GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Retirement Series

United States

Public Old-Age Health Insurance Plan Details

1992-2022

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Retirement Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Retirement Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Retirement Series* are country and time. We prioritize data collection for each country based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country and each broad category of policies covered in the *Gateway Policy Explorer: Retirement Series*.

Author and Contributor Disclaimers

† The opinions expressed here are those of authors and do not necessarily reflect the views of the OECD or of its member countries.

United States

Old-Age Health Insurance
Plan details 1992-2022 * †

The United States operates two public old-age health insurance systems for the general population, known as Medicare and Medicaid. These programs are administered at the national level by the Centers for Medicare and Medicaid Services. Medicare is a social insurance program supporting old-age health care. Individuals are eligible if they are age 65 or are disabled, and are a United States citizen or permanent resident of at least 5 years. Medicaid is a needs-based social assistance program supporting old-age health care. It is a joint federal-state program that pays for health care services for specified groups, one of which are persons 65 and older with limited means. People may be eligible for both benefits. There have been limited reforms to the services provided by Medicare and Medicaid since 1992 and the reforms that have occured have focused on expanding voluntary access to additional health care.

Key Dates
First law: 1965
Major changes since 1992: None

Contents

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† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2022

Overview

The United States (US) operates two public old-age health insurance systems for the general population, known as Medicare and Medicaid. Both systems were created in 1965 and are administered at the national-level (known as the federal-level) by the Centers for Medicare and Medicaid Services (CMS).

Medicare is a social insurance program supporting old-age health care. Individuals are eligible if they are age 65 or are disabled, and are a US citizen or permanent resident of at least 5 years. Medicare has four parts:

- Part A (Hospital Insurance): Insurance administered by the federal government for inpatient care in a hospital or skilled nursing facility (following a hospital stay) —Also pays for some home health care, and hospice care
- Part B (Medical Insurance): Insurance administered by the federal government for health services including doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services
- Part C (Medicare Advantage): Insurance that includes at least all the benefits and services covered under Part A and Part B but is administered by a private health insurer —These plans may offer additional benefits and services (e.g., prescription drug coverage), have alternative requirements for services and lower out-of-pocket costs (from 1997)
- Part D (Medicare prescription drug coverage): Insurance administered by a private company that covers part of prescription drug costs (from 2006)

Individuals do not pay a premium for Part A if they or their spouse paid Medicare taxes for at least 10 years, but there is a standard premium amount for Medicare Part B with an income related monthly adjustment amount for persons and couples with high incomes. Persons not paying their Part A and B premiums lose coverage. Other parts of Medicare are run by private insurance companies that follow rules established by CMS. They are voluntary for persons insured by Medicare.

Medicaid is a needs-based social assistance program supporting old-age health care. It is a joint federal-state program that pays for health care services for specified groups deemed "mandatory categorically needy," including low-income families, qualified pregnant women and children, and individual receiving Supplementary Security Income (i.e., social assistance for the aged, blind and disabled persons of limited means). States may also elect to insure additional groups deemed "optionally categorically needy" or "medically needy" which may relax the requirements for limited means. State governments administer the programs and are required to provide a mandatory set of services, but may also choose to provide certain optional services with federal government funds. Medicaid includes many of the services provided by Medicare Part A and B, and offers benefits not normally covered by Medicare, including nursing home care and personal care services.

Additionally, Medicare Savings Programs help persons with limited means to pay their Medicare premiums for Part A and Part B and, in some cases, additional costs associated with their health care. Medicaid beneficiaries typically qualify for one of these programs.

This document covers the government provided health insurance mentioned above, namely Medicare Parts A and B and Medicaid. There are additional forms of government provided health insurance targeted at specific groups that are not covered here, including the Children's Health Insurance Program, the Department of Defense healthcare insurance for current service members and military retirees, the Veterans Health Administration program for military veterans, and the Indian Health Service program for members of federally-recognized Native American Tribes and Alaska Native people.

There have been limited reforms to the services provided by Medicare and Medicaid since 1992 and the reforms that have occured have focused on expanding voluntary access to additional health care. Reforms during this period affecting a person's old-age health insurance benefits include:

- The "Balanced Budget Act of 1997" (Public Law 105-33), passed and effective from August 5, 1997, introduced Medicare Part C, which provides eligible persons the option to receive Medicare Parts A and B benefits through private health insurers
- The "Medicare Prescription Drug, Improvement, and Modernization Act" (Public Law 108-173), passed December 8, 2003 and effective from January 2006, introduced Medicare Part D, which provides optional prescription drug coverage and made monthly Medicare Part B premiums based on income from 2007
- The "Medicare Improvements for Patients and Providers Act of 2008" (Public Law 110-275), passed July 15, 2008, adjusted the asset limits for some Medicare Saving Progams to account for changes in the consumer price index and provided for annual adjustments in the asset limits
- The "Patient Protection and Affordable Care Act" (Public Law 111-148), passed March 23, 2010, expanded the "optional categorically needy" category to include all US citizens and legal residents up to 133% of the federal poverty line, including adults without dependent children from January 2014 —Expansion of the program was at the discretion of individual states with 14 states not expanding coverage as of December 2020

