

Medicare 101

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California Health Benefits Review Program (CHBRP)
University of California

As more Californians age into Medicare and fewer remain in other state-regulated health insurance programs, it will be important for policymakers to better understand not only how Medicare works, but also how increased enrollment in the program will impact state-regulated health insurance markets and the state’s population. While the Medicare program is federally administered, this shift will influence the size and composition of state-regulated insurance markets, premium trends, and policy decisions. This explainer provides an overview of the federal Medicare program with a focus on its structure, financing, and enrollment trends, and interactions with California’s health insurance system.

Overview of Medicare

What is Medicare?

Medicare is a federal health insurance program run by the Centers for Medicare & Medicaid Services (CMS). Created in 1965, the program mainly covers people age 65 and older. Some people under 65 can also qualify if they have certain disabilities or serious medical conditions, such as kidney failure or amyotrophic lateral sclerosis (ALS).

While CMS sets federal rules for coverage and benefits, states regulate private supplemental plans and help administer joint programs. As shown in Table 1 below, Medicare consists of four primary operational parts alongside supplemental coverage options.

Table 1. Overview of the Primary Components of Medicare

Medicare Part	General Medicare Category	Coverage	Enrollment	Cost to Beneficiary	Administered By
Part A (Hospital Insurance)	Traditional / Original	Inpatient hospital stays, skilled nursing facility care, hospice, limited home health care (a)	Automatic if eligible for Social Security; no premium if work history qualifies	Usually premium-free; deductible and coinsurance apply	Federal government (CMS)

Medicare Part	General Medicare Category	Coverage	Enrollment	Cost to Beneficiary	Administered By
Part B (Medical Insurance)	Traditional / Original	Outpatient services, physician visits, preventive services (b), durable medical equipment	Voluntary; automatic if receiving Social Security unless opting out	Monthly premium (income-based); 20% coinsurance after deductible	Federal government (CMS)
Part C (Medicare Advantage)	Managed Care	Private plans covering Parts A & B, often with extra benefits (e.g., vision, dental); may include drug coverage	Must actively enroll in a Medicare Advantage plan	Varies by plan; may include additional premiums and cost-sharing	Private insurers approved and regulated by CMS
Part D (Prescription Drug Coverage)	Private Standalone / Integrated Plans	Outpatient prescription drugs	Voluntary; must actively enroll	Monthly premium (varies by plan); cost-sharing applies; subject to income-related premium adjustments	Private insurers approved and regulated by CMS
Medigap (Supplemental) (c)	Medigap	Part A & B out-of-pocket costs (e.g., deductibles, coinsurance)	Must be enrolled in Parts A & B; cannot be enrolled in a Medicare Advantage plan	Varies by plan and age; monthly premium paid to insurer	Private insurers; plans standardized federally (d)

Source: California Health Benefits Review Program, 2026.

Notes: (a) Limited home health care refers to part-time or intermittent skilled services provided at home to individuals who are homebound due to illness or injury. Covered services may include skilled nursing, physical therapy, speech-language pathology, and home health aide care (only when paired with skilled services). Medicare does not cover 24-hour care, custodial care, or homemaker services unrelated to a care plan (CMS, n.d.[a]).

(b) Preventive services can include routine screenings, check-ups, patient counseling, immunizations, contraceptive drugs and devices, or other services intended to prevent health issues.

(c) Medicare Part F and Part G are Medigap plans, which are supplemental insurance plans that help cover the costs not paid by Original Medicare (Parts A and B). Plan F is no longer available to those new to Medicare as of January 1, 2020, but those already enrolled can elect to keep it (there are still beneficiaries enrolled).

(d) Massachusetts, Minnesota, and Wisconsin have their own standardized Medigap plans, which may differ from the national plans.

Key: CMS = Centers for Medicare & Medicaid Services.

Original Medicare vs. Private Plan Delivery

- **Original Medicare (Parts A and B):** Also called Traditional Medicare, Original Medicare operates as a fee-for-services system and refers to Part A and Part B together. Part A is premium-free for individuals with sufficient work history, though benefits are subject to a deductible, plus coinsurance for extended inpatient hospital and skilled nursing facility (SNF) stays. Part B has a monthly premium and a 20% coinsurance for most services after meeting an annual deductible, though many preventive services and annual wellness visits are typically covered at no cost.
- **Medicare Advantage (Part C):** Medicare Advantage includes private managed care plans (HMOs, PPOs, and Special Needs Plans¹) that contract with CMS to provide Part A and B benefits. Plans often integrate Part D drug coverage and supplemental benefits (e.g., dental or vision). Subtypes also include Private Fee-for-Service

¹ An SNP provides benefits and services to those with severe and chronic diseases, certain health care needs, or those who also have Medicaid. The plans include care coordination services to tailor their benefits and providers to meet their specific needs. SNPs are either HMO or PPO plan types and cover the same Original Medicare benefits that all Medicare Advantage Plans cover. They may also cover additional services for the groups within the SNP population (CMS, n.d.[d]).

