Primer
Understanding Medicare in North Carolina
December 2025

WHAT IS MEDICARE?

Medicare is a federal health insurance program that covers individuals 65 and older, as well as individuals with disabilities, end-stage renal disease, or amyotrophic lateral sclerosis.[1]

MEDICARE'S ALPHABET OF PARTS

Medicare consists of four parts (A, B, C, & D). Medicare Parts A, B, and D each cover different services. Part C provides a private plan alternative for all Medicare services covered under Parts A and B, except hospice (Figure 1).

Parts A and B: Original Medicare

Parts A and B comprise "Original Medicare," which covers benefits on a fee-for-service basis. Part A is hospital insurance, which provides coverage for inpatient hospital services, posthospital skilled nursing facility services, hospice care, and some home health services.

Most persons aged 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (about 10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Persons under the age of 65 who receive cash disability benefits from Social Security or the Railroad Retirement systems for at least 24 months are also entitled to Part A.[1]

Part B covers physician services, outpatient hospital services, durable medical equipment, and other medical services. Generally, enrollment in Part B is voluntary. All persons entitled to Part A may enroll in Part B by paying a monthly premium.[1]

FIGURE 1. SERVICES COVERED & SOURCES OF FUNDING FOR MEDICARE[1]

Part	Services Covered	Sources Of Funding
Part A: **Hospital Insurance**	• Inpatient hospital services • Skilled nursing care • Hospice care • Some home health services	• Dedicated payroll tax
Part B: **Supplementary Medical Insurance**	• Physician services • Outpatient services • Some home health and preventive services	• Beneficiary premiums • General revenues
Part C: **Medicare Advantage**	• All Part A and Part B services, except hospice	• Dedicated payroll tax • Beneficiary premiums • General revenues
Part D: **Prescription Drug Benefit**	• Outpatient prescription drugs	• Beneficiary premiums • General revenues • State transfer payments

MEDICARE BY THE NUMBERS (2024)[2]

Total Enrollment
67.6 Million

Average Benefit Per Enrollee (Parts A, B, D)
$17,663

Percent of Total Federal Outlays
12%

Percent of GDP
3.8

Part C: Medicare Advantage

As an alternative to enrolling in Original Medicare, beneficiaries can opt for coverage through private plans, called the Medicare Advantage (MA) program. MA enrollees also must enroll in Part B.

Under MA, private health plans are paid a per-person amount to provide all Medicare covered benefits (except hospice) to beneficiaries who enroll in their plan.[1] MA plans may include coverage for additional services that Original Medicare doesn't cover (vision, hearing, dental).[3] Most MA plans include prescription drug coverage (Part D).

Part D: Prescription Drug Benefit

Medicare beneficiaries enrolled in Parts A or B also can enroll in prescription drug plans (Part D). Similar to Part B, enrollment in Part D is voluntary and the beneficiary pays a monthly premium. These private plans provide coverage for outpatient prescription drugs. Plans vary by benefit design, cost sharing, and drugs covered.[1]

Enrollment

When beneficiaries first become eligible for Medicare, they may choose Original Medicare or enroll in a private MA plan. Individuals who choose not to enroll immediately in Parts B or D will have to pay a penalty if they enroll later. Each fall, there is an annual open enrollment period during which beneficiaries may change plans.[1]

DIFFERENCES BETWEEN MEDICARE AND MEDICAID

Medicare

- Covers most North Carolinians ages 65 and older, as well as some with disabilities
- Eligibility is determined by age, work history, and disability status
- Funded by the federal government

Medicaid

- Covers specific populations of North Carolinians with lower incomes
- Eligibility determined by income, resources, age, and health status
- Funded jointly by North Carolina and the federal government

DUAL ELIGIBLES

Certain Medicare beneficiaries qualify for and receive Medicaid benefits. These people are referred to as "dual eligibles." Dual eligibles qualify for Medicaid based on financial and need-based criteria (and are typically in poorer health and older than the rest of the Medicaid population). Certain dual eligibles, called "full-dual" beneficiaries, are eligible for full Medicaid benefits, including medically necessary long-term services and supports, behavioral health benefits, transportation, and wrap-around benefits. Other dual eligibles, called "partial-dual" beneficiaries, are eligible only for assistance with Medicare premiums and cost sharing. Dual eligibles often have high health care costs.

