E. MEDICARE COST-SHARING AND PREMIUM AMOUNTS

HI beneficiaries who use covered services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the HI trust fund to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each of days 61-90 in the hospital. After 90 days in a spell of illness, each individual has 60 lifetime reserve days of coverage, for which the coinsurance amount is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each of days 21-100 of skilled nursing facility services furnished during a spell of illness. No cost sharing is required for home health or hospice services.

Most persons aged 65 and older and many disabled individuals under age 65 are insured for HI benefits without payment of any premium. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, subject to the payment of a monthly premium. In addition, since 1994, voluntary enrollees may qualify for a reduced premium if they have at least 30 quarters of covered employment.

Table V.E1 shows the historical levels of the HI deductible, coinsurance amounts, and premiums, as well as projected values for future years based on the intermediate set of assumptions used in estimating the operations of the trust funds. The values listed in the table for future years are estimates, and the actual amounts are likely to be somewhat different as experience emerges.

Table V.E1.—HI Cost-Sharing and Premium Amounts

		Inpatient daily coinsurance[1]			Monthly premium	
Year	Inpatient hospital deductible[1]	Days 61-90	Lifetime reserve days	SNF daily coinsurance[1]	Standard[2]	Reduced[1]
Historical data:						
1970	$52	$13	$26	$6.50	—	—
1975	92	23	46	11.50	$40	—
1980	180	45	90	22.50	78	—
1985	400	100	200	50.00	174	—
1990	592	148	296	74.00	175	—
1995	716	179	358	89.50	261	$183
2000	776	194	388	97.00	301	166
2005	912	228	456	114.00	375	206
2006	952	238	476	119.00	393	216
2007	992	248	496	124.00	410	226
2008	1,024	256	512	128.00	423	233
2009	1,068	267	534	133.50	443	244
2010	1,100	275	550	137.50	461	254
2011	1,132	283	566	141.50	450	248
2012	1,156	289	578	144.50	451	248
2013	1,184	296	592	148.00	441	243
2014	1,216	304	608	152.00	426	234
2015	1,260	315	630	157.50	407	224
2016	1,288	322	644	161.00	411	226
2017	1,316	329	658	164.50	413	227
Intermediate estimates:						
2018	1,352	338	676	169.00	421	232
2019	1,388	347	694	173.50	436	240
2020	1,436	359	718	179.50	454	250
2021	1,484	371	742	185.50	473	260
2022	1,532	383	766	191.50	493	271
2023	1,580	395	790	197.50	515	283
2024	1,628	407	814	203.50	535	294
2025	1,676	419	838	209.50	552	304
2026	1,724	431	862	215.50	586	322

[1]Amounts shown are effective for calendar years.
[2]Amounts shown for 1970-1980 are for the 12-month periods ending June 30; amounts shown for 1985 and later are for calendar years.

The *Federal Register* notice[97] announcing the HI deductible and coinsurance amounts for 2017 included an estimate of the aggregate cost to HI beneficiaries for the changes in the deductible and coinsurance amounts from 2016 to 2017. At the time of the notice's publication, it was estimated that in 2017 there would be 7.26 million inpatient deductibles paid at $1,316 each, 1.80 million inpatient days subject to coinsurance at $329 per day (for hospital days 61 through 90), 0.88 million lifetime reserve days subject to coinsurance at $658 per day, and 41.8 million extended care days subject to coinsurance at $164.50 per day. Similarly, it was estimated that in 2016 there would be 7.15 million deductibles paid at $1,288 each, 1.77 million days subject to coinsurance at $322 per day (for hospital days 61 through 90), 0.87 million lifetime reserve days subject to coinsurance at $644 per day, and 40.55 million extended care days subject to coinsurance at $161.00 per day. The total increase in cost to

[97]See https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-27389.pdf.

beneficiaries was estimated to be $740 million due to (i) the increase in the inpatient deductible and coinsurance amounts and (ii) the increase in the number of deductibles and daily coinsurance amounts paid.

Table V.E2 displays the SMI cost-sharing and premium amounts for Parts B and D. The projected values for future years are based on the intermediate set of assumptions used in estimating the operations of the Part B and Part D accounts. As a result, these values are estimates, and the actual amounts are likely to be somewhat different as experience emerges. The premiums for 2010 and 2011 also reflect significant additional increases designed to offset the loss of revenues attributable to the hold-harmless provision, as described later in this appendix. Similarly, the 2017 premium was increased due to loss of revenues from the very low Social Security cost-of-living adjustment and the hold-harmless provision.