(PFFS)² plans, which determine provider payment rates independently, and Medical Savings Accounts³ (MSAs), which pair a high-deductible health plan with a savings account. (KFF, 2024a).

- **Prescription Drug Coverage (Part D):** Part D coverage is provided through private plans contracted with Medicare, either added onto Original Medicare or bundled into a Medicare Advantage plan that includes drug coverage. Enrollment is voluntary, but beneficiaries who do not enroll when first eligible may face a late-enrollment penalty added to their monthly premium if they enroll later.
- **Medicare Supplemental Insurance (Medigap):** Medigap is private insurance that helps cover cost sharing under Original Medicare (i.e., copayments, coinsurance, and deductibles) and is only available to beneficiaries enrolled in Original Medicare. Policies are standardized into lettered plans (e.g., Plans A–D, F, G, K–N). Beneficiaries have a six-month Medigap Open Enrollment Period, which begins when they are both over 65 and enrolled in Part B. After this period, insurers in many states may deny coverage for a Medigap plan or charge higher premiums based on health status, depending on state and federal rules.

Medicare Enrollment

Medicare eligibility general begins at age 65. Individuals can sign up during their Initial Enrollment Period, a 7-month window spanning from three months before to three months after their 65th birthday month. Those with qualifying circumstances—such as being impacted by natural disasters, incarceration, or participating in foreign service—may qualify for a Special Enrollment Period. Individuals who miss these windows can enroll during the General Enrollment Period (January 1–March 31 each year), though doing so may incur a lifetime monthly late enrollment penalty that grows the longer the delay in enrollment.

National and California Enrollment Trends

As of May 2026, nationally and in California, Medicare Advantage enrollment slightly outpaces Original Medicare, but displays significantly higher participation in Part B and prescription drug coverage—where Advantage coverage rates exceed Original Medicare by 17 to 25 percentage points, as shown in Table 2 (CMS, 2026a).

Table 2. National and California Medicare Enrollment, May 2026.

Region / Plan Type	Total Beneficiaries	Part A Uptake	Part B Uptake	Prescription Drug Uptake
National – Original Medicare	34.40M	99.51%	83.06%	73.39%
National – Medicare Advantage	36.07M	99.93%	99.97%	88.58%
California – Original Medicare	3.51M	99.48%	83.44%	71.63%
California – Medicare Advantage	3.72M	99.91%	99.94%	96.34%

Source: CMS Monthly Enrollment Data, 2026a.

² A PFFS plan is a type of Medicare Advantage Plan offered by a private insurer that sets its own provider payment rates and cost-sharing rules, allowing beneficiaries to see any Medicare-approved doctor or hospital that accepts the plan's terms (CMS, n.d.[b]).

³ An MSA is a type of Medicare Advantage Plan. They are similar to Health Savings Account (HSA) Plans sponsored by an employer or the state health insurance marketplace. With MSA Plans, patients may choose their health care services and providers; the plans typically do not have a separate network of physicians, other health care professionals, or hospitals (CMS, n.d.[c]).

Beneficiary Demographics

Beneficiaries enrolled in Original Medicare with Medigap, or employer-sponsored supplemental insurance were more likely to have higher incomes, report better health, have more years of education, and be aged 65 or older. In contrast, Original Medicare beneficiaries *without* supplemental coverage were more likely to be under age 65 with disabilities and have lower incomes. Between 2018 and 2022, the number of Original Medicare beneficiaries with no supplemental coverage declined from 5.6 million to 3.2 million. Medicare Advantage enrollees were more likely than those in Original Medicare to identify as Black or Hispanic, self-report fair or poor health, have annual incomes under \$20,000, and have lower levels of educational attainment (Ochieng et al., 2025).

Medicare Financing

Medicare is financed through two federal trust funds:

- 1) **Hospital Insurance Trust Fund:** primarily funded through payroll taxes, this trust supports Medicare Part A and related administrative costs.
- 2) **Supplementary Medical Insurance Trust Fund:** funded through general federal revenue and Medicare beneficiary premiums, this trust supports Medicare Parts B and D (CMS, n.d.[e]).