MEDICARE ENROLLMENT IN NORTH CAROLINA (2024)[4,5]

Total Medicare Enrollment 2,228,458	Original Medicare 994,906
	Medicare Advantage (and other health plans) 1,233,552
Total Part D Enrollment 1,759,278	Stand-Alone Prescription Drug Plans 632,738
	Medicare Advantage Prescription Drug Plans 1,126,540

MEDICARE IN NORTH CAROLINA

In 2024, over 2,200,000 North Carolinians received medical coverage through Original Medicare or MA and other plans. Enrollment in Medicare Part D prescription drug plans reached approximately 1,760,000.

Between 2014 and 2024, total Medicare enrollment in North Carolina increased by 29.7%. Over that same period, as a percentage of total enrollment, enrollment in Original Medicare declined from 72% to 45%, and enrollment in MA plans increased from 28% to 55% (Figure 2).[4]

Between 2014 and 2024, total Part D enrollment in North Carolina increased by 47%. Over that same period, as a percentage of total enrollment, enrollment in stand-alone prescription drug plans declined from 63% to 36%, and enrollment in MA prescription drug plans increased from 37% to 64% (Figure 3).[5]

Figure 2: North Carolina Medicare Enrollment as a Percent of Total Enrollment

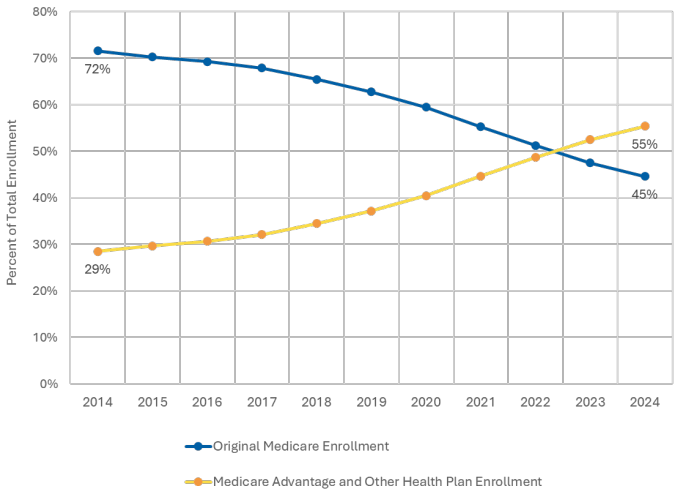
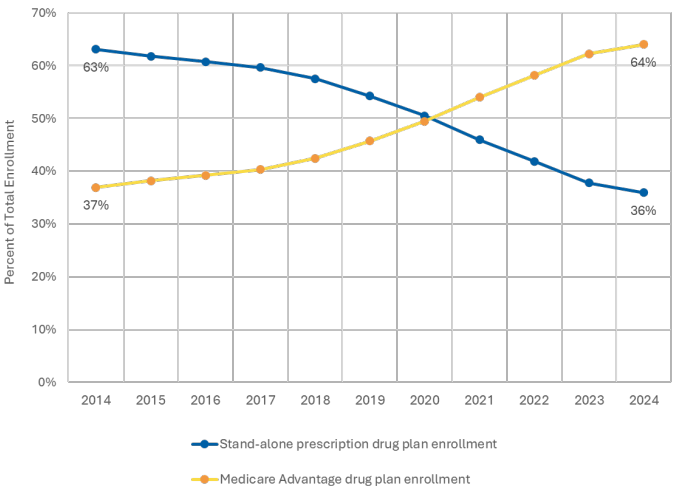


Figure 3: North Carolina Medicare Drug Plan Enrollment as a Percent of Total Enrollment



MEDICARE FINANCING

Medicare's financial operations are accounted for through 2 trust funds maintained by the Department of the Treasury—the Hospital Insurance (HI) trust fund for Part A and the Supplementary Medical Insurance (SMI) trust fund for Parts B and D.

Medicare expenditures are primarily paid for through mandatory spending. Most Medicare expenditures (aside from premiums paid by beneficiaries) are paid for by current workers through income taxes and dedicated Medicare payroll taxes. Medicare taxes paid by current workers are not set aside to cover their future Medicare expenses.[1]

Part A

Part A is funded through the Hospital Insurance (HI) trust fund, which is mainly funded from employee and employer payroll taxes.[1] Interest on federal securities, federal income taxes on Social Security benefits, and Part A premiums also contribute to the HI trust fund's revenue.

