enrollee pays 25%.[51] The initial coverage phase ends once total drug costs exceed a certain point called the initial coverage limit. In 2024, the initial coverage limit is $5,030 in total costs, at which point the beneficiary would have paid $1,666.25 under the standard benefit (that is, the $545 deductible plus $1,121.25 during the initial coverage phase). After the initial coverage phase ends, the beneficiary enters the coverage gap, or donut hole, where they continue to pay 25% cost sharing, but the plan pays 5% and drug manufacturers pay 70% of Part D covered drugs.[52] However, if the enrollee has even higher prescription drug costs (where the enrollee's total out-of-pocket spending, plus any required manufacturer discounts, reaches $8,000), they will pass the catastrophic coverage limit, after which the beneficiary will pay nothing for the cost of their prescription drugs. In this range, their plan will pay 20% of the cost and Medicare will pay 80% of the cost of the drugs.

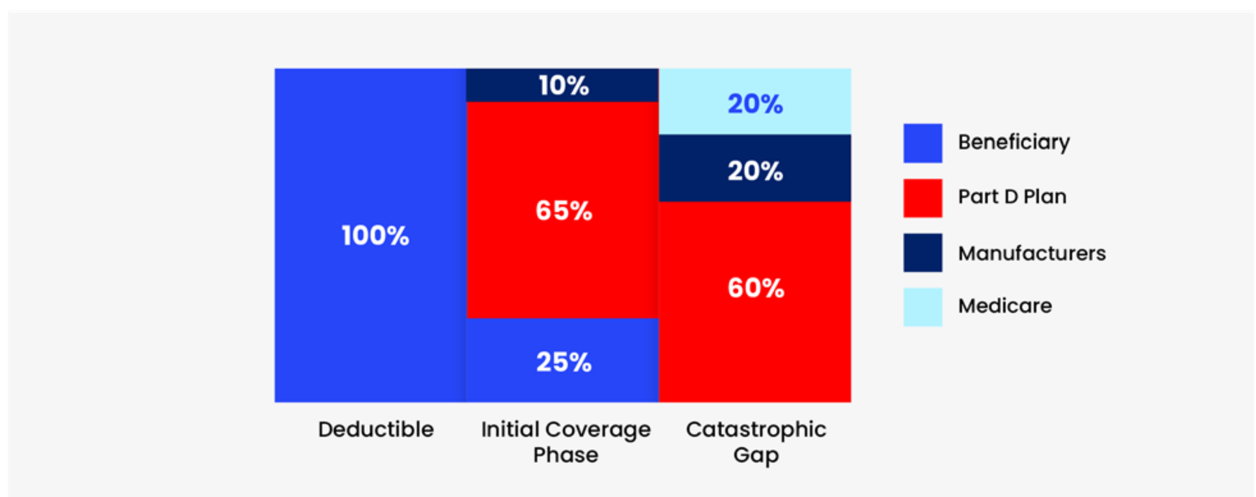
Figure 17: Standard Part B Benefit, 2024



Beginning in 2025, beneficiaries will have the option to enroll in the Medicare Prescription Payment Plan, which will allow them to pay their out-of-pocket prescription drug costs in the form of capped monthly installments.

Cap on beneficiary out-of-pocket costs: The standard Part D benefit design will change in 2025. Beneficiaries will still face an annual deductible, after which they enter the initial coverage period where they still pay 25% of the cost of their drugs, their plan will pay 65% of the cost of the drugs, and manufacturers will pay 10%. However, the coverage gap will be eliminated starting in 2025, and beneficiary out-of-pocket spending for Part D drug costs will be capped at $2,000. So, after the initial coverage phase, the beneficiary will hit the catastrophic cap (set at $2,000 in enrollee out-of-pocket cost for 2025), after which the beneficiary no longer incurs cost sharing. Their plan will pay 60% of the cost of brand drugs, and drug manufacturers and Medicare will each pay 20%. For generic drug costs in the catastrophic phase, the Part D plan pays 60%, but Medicare pays 40% and no manufacturer discount is required.