Eligibility

- **Qualifications**

Medicare: Part A

To be eligible for Medicare Part A, an individual must satisfy one of the following eligibility tracks:

Eligibility Track 1: Premium-Free

An individual is eligible for Part A benefits with no monthly premium if they or their spouse paid Medicare taxes for 40 employment quarters and satisfy the two following requirements —

1. Age requirement: Age 65 or older
2. Citizenship or residency requirements: US citizen, or lawful permanent resident at least five years of continuous residence in the United States immediately prior to Medicare enrollment

Eligibility Track 2: Premium

An individual is eligible for Part A benefits if they satisfy the three following requirements —

1. Age requirement: Age 65 or older
2. Enrollment requirement: Enrolled in Medicare Part B
3. Premium requirement: Pay monthly premiums —amount depends on the number of employment quarters an individual or their spouse paid Medicare taxes. As of 2022:
   - 30-39 quarters: $274
   - Less than 39 quarters: $499

   Premiums by employment quarters and year are available in Table 1

Other eligibility tracks

- Disability: A individual entitled to Social Security Disability Insurance payments for at least 24 months; no premium requirement (i.e., premium-free)
- End Stage Renal Disease: An individual with permanent kidney failure requiring dialysis or transplant; no premium requirement (i.e., premium-free)

Medicare: Part B

To be eligible to enroll in Medicare Part B, an individual must satisfy one of the following eligibility tracks:

Eligibility Track 1: Part A Premium-Free

An individual is eligible for Part B benefits if they satisfy a premium-free eligibility track for Medicare Part A benefits (e.g., Eligibility track 1) and pay monthly Part B premiums. Since 2007, the amount depends on a person's income and in 2022 ranges from $170 for persons with less than $91,000 or couples with less than $182,000 in annual income, to $578.30 for persons with at least $500,000 or couples with at least $750,000 in annual income.

- Premiums by year and income bracket: Table 2
- Income brackets for unmarried persons: Table 3
- Income brackets for married persons filing joint tax returns: Table 4
- Income brackets for married persons filing separate tax returns: Table 5

Eligibility Track 2: All other cases

An individual is eligible for Part B benefits if they satisfy the three following requirements —

1. Age requirement: Age 65 or older
2. Citizenship or residency requirements: US citizen residing in the US, or lawful permanent resident at least five years of continuous residence in the United States immediately prior to Medicare enrollment and currently residing in the US
3. Premium requirement: Same monthly premiums as Medicare Part B eligibility track 1

Medicaid

To be eligible to enroll in Medicaid, an individual must satisfy one of the following eligibility tracks:

Main Eligibility Track for Persons in Old-Age

Qualify for Supplementary Security Income (SSI) - See policy document *United States: Old Age Social Assistance Plan Details* for more information. To qualify for SSI, a person must satisfy the two following requirements:

1. Work limitation or age requirements
   Individual must satisfy one of the following conditions —
   (a) Age 65 or older

(b) Blind: A person whose vision, with use of a correcting lens, is 20/200 or less in the better eye or who has tunnel vision of 20 degrees or less
(c) Disabled: A person who satisfies one of the following conditions —
   i. Age 18 or older and meets the definition of disability for adults under Social Security law
   ii. Under age 18 and meets the definition of disability for children under Social Security law

2. Limited means requirement
An individual and, if married, their spouse's monthly income and assets satisfy the following conditions —
(a) Countable income is less than the maximum monthly SSI benefit: $841 for an individual and $1,261 for a couple in 2022; the maximum is reduced by one-third if an individual lives in another person's household (e.g., with a independent child; in a group setting) —See Table 6 for maximum monthly SSI benefits by year

Details on the determination of countable income are included in the *Benefits* section of the policy document *United States: Old Age Social Assistance Plan Details*.

(b) Assets below the resource threshold for SSI benefits: $2,000 for an individual and $3,000 for a couple for years 1992 to 2022

Assets include liquid assets (e.g., cash, bank accounts) and illiquid assets (e.g., property, investments). Some assets are excluded, such as an individual's primary residence, one automobile, business property, household goods and personal effects regardless of value.

Other Eligibility Tracks
Individuals may also be qualified for Medicaid if they are part of one of the following groups:
- Low-income families
- Qualified pregnant women and children
- Disabled individuals with low incomes are covered by Medicaid. However, states are allowed to have different eligibility requirements than the SSI disability program.
- Other "mandatory categorically needy" groups —
- State governments may also elect to insure additional groups deemed "optionally categorically needy" or "medically needy" which may relax limited means requirements.

See CMS (2022) for detail on these additional groups.