Table V.E2.—SMI Cost-Sharing and Premium Amounts

	Part B		Part D			
Calendar year	Standard monthly premium[1]	Annual deductible[2]	Base beneficiary premium	Deductible	Initial benefit limit	Catastrophic threshold
Historical data:						
1970	$4.00	$50	—	—	—	—
1975	6.70	60	—	—	—	—
1980	8.70	60	—	—	—	—
1985	15.50	75	—	—	—	—
1990	28.60	75	—	—	—	—
1995	46.10	100	—	—	—	—
2000	45.50	100	—	—	—	—
2005	78.20	110	—	—	—	—
2006	88.50	124	$32.20	$250	$2,250	$3,600
2007	93.50	131	27.35	265	2,400	3,850
2008	96.40	135	27.93	275	2,510	4,050
2009	96.40	135	30.36	295	2,700	4,350
2010	110.50	155	31.94	310	2,830	4,550
2011	115.40	162	32.34	310	2,840	4,550
2012	99.90	140	31.08	320	2,930	4,700
2013	104.90	147	31.17	325	2,970	4,750
2014	104.90	147	32.42	310	2,850	4,550
2015	104.90	147	33.13	320	2,960	4,700
2016	121.80	166	34.10	360	3,310	4,850
2017	134.00	183	35.63	400	3,700	4,950
Intermediate estimates:						
2018	134.00	183	37.54	405[3]	3,750[3]	5,000[3]
2019	134.00	183	40.11	425	3,950	5,250
2020	139.00	190	42.16	450	4,210	6,650
2021	145.70	201	44.23	475	4,470	7,050
2022	151.50	212	46.17	500	4,730	7,450
2023	160.20	224	48.12	525	4,990	7,850
2024	169.20	237	50.11	555	5,250	8,250
2025	177.30	248	51.69	585	5,520	8,700
2026	190.20	266	53.83	610	5,770	9,100

[1]Amounts shown for 1970-1980 are for the 12-month periods ending June 30; amounts shown for 1985 and later are for calendar years.
[2]Prior to the Medicare Modernization Act, the Part B deductible was fixed by statute and had only occasionally been adjusted. The Medicare Modernization Act raised the deductible to $110 in 2005 and specified that it be indexed by average per beneficiary Part B expenditures thereafter.
[3]These amounts have already been determined.

The Part B monthly premiums displayed in table V.E2 are the standard premium rates paid by most Part B enrollees. However, there are three provisions that alter the premium rate for certain Part B enrollees. First, there is a premium surcharge for those beneficiaries who enroll after their initial enrollment period. Second, beginning in 2007, there is a higher income-related premium for those individuals whose modified adjusted gross income exceeds a specified threshold. Table V.E3 displays these Part B income-related premium amounts for 2007 through 2026, based on the intermediate set of assumptions.

Table V.E3.—Part B Income-Related Monthly Premium Amounts[1]

	Ultimate percentage of program costs represented by premium			
Calendar year	35%	50%	65%	80%
Historical data:				
2007	$105.80	$124.40	$142.90	$161.40
2008	122.20	160.90	199.70	238.40
2009	134.90	192.70	250.50	308.30
2010	154.70	221.00	287.30	353.60
2011	161.50	230.70	299.90	369.10
2012	139.90	199.80	259.70	319.70
2013	146.90	209.80	272.70	335.70
2014	146.90	209.80	272.70	335.70
2015	146.90	209.80	272.70	335.70
2016	170.50	243.60	316.70	389.80
2017	187.50	267.90	348.30	428.60
Intermediate estimates:				
2018	187.50	267.90	348.30	428.60
2019	187.50	267.90	348.30	428.60
2020	194.60	278.00	361.40	444.80
2021	203.90	291.30	378.70	466.10
2022	212.10	303.00	393.90	484.80
2023	224.20	320.30	416.40	512.50
2024	236.80	338.30	439.80	541.30
2025	248.20	354.50	460.90	567.20
2026	266.20	380.30	494.40	608.50

[1]Includes the impact of the 3-year transition in 2007 and 2008.

In 2017 the initial threshold is $85,000 for an individual tax return and $170,000 for a joint return. The thresholds are not indexed to inflation in the years 2011 through 2019 but are indexed thereafter. Individuals exceeding the threshold will pay premiums covering 35, 50, 65, or 80 percent of the average program cost for aged beneficiaries, depending on their income level, compared to the standard premium covering 25 percent. Effective in 2018, MACRA lowered certain income thresholds used for determining the income-related monthly adjustment amounts to be paid by beneficiaries, resulting in a greater number of beneficiaries paying the higher amounts. In addition, beginning in 2020, the legislation adjusted the methodology used to index the thresholds, and accordingly more beneficiaries will be subject to the income-related premiums.

Lastly, Part B premiums may also vary from the standard rate because a hold-harmless provision can lower the premium rate for individuals

who have their premiums deducted from their Social Security benefits. On an individual basis, this provision limits the dollar increase in the Part B premium to the dollar increase in the individual's Social Security benefit. As a result, the person affected pays a lower Part B premium, and the net amount of the individual's Social Security benefit does not decrease despite the greater increase in the premium.

Most services under Part B are subject to an annual deductible and coinsurance. The annual deductible was set by statute through 2005. Thereafter, it increases with the increase in the Part B aged actuarial rate to approximate the growth in per capita Part B expenditures.[98] After meeting the deductible, the beneficiary pays an amount equal to the product of the coinsurance percentage and the remaining allowed charges. The coinsurance percentage is 20 percent for most services. For those services not subject to the deductible or coinsurance (clinical laboratory tests, home health agency services, and most preventive care services), the beneficiary pays nothing.

The Part D average premiums displayed in table V.E2 are the estimated base beneficiary premiums. Starting in 2009, the national average plan bid is based on the enrollment-weighted average. The actual premium that a beneficiary pays varies according to the plan in which the beneficiary enrolls. The average paid premium has always been lower than the base beneficiary premium; the average paid premium was about $33 in 2016 and increased to about $35 in 2017 due to drug spending growth. Since beneficiaries may switch plans each year once the premium rates become known, the Trustees assume that the estimated average premium rate paid by beneficiaries will continue to be slightly less than the base beneficiary premium in future years.

Similar to Part B, there are two provisions that affect the premium rate for certain Part D beneficiaries. First, there is a Part D late enrollment penalty for those beneficiaries enrolling after their initial enrollment period. Second, starting in 2011, individuals whose modified adjusted gross income exceeds the same thresholds applicable to the Part B premium pay an income-related premium in addition to the premium charged by the plan in which the individual enrolled. The amount of the income-related premium adjustment is dependent on the

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[98]The current mechanism to index the Part B deductible has technical computational issues mainly due to the timing of the calculation. The Part B deductible for any given year is indexed by the increase in the monthly aged actuarial rate for that same year, which represents estimated monthly per capita expenditures. However, these expenditures are dependent on the Part B deductible, which is not known until the actuarial rate is determined. The result is circularity in the modeling process.

individual's income level, and the extra premium amount is the difference between 35, 50, 65, or 80 percent and 25.5 percent, applied to the National Average Monthly Bid Amount adjusted for reinsurance. Effective in 2018, MACRA made the same changes to the income ranges and threshold methodology for Part D that were previously described for Part B. Table V.E4 displays the historical and projected Part D income-related premium adjustment amounts for 2011 through 2026, based on the intermediate set of assumptions.

Table V.E4.—Part D Income-Related Monthly Premium Adjustment Amounts

	Percentage of program costs represented by premium			
Calendar year	35%	50%	65%	80%
Historical data:				
2011	$12.00	$31.10	$50.10	$69.10
2012	11.60	29.90	48.10	66.40
2013	11.60	29.90	48.30	66.60
2014	12.10	31.10	50.20	69.30
2015	12.30	31.80	51.30	70.80
2016	12.70	32.80	52.80	72.90
2017	13.30	34.20	55.20	76.20
Intermediate estimates:				
2018	14.00	36.20	58.40	80.60
2019	15.10	38.90	62.70	86.60
2020	15.90	41.10	66.30	91.50
2021	16.80	43.40	69.90	96.50
2022	17.60	45.40	73.20	101.00
2023	18.40	47.50	76.60	105.70
2024	19.30	49.80	80.20	110.70
2025	20.10	51.80	83.60	115.30
2026	21.10	54.50	87.90	121.20

In addition, there are premium and cost-sharing subsidies for those beneficiaries with incomes less than 150 percent of the Federal poverty level and with assets in 2017 less than $13,820 for an individual and $27,600 for a couple. The asset thresholds are indexed in subsequent years by the Consumer Price Index (CPI-U). Under the current statutory adjustment formula, the asset figures for 2017 increase for both an individual and a couple as a result of increases in the CPI-U.

Under standard Part D coverage, there is an initial deductible. After meeting the deductible, the beneficiary pays 25 percent of the remaining costs up to the initial benefit limit. Beyond this limit, prior to 2011, the beneficiary paid all the drug costs until his or her total out-of-pocket expenditures reached the catastrophic threshold. (This total includes the deductible and coinsurance payments for expenses up to the initial benefit limit.) The ACA will gradually fill in the coverage gap from 2011 until 2020, when beneficiaries will pay 25 percent of the drug costs between the deductible and the catastrophic threshold under the standard coverage. In 2017, after reaching the catastrophic threshold, the beneficiary pays the greater of (i) 5 percent of the drug cost or (ii) $3.30 for generic or preferred multiple-source drugs or $8.25

for preferred single-source drugs. The latter copayment amounts from 2017 are indexed annually by per enrollee Part D average costs. Beneficiaries qualifying for the Part D low-income subsidy pay substantially reduced premium and cost-sharing amounts. Many Part D plans offer alternative coverage that differs from the standard coverage described above. The majority of beneficiaries have not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat copayments for covered drugs, and, in some cases, partial coverage in the coverage gap.