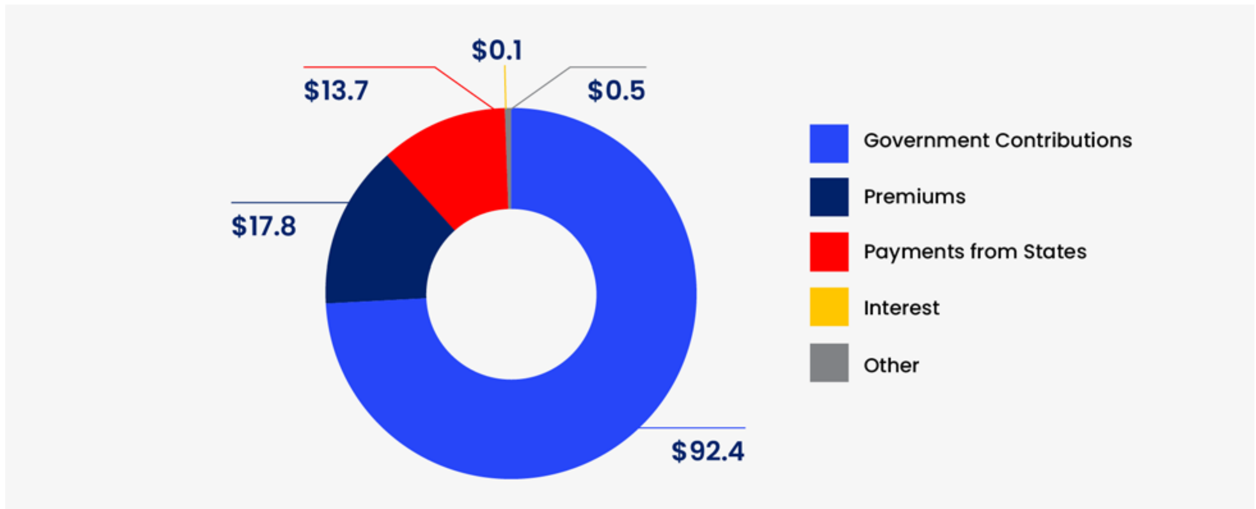
Figure 18: Standard Part D Benefit Design, 2025



In addition, beginning in 2025, beneficiaries will have the option to pay the required cost sharing in capped monthly installments. This was designed to help beneficiaries better afford their drug costs.[53]

Source of financing: Part D is financed through the SMI trust fund, which is funded through beneficiary premiums (approximately 25.5%) and general revenue.

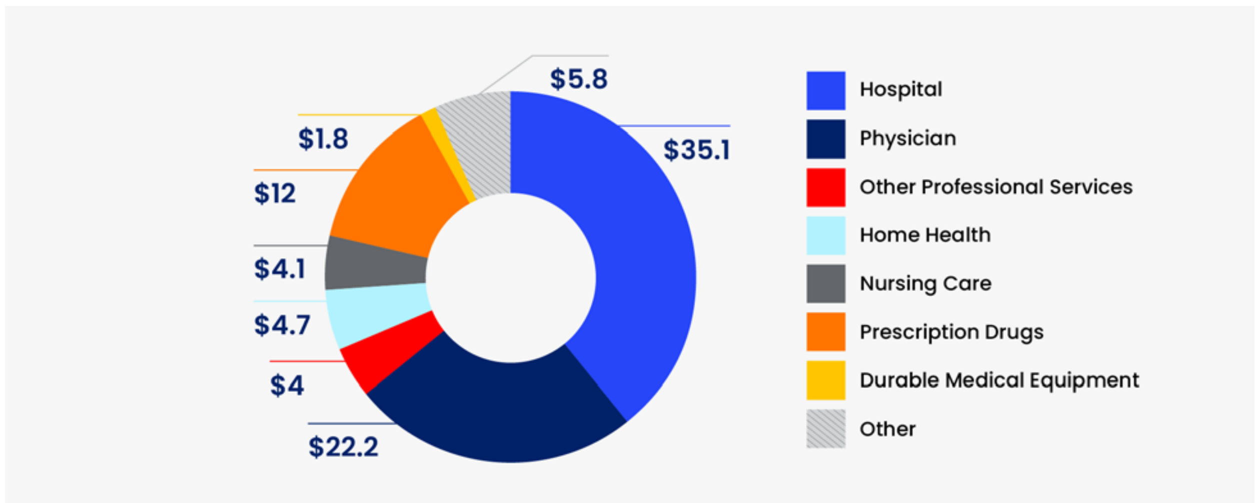
Figure 19: Part D Finances, 2022 (in billions)



Source: 2023 Medicare Trustees Report.

Medicare spending for 2021 was estimated to total over $900.8 billion or 21% of total national health expenditures. The breakdown of spending is as follows:

Figure 20: Medicare Expenditures by Category, 2021 (in billions)



Note: The term "other" includes other professional services, dental services, other non-durable medical products, and other health, residential, and personal care.
Source: Centers for Medicare & Medicaid Services. NHE Tables. Table 19: National Health Expenditures by Type of Expenditure and Program: Calendar Year 2021. Available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.