Medicare Savings Programs

Medicare Savings Programs help persons with limited means to pay their Medicare premiums for Part A and Part B and, in some cases, additional costs associated with their health care. There are four programs which differ in their eligibility criteria and what they cover. MSP programs with more restrictive eligibility conditions generally cover more Medicare-related costs. Each program relies on a definition of countable income and assets similar to Supplemental Security Income (See Medicaid's main eligibility track for these definitions). Additionally, income requirements are based on Federal Poverty Guidelines (FPG) defined by the Department of Health and Human Services. MSP programs in order of most to least restrictive means tests:

1. Qualified Medicare Beneficiary (QMB)
A person is eligible for QMB if they satisfy the two following conditions:
   - Income test: Countable income below 100% of FPG plus $20, equal to $1,153 for individuals and $1,546 for couples in 2022
   - Asset test: Resources below $8,400 for individuals and $12,600 in 2022
2. Specified Low-Income Medicare Beneficiary (SLMB)
A person is eligible for SLMB if they satisfy the three following conditions:
   - Income test: Countable income below 120% of FPG plus $20, equal to $1,379 for individuals and $1,851 for couples in 2022
   - Asset test: Resources below $8,400 for individuals and $12,600 in 2022
   - Other requirements: Individuals must be enrolled in Medicare Part A
3. Qualifying Individual (QI)
A person is eligible for QI if they satisfy the three following conditions:
   - Income test: Countable income below 135% of FPG plus $20, equal to $1,153 for individuals and $1,546 for couples in 2022
   - Asset test: Resources below $8,400 for individuals and $12,600 in 2022
   - Other requirements: Individuals must be enrolled in Medicare Part A and not be eligible for Medicaid

4. Qualified disabled and working individuals (QDWI)
   A person is eligible for QDWI if they satisfy the two following conditions:
   - Income test: Countable income below 135% of FPG plus $20, equal to $1,153 for individuals and $1,546 for couples in 2022
   - Asset test: Resources below $8,400 for individuals and $12,600 in 2022
   - Other requirements: Individuals under 65 with a qualifying disability who lost premium-free Part A coverage after returning to work and now must enroll in and purchase Part A coverage and are not eligible for Medicaid

SSI beneficiaries typically qualify for QMB. Enrollment in MSPs are handled by state Medicaid systems and eligibility for MSPs may be expanded in some states. The following reference tables provide information on minimum income and asset tests for MSP programs over time and location —
- Federal poverty guidelines by year: Table 7
- MSP income limits by year: Table 8
- MSP asset limits by year: Table 9

Notes
1. Whether disabled SSI recipients are automatically eligible for and enrolled in Medicaid depends on the state that the recipient lives in —See Table 10
2. See §2112 of the Social Security Handbook (SSA, 2022) for additional detail related to work limitation or age requirements related to SSI. Additional information pertaining to the detemination of resources is available in §2148-2166. This includes additional forms of excludable assets noted in §2156 and some assets are not considered resources for the purposes of applying the resource limit as noted in §2151.

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: Medicare: No; Medicaid: Yes

Coverage

Medicare: Part A
Part A beneficiaries are eligible to receive certain services and supplies depending on the type of care:
1. Hospital inpatient care
   - Semi-private rooms
   - Meals
   - General nursing
   - Drugs as part of inpatient treatment
   - Continued care at a skilled nursing facility after leaving the hospital —Part A covers charges similar to what is would have covered in the hospital including therapy for rehabilitation
2. Hospice care
3. Home health care
   - Part-time skilled nursing care or home health aide
   - Therapy (e.g., occupational, physical)
   - Medical social services
   - Medical supplies for home use
4. Mental health inpatient stay
   - Similar services as hospital inpatient care
   - Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime

Medicare: Part B
There are eight major types of care covered by Medicare Part B if approved by Medicare:
1. Medical services: This includes doctor visits, including primary care physician, specialists and doctors providing care during an in-patient settings, but may also include other Medicare-approved healthcare providers
2. Outpatient Therapy
3. Clinical laboratory services
4. Home health services
5. Durable medical equipment
6. Outpatient hospital services
7. Outpatient mental health services

8. Partial hospitalization mental health services
9. Ambulatory services

Some of the items and services Medicare Parts A and B do not cover include:

- Long-term care (except for inpatient care in a skilled nursing facility that is not custodial or long-term care)
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care

Medicaid

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. Federal law requires states to provide certain mandatory benefits and allows states the choice of covering other optional benefits. Mandatory services include:

- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Physician services
- Early and periodic screening, diagnostic, and treatment services
- Laboratory and x-ray services

Optional services include:

- Prescription drugs
- Therapy services (e.g., occupational; physical therapy)
- Hospice care
- Dental care (including dentures)
- Eye care and glasses

See Table 11 for an extended list.

Medicare Savings Programs

Medicare Savings Programs help persons with limited means to pay their Medicare premiums for Part A and Part B and, in some cases, additional costs associated with their health care. There are four programs which differ in their eligibility criteria and what they cover. MSP programs with more restrictive eligibility conditions generally cover more Medicare-related costs. Coverage of MSP programs in order of most to least restrictive means tests:

1. Qualified Medicare Beneficiary (QMB): Pays Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments
2. Specified Low-Income Medicare Beneficiary (SLMB): Pays Medicare Part B Premiums
3. Qualifying Individual (QI): Pays Medicare Part B Premiums
4. Qualified disabled and working individuals (QDWI): Pays Medicare Part A premiums

Costs

Medicare: Part A

Part A beneficiary costs differ by type of care received. There are four major types of care covered by Medicare Part A:

1. Hospital inpatient care
   Part A beneficiary costs differ depending on the number of days spent in a hospital or skilled nursing facility during a "benefit period." A benefit period begins the day a beneficiary is admitted to a hospital or skilled nursing facility. The benefit period ends when the beneficiary has not received any care from these types of facilities for 60 consecutive days. Additionally, Medicare Part A provides each person with 60 "lifetime reserve days," where costs can be covered for an extended period of time. Beneficiary deductible and copayment costs per benefit period vary by facility:
   - Deductible (fixed amount for any service): 100% of cost up to 100% of the Inpatient Hospital Deductible (IHD), which is $1,556 in 2022 —See Table 1 for IHD values by year
   - Coinsurance for hospitals (fixed daily percentage of continuing service costs)
     - Days 1-60: $0
     - Days 60-90: 100% of costs up to 25% of the IHD, which is $389 in 2022

    - After 90 days with lifetime reserve days: 100% of costs up to 50% of the IHD, which is $778 in 2022
    - After 90 days without lifetime reserve days: 100% of costs
  - Coinsurance for skilled nursing facilities following hospital stays
    - Days 1-20: $0
    - Days 20-100: 100% of costs up to 12.5% of the IHD, which is $194.50 in 2022
    - After 100 days: 100% of costs

2. Hospice care: $0
3. Home health care: $0 for services and 20% of the Medicare-approved amount for durable medical equipment (e.g., wheelchair, hospital bed)
4. Mental health inpatient stay: Same costs as hospital inpatient stay. There is also a lifetime limit of 190 days in psychiatric hospitals.

Medicare: Part B

Part B beneficiary costs vary by type of service. They are typically 20% of the service's cost. In cases with a non-zero cost a beneficiary must first pay at least their annual deductible before Medicare covers additional costs. In 2022, the annual deductible was $233. See Table 12 for the annual deductible by year. There is no maximum copayment for Medicare Part B. Individuals can purchase supplemental Medicare insurance that can help with copayments and, in some cases, provide a maximum annual copayment amount. These policies are known as Medigap policies.

There are nine major types of care covered by Medicare Part B:

1. Medical services (e.g., doctor visits): 20% of the Medicare-approved amount
2. Outpatient Therapy: 20% of the Medicare-approved amount
3. Clinical laboratory services: $0 for Medicare-approved services
4. Home health services: $0 for Medicare-approved services
5. Durable medical equipment: 20% of the Medicare-approved amount
6. Outpatient hospital services
    - Doctor or other health provider services: 20% of the Medicare-approved amount for the services and the total copayment is capped at 100% of the IHD
    - Hospital services: Typically same coinsurance rates for hospital inpatient care and the total copayment is capped at 100% of the IHD
7. Outpatient mental health services: 20% of the Medicare-approved amount
    - Doctor or other health provider services: 20% of the Medicare-approved amount for the services and the total copayment is capped at 100% of the IHD
    - Facility services: If services are provided in a clinic or hospital setting, additional copayments or coinsurance rates may apply
8. Partial hospitalization mental health services: 20% of the Medicare-approved amount
    - Doctor or other health provider services: 20% of the Medicare-approved amount for the services and the total copayment is capped at 100% of the IHD
    - Facility services: A coinsurance rate applies that depends on the facility and care received
9. Ambulatory services: 20% of the Medicare-approved amount

Service covered but not mentioned typically have a coinsurance rate of 20% of the Medicare-approved amount.

Medicaid

States can impose copayments, coinsurance, deductibles, and other similar charges on most Medicaid-covered benefits, both inpatient and outpatient services, and the amounts that can be charged vary with income. All out of pocket charges are based on the individual state's payment for that service. Cost sharing for most services is limited to nominal or minimal amounts. The maximum copayment that Medicaid may charge is typically based on what the state pays for that service, as described in Table 13.

Out-of-pocket costs cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. Generally, out-of-pocket costs apply to all Medicaid enrollees except those specifically exempted by law and most are limited to nominal amounts. Exempted groups include children, terminally ill individuals, and individuals residing in an institution. Because Medicaid covers particularly low-income and often very sick patients, services cannot be withheld for failure to pay, but enrollees may be held liable for unpaid copayments.

Medicare Savings Programs

MSPs cover the costs of Medicare premiums. MSPs typically do not require out of pocket costs for application or participation.

Tables and Formulas

Table 1: Medicare Part A Premium and Deductibles

Year	Monthly Premium (30 - 39 EQ)	Monthly Premium (< 30 EQ)	Inpatient Hospital Deductible (IHD)
1992	$192	$192	$652
1993	221	221	676
1994	184	245	696
1995	183	261	716
1996	188	289	736
1997	187	311	760
1998	170	309	764
1999	170	309	768
2000	166	301	776
2001	165	300	792
2002	175	319	812
2003	174	316	840
2004	189	343	876
2005	206	375	912
2006	216	393	952
2007	226	410	992
2008	233	423	1,024
2009	244	443	1,068
2010	254	461	1,100
2011	248	450	1,132
2012	248	451	1,156
2013	243	441	1,184
2014	234	426	1,216
2015	224	407	1,260
2016	226	411	1,288
2017	227	413	1,316
2018	232	422	1,340
2019	240	437	1,364
2020	252	464	1,408
2021	259	471	1,484
2022	274	499	1,556

Sources: Historical rates and brackets are available in Tables 2.C1 of Social Security's Annual Statistical Supplement of 2015 SSA (2016). This is the last Annual Statistical Supplement this table was reported. Subsequent years have been collected from annual CMS press releases on annual rates.