In 2023, Medicare expenditures exceeded \$1 trillion, accounting for 21% of total national health spending and about 10% of the federal budget (Cubanski and Neuman, 2024). From 2021 to 2023, net Medicare spending increased nearly 18%, reflecting demographic shifts and increased utilization. In 2024, total U.S. health spending reached \$5.3 trillion, or \$15,474 per person, accounting for 18.0% of the Gross Domestic Product (CMS, 2026b).

Medicare Spending in California

California's per-enrollee Medicare spending is slightly higher than the national average. The state spends relatively more on services such as inpatient hospital care, post-acute care, and hospice, while spending less on areas like imaging, durable medical equipment, ambulance services, and some outpatient care. Despite year-over-year fluctuations, California's overall Medicare spending has generally followed national growth trends between 2019 and 2023.

Medicare Interaction with California Health Insurance

While Medicare is a federally administered program, it intersects with California's health insurance landscape and can influence the state's regulatory environment and health policy discussions.

- **Dual-Eligible Beneficiaries (Medi-Cal Wrapping):** Approximately 1.8 million Californians are dual eligible for Medicare and Medi-Cal –about one in four Medicare beneficiaries in the state (KFF, 2024b). Medicare acts as the primary payer for medical care, while Medi-Cal covers Medicare cost sharing and wraps around secondary services such as long-term services and supports (LTSS).⁴ Duals represent a distinct population with higher levels of need and utilization, including many older adults and people with long-term disabilities. Compared to Medicare-only beneficiaries, dual-eligible individuals are more likely to report fair or poor health (13% vs. 4%) and have higher rates of chronic conditions and functional limitations. Although individuals under age 65 account for a small share of total dual enrollees, they represent 7% of Medicare beneficiaries and 5% of Medicaid beneficiaries, yet account for approximately 13% of Medicare spending and 10% of Medicaid spending (MedPAC, 2024; DHCS,

⁴ LTSS refers to medical, personal, and social care services needed by older adults or people with disabilities who cannot perform everyday activities on their own.

2025). In California, dual-eligible individuals may receive Medicare and Medi-Cal benefits through various coverage arrangements.

- **Dual Market Regulation (Medigap):** In California, both the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) oversee aspects of Medigap policy approvals, rating structures, and consumer protections. These state-level rules influence how beneficiaries can access and afford supplemental coverage.
- **Marketplace Transitions (Covered California):** The state's health insurance marketplace, Covered California, accounts for individuals transitioning into Medicare. Medicare eligibility disqualifies individuals from receiving Covered California subsidies, but enrollment coordination is not automatic. Beneficiaries must actively cancel Covered California plans after gaining Medicare eligibility, which may create administrative complexities for temporary gaps in coverage for beneficiaries.
- **Impact on State Risk Pools:** As California's population ages, a growing proportion of the state's residents will shift from commercial and state-regulated plans into Medicare. The state's population aged 65 and older is projected to grow by nearly 60% by 2040 compared to 2020 (Johnson et al., 2025). This transition may have implications for the size and composition of state-regulated risk pools,⁵ premium calculations, and the types of populations affected by state legislation, particularly those examined through CHBRP analyses.

Conclusion

California's growing population and the growing number of Medicare beneficiaries are changing the state's health insurance landscape. While Medicare is a federal program and is generally outside CHBRP's scope because it is not state regulated, understanding how Medicare works is becoming increasingly important. As more Californians transition from employer-sponsored and state-regulated coverage into Medicare, these shifts will affect the populations, insurance markets, and policies that CHBRP evaluates. Although Original Medicare is governed by federal rules, Medicare interacts with California's health insurance system through programs such as Medi-Cal, Medicare Advantage, and Medigap. As enrollment continues to grow, California policymakers will increasingly encounter legislation that indirectly affects Medicare beneficiaries and the broader health care system. A basic understanding of Medicare's eligibility, coverage options, financing, and enrollment trends provides important context for evaluating state health policy and anticipating future changes in California's insurance market.

⁵ Risk pools refers to the group of enrollees whose combined health risk and costs an insurer uses to set premiums.

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource [Academic Rigor on a Legislature's Timeline](#).

To read any of the 200+ bill analyses CHBRP has completed, see the [Completed Analysis](#) page on [CHBRP's website](#). In addition to analysis of introduced legislation, CHBRP produces [other publications](#) including several annually updated resources, as well as issue briefs and explainers.

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