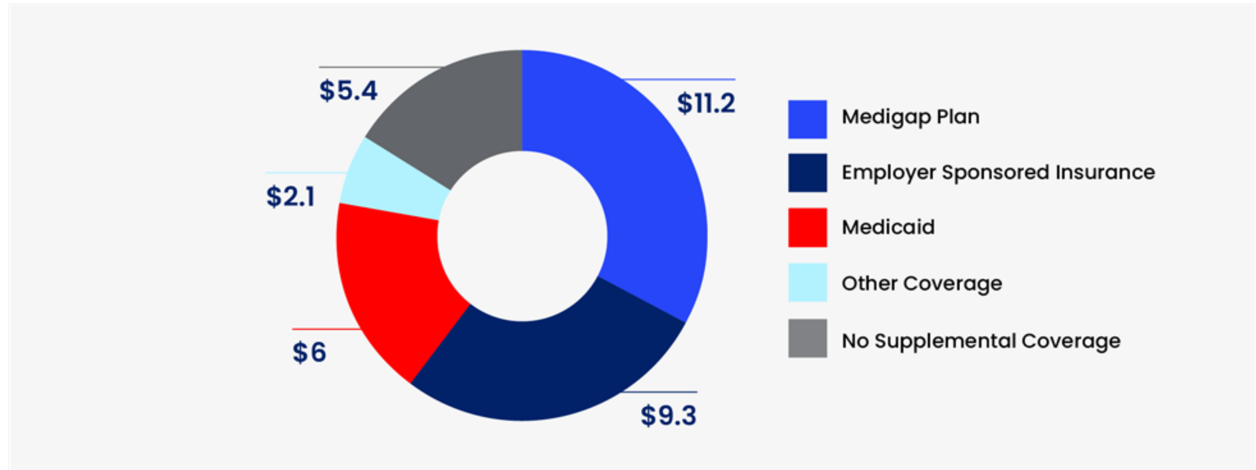
Medicare Supplemental Coverage

Medicare beneficiaries who are enrolled in traditional Medicare (Parts A and B) may choose to purchase a supplemental Medicare policy (often called Medigap) to help pay some of the cost sharing associated with traditional Medicare.[54] Medigap plans are offered by private companies. The plans are standardized,[55] meaning that the benefits offered will be the same across plan carriers. These standardized plans vary in terms of the generosity of the benefit, with some plans providing limited supplemental coverage and others offering more robust coverage. Premiums for these plans will vary depending on geography and the type of plan chosen.

Some beneficiaries may have supplemental coverage in the form of employer-sponsored insurance, either because they receive benefits as a dependent of someone who receives employer-sponsored insurance, or because they have health benefits as part of a retirement package.

Some low-income beneficiaries may qualify for both Medicare and Medicaid, in which case the Medicaid coverage operates as a type of supplemental coverage.

Figure 21: Medicare Supplemental Coverage, 2019 (in millions)



Note: This chart reflects data from 2019 and excludes beneficiaries who are enrolled in Medicare Advantage plans. In 2019 roughly 23.1 million Medicare beneficiaries were enrolled in Medicare Advantage plans.
Source: Tarazi, W., Welch, WP., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., and Sommers, BD. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. (Issue Brief No. HP2022-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2022.

Beneficiaries may decide over the course of their Medicare enrollment to switch between obtaining coverage through traditional Medicare versus Medicare Advantage. However, there are limitations in doing so. Beneficiaries who initially decline enrollment in a Medigap plan (either because they have enrolled in a Medicare Advantage plan or because they choose to forego supplemental coverage) may be ineligible to purchase a Medigap plan outside their initial enrollment period.

The best time for a beneficiary to enroll in a Medigap plan (as a supplement to traditional Medicare) is during their first eligibility period (generally within six months of turning 65).[56] During this time, a Medigap plan must offer a beneficiary coverage and cannot take into account their individual health history in determining the premiums for the plan. Beneficiaries who want to enroll in a Medigap plan after this period may only do so during the annual enrollment period[57] and will likely be subject to medical underwriting, meaning that the plan can charge higher premiums depending on the health status of the beneficiary.

Medicare Advantage plans are prohibited from taking into account a person's medical history when determining premiums or coverage at any time (including the initial enrollment period and any subsequent year). Thus, beneficiaries who lack supplemental coverage (for example, if they are medically underwritten by a Medigap plan) can enroll in a Medicare Advantage plan. However, Medicare Advantage plans are able to use certain utilization management tools (such as prior authorization or step therapy) before the plan will cover certain drugs or services. In addition, Medicare Advantage plans have requirements that enrollees in the plan use providers that participate in the plan's network.

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18 2024 Medicare Parts A and B fact sheet.

19 Beneficiaries only have 60 “lifetime reserve days” over the course of their lifetime. Beneficiaries who exhaust their lifetime reserve days (following 90 days of inpatient care) are responsible for the full cost of the remainder of their hospital stay. https://www.medicare.gov/basics/costs/medicare-costs#collapse-4808. Beneficiaries who receive mental health services on an inpatient basis face different cost-sharing.

20 Medicare will only pay for skilled nursing facility (SNF) extended-care services immediately following a medically necessary three-consecutive-day inpatient hospital stay (3-Day rule). 42 U.S.C. § 409.30(a).

21 2024 Medicare Parts A and B factsheet.

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23 2023 Medicare Trustees Report.

24 Centers for Medicare & Medicaid Services. Internet-Only Manual, Pub 100-02, Chapter 15, 50.4.5 Off Label Use of Anti-Cancer Drugs and Biologicals.

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26 Medicare uses the beneficiary’s reported income to the Internal Revenue Service (IRS) on their tax return from two years prior for purposes of determining a beneficiary’s income.

27 Beginning in 2023, Medicare beneficiaries who were 36 months post-kidney transplant (and thus no longer eligible for Medicare) can choose to pay a monthly premium to continue Part B coverage of immunosuppressive drugs. More information on premium amounts for immunosuppressive coverage only can be found at https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles.

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