Notes: EQ = Employment quarters, which are calendar quarters where a worker or their spouse paid Medicare taxes. Beginning in 1994, a reduced premium is available to premium-paying Medicare Part A enrollees with at least 30 quarters of Medicare-covered employment (either their own or through a current or former spouse if the marriage meets certain duration criteria).

Table 2: Premium Rates for Income-Related Monthly Premium (Part B)

Year	Bracket 1	Bracket 2	Bracket 3	Bracket 4	Bracket 5	Bracket 6
1992	$31.80					
1993	36.60					
1994	41.10					
1995	46.10					
1996	42.50					
1997	43.80					
1998	43.80					
1999	45.50					
2000	45.50					
2001	50.00					
2002	54.00					
2003	58.70					
2004	66.60					
2005	78.20					
2006	88.50					
2007	93.50	$105.80	$124.40	$142.90	$161.40	
2008	96.40	122.20	160.90	199.70	238.40	
2009	96.40	134.90	192.70	250.50	308.30	
2010	110.50	154.70	221.00	287.30	353.60	
2011	115.40	161.50	230.70	299.90	369.10	
2012	99.40	139.90	199.80	259.70	319.70	
2013	104.90	146.90	209.80	272.70	335.70	
2014	104.90	146.90	209.80	272.70	335.70	
2015	104.90	146.90	209.80	272.70	335.70	
2016	121.80	170.50	243.60	316.70	389.80	
2017	134.00	187.50	267.90	348.30	428.60	
2018	134.00	187.50	267.90	348.30	428.60	
2019	135.50	189.60	270.90	352.20	433.40	$460.50
2020	144.60	202.40	289.20	376.00	462.70	491.60
2021	148.50	207.90	297.00	386.10	475.20	504.90
2022	170.10	238.10	340.20	442.30	544,30	578.30

Sources: Historical rates and brackets are available in Tables A-1 and A-2 of CRS (2021).

Notes: The 2003 reform, as modified by the Deficit Reduction Act of 2005 (P.L. 109-171), required that beginning in 2007, higher-income beneficiaries pay higher Part B premiums. Brackets are defined in separate tables:

- Unmarried persons: Table 3
- Married persons filing joint tax returns: Table 4
- Married persons filing separate tax returns: Table 5

Table 3: Income Brackets for Medicare Premium of Unmarried Persons

Period	Bracket 1	Bracket 2	Bracket 3	Bracket 4	Bracket 5	Bracket 6
Before 2006	All income levels					
2007	≤ $80,000	$80,001 - $100,000	$100,001 - $150,000	$150,001 - $200,000	> $200,000	
2008	≤ 82,000	82,001 - 102,000	102,001 - 153,000	153,001 - 205,000	> 205,000	
2009-2012	≤ 85,000	85,001 - 107,000	107,001 - 160,000	160,001 - 213,000	> 213,000	
2013-2015	≤ 85,000	85,001 - 107,000	107,001 - 160,000	160,001 - 214,000	> 214,000	
2016-2017	≤ 85,000	85,001 - 107,000	107,001 - 160,000	160,001 - 214,000	> 214,000	
2018	≤ 85,000	85,001 - 107,000	107,001 - 133,500	133,501 - 160,000	> 160,000	
2019	≤ 85,000	85,001 - 107,000	107,001 - 133,500	133,501 - 160,000	160,001 - 500,000	> 500,000
2020	≤ 87,000	87,001 - 109,000	109,001 - 136,000	136,001 - 163,000	163,001 - 500,000	> 500,000
2021	≤ 88,000	88,001 - 111,000	111,001 - 138,000	138,001 - 165,000	165,001 - 500,000	> 500,000
2022	≤ 91,000	91,001 - 114,000	114,001 - 142,000	142,001 - 170,000	170,001 - 500,000	> 500,000

Sources: Historical rates and brackets are available in Tables A-1 and A-2 of CRS (2021).

Notes: The 2003 reform, as modified by the Deficit Reduction Act of 2005 (P.L. 109-171), required that beginning in 2007, higher-income beneficiaries pay higher Part B premiums. Rates are defined in Table 2.

Table 4: Income Brackets for Medicare Premium of Married Persons Filing Joint Tax Returns

Year	Bracket 1	Bracket 2	Bracket 3	Bracket 4	Bracket 5	Bracket 6
Before 2006	All income levels					
2007	≤ $160,000	$160,001 - $200,000	$200,001 - $300,000	$300,001 - $400,000	> $400,000	
2008	≤ 164,000	164,001 - 204,000	204,001 - 306,000	306,001 - 410,000	> 410,000	
2009-2012	≤ 170,000	170,001 - 214,000	214,001 - 320,000	320,001 - 426,000	> 426,000	
2013-2015	≤ 170,000	170,000 - 214,000	214,000 - 320,000	320,000 - 428,000	> 428,000	
2016-2017	≤ 170,000	170,000 - 214,000	214,000 - 320,000	320,000 - 428,000	> 428,000	
2018	≤ 170,000	170,001 - 214,000	214,001 - 267,000	267,001 - 320,000	> 320,000	
2019	≤ 170,000	170,001 - 214,000	214,001 - 267,000	267,001 - 320,000	320,001 - 750,000	> 750,000
2020	≤ 174,000	174,001 - 218,000	218,001 - 272,000	272,001 - 326,000	326,001 - 750,000	> 750,000
2021	≤ 176,000	176,001 - 222,000	222,001 - 276,000	276,001 - 330,000	330,001 - 750,000	> 750,000
2022	≤ 182,000	182,001 - 228,000	228,001 - 284,000	284,001 - 340,000	340,001 - 750,000	> 750,000

Sources: Historical rates and brackets are available in Tables A-1 and A-2 of CRS (2021).

Notes: The 2003 reform, as modified by the Deficit Reduction Act of 2005 (P.L. 109-171), required that beginning in 2007, higher-income beneficiaries pay higher Part B premiums. Rates are defined in Table 2.

Table 5: Income Brackets for Medicare Premium of Married Persons Filing Separate Tax Returns

Year	Bracket 1	Bracket 4	Bracket 5	Bracket 6
Before 2006	All income levels			
2007	≤ $80,000	$80,001 - $120,000	> $120,000	
2008	≤ 82,000	82,001 - 123,000	> 123,000	
2009	≤ 85,000	85,001 - 128,000	> 128,000	
2010 - 2018	≤ 85,000	85,001 - 129,000	> 129,000	
2019	≤ 85,000		85,001 - 415,000	> 415,000
2020	≤ 87,000		87,001 - 413,000	> 413,000
2021	≤ 88,000		88,001 - 412,000	> 412,000
2022	≤ 91,000		91,001 - 409,000	> 409,000

Sources: Historical rates and brackets are available in Tables A-1 and A-2 of CRS (2021).
Notes: The 2003 reform, as modified by the Deficit Reduction Act of 2005 (P.L. 109-171), required that beginning in 2007, higher-income beneficiaries pay higher Part B premiums. Rates are defined in Table 2.

Table 6: Maximum Federal Benefit Rates by Year

Year	Individual	Couple
1992	$422	$633
1993	434	652
1994	446	669
1995	458	687
1996	470	705
1997	484	726
1998	494	741
1999	500	751
2000	513	769
2001	531	796
2002	545	817
2003	552	829
2004	564	846
2005	579	869
2006	603	904
2007	623	934
2008	637	956
2009	674	1,011
2010	674	1,011
2011	674	1,011
2012	698	1,048
2013	710	1,066
2014	721	1,082
2015	733	1,100
2016	733	1,100
2017	735	1,103
2018	750	1,125
2019	771	1,157
2020	783	1,175
2021	794	1,191
2022	841	1,261

Source: SSI Federal Payment Amounts (SSA, 2022)

Table 7: Federal Poverty Guidelines by Year

Year	Individual	Couple	Individual (Hawaii)	Couple (Hawaii)	Individual (Alaska)	Couple (Alaska)
1992	$568	$766	$653	$881	$708	$957
1993	581	786	670	905	725	982
1994	613	820	706	943	767	1,025
1995	623	836	718	963	778	1,045
1996	645	863	743	993	805	1,078
1997	658	884	756	1,017	823	1,106
1998	671	904	772	1,040	839	1,131
1999	687	922	791	1,061	860	1,153
2000	696	938	799	1,078	869	1,172
2001	716	968	824	1,113	894	1,209
2002	738	995	850	1,145	923	1,244
2003	748	1,010	861	1,162	934	1,262
2004	776	1,041	892	1,197	969	1,301
2005	798	1,069	918	1,230	996	1,336
2006	817	1,100	939	1,265	1,021	1,375
2007	851	1,141	979	1,313	1,064	1,427
2008	867	1,167	997	1,342	1,083	1,458
2009	903	1,214	1,038	1,397	1,128	1,518
2010	903	1,214	1,038	1,397	1,128	1,518
2011	908	1,226	1,045	1,411	1,133	1,532
2012	931	1,261	1,072	1,451	1,164	1,577
2013	958	1,293	1,103	1,488	1,196	1,615
2014	973	1,311	1,118	1,508	1,215	1,638
2015	981	1,328	1,129	1,528	1,227	1,660
2016	990	1,335	1,139	1,536	1,237	1,668
2017	1,005	1,353	1,155	1,556	1,255	1,691
2018	1,012	1,372	1,163	1,578	1,265	1,715
2019	1,041	1,409	1,198	1,622	1,300	1,761
2020	1,063	1,437	1,223	1,653	1,329	1,796
2021	1,073	1,452	1,235	1,670	1,341	1,814
2022	1,133	1,526	1,303	1,755	1,416	1,908

Source: ASPE (2022)

Notes: Individual and couple rates corresponds to additional one- and two-person Federal Poverty Guidelines produced by the Department of Health and Human Services. They are not the same as Federal Poverty Levels that are used by the US Census Bureau in their statistics.

Table 8: Medicare Saving Program Eligibility: Income Limits by State (2022)

Type	Formula (FPG = Federal Poverty Guidelines)	Individual	Couple	Individual (Hawaii)	Couple (Hawaii)	Individual (Alaska)	Couple (Alaska)
Qualified Medicare beneficiary (QMB)	$FPG + 20$	$1,153	$1,546	$1,323	$1,775	$1,416	$1,908
Specified low income Medicare beneficiary (SLMB)	$1.20 \times FPG + 20$	1,379	1,851	1,584	2,126	1,719	2,310
Qualifying individual (QI)	$1.35 \times FPG + 20$	1,549	2,080	1,779	2,389	1,932	2,596
Qualified disabled and working individuals (QDWI)	$2.00 \times FPG + 20$	4,615	6,189	2,626	3,530	2,852	3,836

Source: Medicare Savings Programs (CMS, 2022)

Notes: The rates in the third and fourth column apply for the 48 contiguous states and the District of Columbia. Individual and couple rates corresponds to additional one- and two-person Federal Poverty Guidelines produced by the Department of Health and Human Services. They are not the same as Federal Poverty Levels that are used by the US Census Bureau in their statistics. See Table 7 for Federal Poverty Guidelines by year and state from 1992 to 2022.

Table 9: Medicare Saving Program Eligibility: Asset Limits by Year

Period	Individual	Couple
1992 to 2009	$4,000	$6,000
2010	6,600	9,910
2011	6,680	10,020
2012	6,940	10,410
2013	7,080	10,620
2014	7,160	10,750
2015	7,280	10,930
2016	7,280	10,930
2017	7,390	11,090
2018	7,560	11,340
2019	7,730	11,600
2020	7,860	11,800
2021	7,970	11,960
2022	8,400	12,600

Source: Dual Eligible Beneficiaries Under Medicare and Medicaid (CMS, 2020)

Notes: The limits apply in all states. Resource limits are indexed to the annual change in the Consumer Price Index for Urban Consumers in September of the previous year from 2010 and are rounded to the nearest $10.

Table 10: Medicaid enrollment for SSI disability program recipients

Type	States
Automatic enrollment in Medicaid (Administered by Social Security)	The District of Columbia and the following thirty-three states let Social Security determine Medicaid eligibility using SSI criteria and they allow Social Security to enroll SSI recipients: • Alabama, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming
Automatic enrollment in Medicaid (Administered by the State)	A few states make their own Medicaid eligibility decisions using the same income, resource, and disability criteria that Social Security uses for the SSI program, which means that everyone who receives SSI in those jurisdictions should qualify for Medicaid. These states, however, require the SSI recipient to file a separate Medicaid application. These states include: • Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, and the Northern Mariana Islands
Medicaid Enrollment Is Not Automatic	Eleven states have elected to use eligibility criteria for Medicaid that are more restrictive than SSI's. In most of these states, the rules about income and resources or the definition of disability are more restrictive for Medicaid than they are for SSI. Still, the federal government has imposed rules to limit how restrictive the states can be when screening SSI recipients for Medicaid eligibility.The States with their own Medicaid Eligibility Criteria (209(b) states) include: • Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

Notes: Social Security refers to states where Medicaid enrollment is not automatic as "209(b) states," corresponding to section 209(b) of the Social Security Amendments of 1972 that give states the option of using their own criteria for Medicaid. Indiana ceased being a 209(b) state in 2014.

Table 11: Health Services Required and Optional for State Medicaid Programs

Type	Coverage
Mandatory coverage	• Inpatient hospital services • Outpatient hospital services • EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services • Nursing Facility Services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family planning services • Nurse Midwife services • Certified Pediatric and Family Nurse Practitioner • services • Freestanding Birth Center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women
Optional coverage	• Prescription Drugs • Clinic services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Podiatry services • Optometry services • Dental Services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal Care • Hospice • Case management • Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD) • Services in an intermediate care facility for Individuals with Intellectual Disability State Plan Home and Community Based Services • Self-Directed Personal Assistance Services • Community First Choice Option • TB Related Services • Inpatient psychiatric services for individuals under age 21 • Other services approved by the Secretary • Health Homes for Enrollees with Chronic Conditions

Source: Mandatory & Optional Medicaid Benefits (CMS, 2022)

Table 12: Annual Deductible for Medicare Part B

Year	Deductible
1992 - 2004	$100
2005	110
2006	124
2007	131
2008	135
2009	135
2010	155
2011	162
2012	140
2013	147
2014	147
2015	147
2016	166
2017	183
2018	183
2019	185
2020	198
2021	203
2022	233

Source: Values before 2017 are available in Tables 2.C1 of Social Security's Annual Statistical Supplement of 2015 SSA (2016). This is the last Annual Statistical Supplement this table was reported. Subsequent years have been collected from annual CMS press releases entitled "Medicare Parts A & B Premiums and Deductibles" (see CMS, 2016, for an example).

Table 13: Medicaid Maximum Allowable Copayments (2013)

Services and Supplies	Income Level: $\leq 100\%$ of the FPG	Income Level: $100\% <$ FPG $\leq 150\%$	Income Level: $>150\%$ of the FPG
Institutional Care (inpatient hospital care, rehab care, etc.)	$75	10% of the state's service cost	20% of the state's service cost
Non-Institutional Care (physician visits, physical therapy, etc.)	$4	10% of the state's service cost	20% of the state's service cost
Non-emergency use of the ER	$8	$8	Up to 5% of the families income
Drugs: Preferred	$4	$4	$4
Drugs: Non-preferred	$8	$8	20% of the state's service cost

Source: Cost Sharing Out of Pocket Costs (CMS, 2022) - 2013 was the most recent information provided by Medicaid. Historical information has not been identified.

Notes: Preferred drugs are specificed in a state provided list that reflects drugs a state encourages providers to prescribe over others as a means to negotiate better rates from manufacturers.

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/policy-explorer).

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US Congress (2010). Public Law 111-148: Patient Protection and Affordable Care Act (124 Stat. 119, March 23, 2010). As of March 15, 2022. [Link]

Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Centers for Medicare and Medicaid Services (CMS): The government organization responsible for administration of old-age health insurance

Claimable Benefit: A pension where the beneficiary must actively file a claim for benefits with the government's pension authority.

Federal Poverty Guidelines (FPG): Levels established by the Department of Health and Human Services that are used as a benchmark for benefit eligibility for Medicare Savings Plans

Medicaid: Medicaid is a needs-based social assistance program supporting old-age health care. It is a joint federal-state program that pays for health care services for specified groups deemed "mandatory categorically needy," including low-income families, qualified pregnant women and children, and individual receiving Supplementary Security Income (i.e., social assistance for the aged, blind and disabled persons of limited means). States may also elect to insure additional groups deemed "optionally categorically needy" or "medically needy" which may relax limited means requirements.

Medicare Part A: Medicare Part A is subset of Medicare insurance coverage. It is administered by the federal government and provides for inpatient care in a hospital or skilled nursing facility (following a hospital stay) —Also pays for some home health care, and hospice care. Also known as "hospital insurace."

Medicare Part B: Medicare Part B is subset of Medicare insurance coverage. It is administered by the federal government and provides for health services including doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services

Medicare Part C: Medicare Part C is subset of Medicare insurance coverage. It is administered by the private insurance companies and provides at least the benefits and services covered under Part A and Part B. These plans may offer additional benefits and services (e.g., prescription drug coverage), have alternative requirements for services and lower out-of-pocket costs.

Medicare Part D: Medicare Part D is subset of Medicare insurance coverage. It has been available since 2006 and is administered by the federal government. It covers part of prescription drug costs.

Medicare Savings Plans (MSP): Joint federal and state program that covers some or all of Medicare Part A and Part B premiums as well as some deductibles, coinsurance, and copayments for services provided through these systems. Consists of four separate sub-programs where eligibility differ primarily on increasing maximum income levels (in order from lowest to greatest income thresholds): Qualified Medicare Beneficiary (QMB) Program; Specified Low-Income Medicare Beneficiary (SLMB) Program; Qualifying Individual (QI) Program; Qualified Disabled Working Individual (QDWI) Program.

Medicare: Medicare is a social insurance program supporting old-age health care. Individuals are eligible if they or their spouse worked in a Medicare-covered occupation and earning at least 40 quarters of coverage, are a US citizen or permanent resident of at least 5 years, and are age 65 or are disabled.

Qualified Benefit: A benefit is qualified if an individual must continue to meet certain standards, such as a means test, to continue receipt of benefits.

Qualified Disabled Working Individual (QDWI) Program: MSP program that help pay Medicare Part A premiums for disabled and working beneficiaries under age 65. This program serves persons not receiving Medicaid with incomes up to 200

Qualified Medicare Beneficiary (QMB) Program: MSP program that helps eligible beneficiaries pay Medicare Part A and/or Part B premiums, as well as deductibles, coinsurance, and copayments for covered services. This program serves persons with incomes up to 100

Qualifying Individual (QI) Program: MSP program that helps eligible beneficiaries pay Medicare Part B premiums, but number of beneficiaries can be limited by a state based on available resources. This program serves persons with incomes up to 135

Specified Low-Income Medicare Beneficiary (SLMB) Program: MSP program that helps eligible beneficiaries pay Medicare Part B premiums. This program serves persons with incomes up to 120

Supplemental Security Income (SSI): The official name of US old-age social assistance

Version information

Current Version: 2.1 (August 2023)

Version History

- 1.0 (March 2021): First version
- 2.0 (May 2022): Revisions to formatting and updating of values

- 2.1 (August 2023): Updated formatting

Additional resources

The following resources provide additional details for the interested reader:

Centers for Medicare and Medicaid Services (2022) *Medicare.org*.
Available at: https://www.medicare.gov
Features: Medicare's main site provides substantial information on how the program is currently administered from the site menu (located in the lower left of the website as of March 2022)

Centers for Medicare and Medicaid Services (2022) *Medicaid.org*.
Available at: https://www.medicaid.gov/medicaid/index.html
Features: Medicaids main site provides substantial information on how the program is currently administered - see section on "Policy and Program Topics." Additionally, the website also provides links to individual state Medicaid websites.

Social Security Administration (2016) *Annual Statistical Supplement, 2015*.
Available at: https://www.ssa.gov/policy/docs/statcomps/supplement/2015/index.html
Features: This document provides rich background on the history of the Medicare and Medicaid programs.

Congression Research Service (2021). *Medicare Part B: Enrollment and Premiums*. Report R40082. Updated June 15, 2021
Available at: https://sgp.fas.org/crs/misc/R40082.pdf
Features: This document provides extensive background on Medicare Part B and the Medicare Savings Programs.