Financing the HI trust fund is expected to be an issue in the future. Medicare Trustees estimate that the HI trust fund will be depleted in 2033. At that point, HI revenues are projected to cover 89% of incurred program costs.[2]

Part B

Part B is funded through the Supplementary Medical Insurance (SMI) trust fund. Beneficiary premiums and federal general revenues finance the SMI trust fund.[1]

Part C

Funding for Part C comes from the HI trust fund and the SMI trust fund.[1] Funding comes from payroll taxes, beneficiary premiums, and general revenues. Beneficiaries who enroll in Part C typically pay both a monthly Part B premium and a premium to their Medicare Advantage plan.

Part D

Part D is funded through beneficiary premiums, general revenues, and state clawback payments. Clawback payments are payments from states to Medicare for the cost of drugs that states would be expected to pay for dual eligible beneficiaries through Medicaid, that was instead paid by Medicare through Part D.

Premiums paid by beneficiaries vary by plan. In addition, beneficiaries with higher income pay higher premiums and low-income beneficiaries can receive premium subsidies.[1]

WHO ADMINISTERS MEDICARE?[1]

The Centers for Medicare & Medicaid (CMS), within the Department of Health and Human Services (DHHS), has primary operational responsibilities for the Medicare program. Such responsibilities include managing program finances, developing policies and regulations, setting payment rates, and developing the program's information-technology infrastructure.

The Social Security Administration provides administrative support, such as enrolling beneficiaries into the program and issuing Medicare beneficiary cards.

CMS contracts with various private entities, including private health insurance companies, to help administer the program.

SUPPLEMENTAL HEALTH INSURANCE

Although Medicare covers many types of health care services, beneficiaries still face gaps in coverage and high out-of-pocket spending. Original Medicare does not cover long-term services and supports, dental services, hearing aids, and eyeglasses. Furthermore, there is also no cap on annual out-of-pocket spending on cost-sharing charges for services covered under Parts A and B.[1]

Medicare beneficiaries can obtain a few different types of health insurance to pay for costs not covered by Medicare.

Nationally, employer-sponsored insurance coverage provided supplemental insurance for 21% of Medicare beneficiaries in 2022. Over time the number of employers offering health insurance coverage has declined significantly.[6]

Medigap plans are another supplemental insurance option and covered 21% of beneficiaries in 2022. Private insurance companies offer Medigap plans as a way to cover costs, including deductibles, coinsurance, and copayments, not covered by Medicare Parts A and B.[6]

Rather than obtain supplemental health insurance, some Medicare beneficiaries decide to enroll in Medicare Advantage plans (Part C). MA plans can cover services not covered by Original Medicare and have an annual cap on catastrophic out-of-pocket spending.[3]

MEDICARE REFORM

As required by the Affordable Care Act, the Center for Medicare and Medicaid Innovation was established to test and evaluate innovative payment and service delivery models to reduce program expenditures.[1]

Examples of these models include providing payment incentives for groups of doctors, hospitals, and other health care providers (Accountable Care Organizations, or ACOs) to coordinate the services they provide to Medicare beneficiaries; bundling payments for services provided in different settings during a beneficiary's episode of care; and reimbursing health providers based on the quality of care rather than on the volume of services.

Among the 62.5 million Medicare beneficiaries with both Part A and Part B coverage in 2025, 79% are in Medicare managed care (Medicare Advantage or other private plans) or ACO models. Only 21% of Medicare beneficiaries with both Part A and B coverage are in traditional fee-for-service Medicare.[6]

REFERENCES

1. Binder C, Davis PA, Hahn J, et al. Medicare Primer. https://crsreports.congress.gov
2. Chavez-DeRemer L, Kennedy RF, Bessent S, Bisignano FJ. 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.; 2025. Accessed September 24, 2025. https://www.cms.gov/oact/tr/2025
3. Centers for Medicare & Medicaid Services. Understanding Medicare Advantage Plans. Accessed September 24, 2025. https://www.medicare.gov/publications/12026-understanding-medicare-advantage-plans.pdf
4. Kaiser Family Foundation. Total Number of Medicare Beneficiaries by Type of Coverage. 2024. Accessed September 23, 2025. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries
5. Kaiser Family Foundation. Medicare Beneficiaries Enrolled in Part D Coverage. 2024. Accessed September 23, 2025. https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-enrolled-in-part-d-coverage
6. MedPAC. A Data Book: Health Care Spending and the Medicare Program.; 2025. Accessed September 24, 2025. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf