

SECTION 2. MEDICARE

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OVERVIEW

Medicare is a nationwide health insurance program for the aged and certain disabled persons. The program consists of two parts—part A; hospital insurance and part B, supplementary medical insurance. Total program outlays were \$194.2 billion in fiscal year 1996. Net outlays after deduction of beneficiary premiums were \$174.2 billion.

COVERAGE

Almost all persons over age 65 are automatically entitled to Medicare part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 who are receiving Social Security cash benefits on the basis of disability. Most persons who need a kidney transplant or renal dialysis may also be covered, regardless of age. In fiscal year 1997, part A covered an estimated 38.1 million aged and disabled persons (including those with chronic kidney disease).

Medicare part B is voluntary. All persons over age 65 and all persons enrolled in part A may enroll in part B by paying a monthly premium—\$43.80 in 1997 and 1998. In fiscal year 1997, part B covered an estimated 36.5 million aged and disabled persons.

BENEFITS

Part A provides coverage for inpatient hospital services, up to 100 days of posthospital skilled nursing facility (SNF) care, home health services, and hospice care. Patients must pay a deductible (\$760 in 1997 and \$764 in 1998) each time their hospital admission begins a benefit period. (A benefit period begins when a patient enters a hospital and ends when she has not been in a hospital or SNF for 60 days.) Medicare pays the remaining costs for the first 60 days of hospital care. The limited number of beneficiaries requiring care beyond 60 days are subject to additional charges. Patients requiring SNF care are subject to a daily coinsurance charge for days 21-100 (\$95 in 1997 and \$95.50 in 1998). There are no cost-sharing charges for home health care and limited charges for hospice care.

Part B provides coverage for physicians' services, laboratory services, durable medical equipment, outpatient hospital services, and other medical services. The program generally pays 80 percent of Medicare's fee schedule or other approved amount after the beneficiary has met the annual \$100 deductible. The beneficiary is liable for the remaining 20 percent.

PAYMENTS FOR SERVICES

Taken together, spending for inpatient hospital and physicians' and related services accounts for close to 70 percent of Medicare benefit payments. Medicare makes payments for inpatient hospital services under a prospective payment system (PPS); a predetermined rate is paid for each inpatient stay based on the patient's admitting diagnosis. Payment for physicians' services is made on the basis of a fee schedule. Specific payment rules are also used for other services.

ADMINISTRATION

Medicare is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (DHHS). Much of the day-to-day work of reviewing claims and making payments is done by intermediaries (for part A) and carriers (for part B). These are generally commercial insurers or Blue Cross Blue Shield plans.

FINANCING

Medicare part A is financed primarily through the hospital insurance (HI) payroll tax levied on current workers and their employers. Employers and employees each pay a tax of 1.45 percent on all earnings. The self-employed pay a single tax of 2.9 percent on earnings.

Part B is financed through a combination of monthly premiums levied on program beneficiaries and Federal general revenues. In 1997 and 1998, the premium is \$43.80. Beneficiary premiums have generally represented about 25 percent of part B costs; Federal general revenues (that is, tax dollars) account for the remaining 75 percent.

FEDERAL OUTLAYS

Total program outlays were \$194.2 billion in fiscal year 1996. Net outlays (that is, net of premiums beneficiaries pay for enrollment, largely for part B) were \$174.2 billion.

Tables 2-1, 2-2, and 2-3 provide historical spending and coverage data for Medicare. Table 2-4 provides State-by-State information for fiscal year 1996.

TABLE 2-1.—MEDICARE OUTLAYS, FISCAL YEARS 1967–2007

[In millions of dollars]

Fiscal year	Part A	Part B	Total Medicare outlays	Medicare premium offsets	Net Medicare outlays	Percent increase (over prior year)
1967	\$2,597	\$798	\$3,395	(\$647)	\$2,748	.....
1968	3,815	1,532	5,347	(698)	4,649	69.2
1969	4,758	1,840	6,598	(903)	5,695	22.5
1970	4,953	2,196	7,149	(936)	6,213	9.1
1971	5,592	2,283	7,875	(1,253)	6,622	6.6
1972	6,276	2,544	8,820	(1,340)	7,480	13.0
1973	6,842	2,637	9,479	(1,427)	8,052	7.6
1974	8,065	3,283	11,348	(1,708)	9,640	19.7
1975	10,612	4,170	14,782	(1,907)	12,875	33.6
1976	12,579	5,200	17,779	(1,945)	15,834	23.0
TQ	3,404	1,401	4,805	(541)	4,264	NA
1977	15,207	6,342	21,549	(2,204)	19,345	NA
1978	17,862	7,350	25,212	(2,443)	22,769	17.7
1979	20,343	8,805	29,148	(2,653)	26,495	16.4
1980	24,288	10,746	35,034	(2,945)	32,089	21.1
1981	29,248	13,240	42,488	(3,340)	39,148	22.0
1982	34,864	15,559	50,423	(3,856)	46,567	19.0
1983	38,551	18,317	56,868	(4,253)	52,615	13.0
1984	42,295	20,374	62,669	(4,942)	57,727	9.7
1985	48,667	22,730	71,397	(5,562)	65,835	14.0
1986	49,685	26,217	75,902	(5,739)	70,163	6.6
1987	50,803	30,837	81,640	(6,520)	75,120	7.1
1988	52,730	34,947	87,677	(8,798)	78,879	5.0
1989	58,238	38,316	96,554	(11,590)	84,964	7.7
1990	66,687	43,022	109,709	(11,607)	98,102	15.5
1991	70,742	47,021	117,763	(12,174)	105,589	7.6
1992	81,971	50,285	132,256	(13,232)	119,024	12.7
1993	91,604	54,254	145,858	(15,305)	130,553	9.7
1994	102,770	59,724	162,494	(17,747)	144,747	10.9
1995	114,883	65,213	180,096	(20,241)	159,855	10.4
1996	125,300	68,946	194,246	(20,088)	174,158	8.9
1997 ¹	136.1	72.7	208.8	(20.2)	188.6	8.3
1998 ¹	141.1	79.6	220.7	(21.2)	199.5	5.8
1999 ¹	144.6	88.8	233.4	(23.4)	210.0	5.3
2000 ¹	147.9	98.4	246.3	(25.8)	220.4	5.0
2001 ¹	156.7	112.8	269.5	(28.6)	241.0	9.3
2002 ¹	157.9	121.0	278.9	(31.8)	247.1	2.5
2003 ¹	168.6	138.5	307.0	(35.5)	271.6	9.9
2004 ¹	178.8	154.3	333.1	(39.8)	293.4	8.0
2005 ¹	195.6	174.2	369.8	(44.2)	325.6	11.0
2006 ¹	200.7	182.8	383.5	(48.7)	334.8	2.8
2007 ¹	219.8	207.7	427.5	(53.5)	374.0	11.7

¹ CBO projections (excludes discretionary spending; in billions of dollars).

Note.—Totals may not add due to rounding. TQ = transitional quarter.

Source: Office of the President, 1997.

TABLE 2-2.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES, AND AVERAGE MEDICARE BENEFIT PAYMENTS PER ENROLLEE, SELECTED YEARS 1975-99

[Beneficiaries in thousands]

Fiscal year	1975 (actual)	1980 (actual)	1985 (actual)	1990 (actual)	1994 (actual)	1995 (actual)	1996 (est.) ¹	1997 (est.) ¹	1998 (est.) ¹	1999 (est.) ¹	Average annual growth 1975-85 (percent)	Average annual growth 1985-95 (percent)	Projected average annual growth 1995-99 (percent)
Part A													
Persons enrolled (monthly average):													
Aged	21,795	24,571	27,121	30,050	32,233	32,650	32,925	33,114	33,312	33,521	2.2	1.9	0.7
Disabled	2,047	2,967	2,943	3,313	4,181	4,489	4,750	5,003	5,249	5,504	3.7	4.3	5.2
Total	23,842	27,538	30,064	33,363	36,414	37,139	37,675	38,117	38,561	39,025	2.3	2.1	1.2
Beneficiaries receiving reim-													
bursed services:													
Aged	4,906	5,943	6,168	6,314	7,010	7,080	7,170	7,250	7,340	7,430	2.3	1.4	1.2
Disabled	456	721	672	675	882	920	975	1,035	1,090	1,150	4.0	3.2	5.7
Total	5,362	6,664	6,840	6,989	7,872	8,000	8,145	8,285	8,430	8,580	2.5	1.6	1.8
Average annual benefit per													
person enrolled:^{2 3}													
Aged	\$432	\$853	\$1,563	\$1,947	\$2,794	\$3,078	\$3,323	\$3,616	\$3,876	\$4,151	13.7	7.0	7.8
Disabled	460	948	1,809	2,176	2,700	2,874	3,054	3,256	3,442	3,638	14.7	4.7	6.1
Total	434	863	1,587	1,970	2,783	3,053	3,289	3,569	3,817	4,079	13.8	6.8	7.5
Part B													
Persons enrolled (average):													
Aged	21,504	24,422	27,049	29,426	31,335	31,622	31,891	32,177	32,361	32,547	2.3	1.6	0.7

TABLE 2-2.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES, AND AVERAGE MEDICARE BENEFIT PAYMENTS PER ENROLLEE, SELECTED YEARS 1975-99—Continued

[Beneficiaries in thousands]

Fiscal year	1975 (actual)	1980 (actual)	1985 (actual)	1990 (actual)	1994 (actual)	1995 (actual)	1996 (est.) ¹	1997 (est.) ¹	1998 (est.) ¹	1999 (est.) ¹	Average annual growth 1975-85 (percent)	Average annual growth 1985-95 (percent)	Projected average annual growth 1995-99 (percent)
Disabled	1,835	2,698	2,672	2,907	3,638	3,874	4,087	4,304	4,545	4,780	3.8	3.8	5.4
Total	23,339	27,120	29,721	32,333	34,973	35,496	35,978	36,481	36,906	37,327	2.4	1.8	1.3
Beneficiaries receiving reim- bursed services:													
Aged	11,311	16,034	20,199	23,820	26,118	26,681	27,044	27,544	27,952	28,332	6.0	2.8	1.5
Disabled	797	1,669	1,933	2,184	2,867	3,093	3,289	3,503	3,733	3,962	9.3	4.8	6.4
Total	12,108	17,703	22,132	26,004	28,985	29,774	30,333	31,047	31,685	32,294	6.2	3.0	2.1
Average annual benefit per person enrolled: ²													
Aged	\$153	\$348	\$705	\$1,250	\$1,601	\$1,728	\$1,797	\$2,011	\$2,197	\$2,410	16.5	9.4	8.7
Disabled	259	610	1,022	1,603	2,154	2,282	2,408	2,370	2,500	2,657	14.7	8.4	3.9
Total	161	374	734	1,282	1,658	1,788	1,867	2,054	2,234	2,441	16.4	9.3	8.1

¹ Represents projections of current law. Does not include legislative proposals. ² Does not include administrative cost. ³ Includes part A catastrophic benefits in fiscal year 1990.

Source: Health Care Financing Administration, Division of Budget.

TABLE 2-3.—BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PART A AND PART B, SELECTED FISCAL YEARS 1975-98
[Dollars in millions]

	1975		1980		1985		1990		1995		1998 (est.) ¹		Average annual growth (percent)		
	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	1975-85	1985-95	1995-98
Part A															
Inpatient hospital services	70.5	\$9,947	67.4	\$22,860	65.0	\$45,218	55.3	\$59,285	49.4	\$87,441	47.6	\$109,299	16.3	6.8	7.7
Skilled nursing facility services	1.9	273	1.2	392	0.8	550	2.6	2,821	5.1	9,104	6.0	13,779	7.3	32.4	14.8
Home health services	0.9	133	1.5	524	2.7	1,908	3.1	3,297	8.5	14,995	9.5	21,879	30.5	22.9	13.4
Hospice services	0	0	0	0	0	34	0.3	318	1.0	1,854	1.0	2,214	NA	49.2	6.1
Total benefit payments	73.3	10,353	70.1	23,776	68.6	47,710	61.3	65,721	64.1	113,394	64.1	147,171	16.5	9.0	9.1
Part B															
Physician services ²	21.7	3,067	23.0	7,813	24.1	16,788	27.0	28,922	22.8	40,376	20.2	46,325	18.5	9.2	4.7
Outpatient services	3.7	529	5.3	1,803	5.6	3,917	7.8	8,365	8.2	14,576	8.7	19,902	22.2	14.0	10.9
Other medical and health services	1.2	169	1.6	528	1.6	1,103	3.9	4,165	4.8	8,530	7.1	16,229	20.6	22.7	23.9
Total benefit payments	26.7	3,765	29.9	10,144	31.4	21,808	38.7	41,452	35.9	63,482	35.9	82,456	19.2	11.3	9.1
Total parts A and B	100.0	14,118	100.0	33,920	100.0	69,518	100.0	107,173	100.0	176,876	100.0	229,627	17.3	9.8	9.1

¹ Represents law in effect prior to enactment of the Balanced Budget Act of 1997.

² Includes other services.

NA—Not available.

Note.—Totals may not add due to rounding.

Source: Health Care Financing Administration, Division of Budget.

TABLE 2-4.—MEDICARE ESTIMATED BENEFIT PAYMENTS BY STATE, FISCAL YEAR 1996

State	Medicare estimated benefit payments ¹	HI and/or SMI Medicare enrollment ²	Estimated benefit payments per enrollee
Alabama	\$3,349,478	650,941	\$5,146
Alaska	155,548	35,281	4,409
Arizona	2,949,642	613,992	4,804
Arkansas	1,749,406	426,645	4,100
California	21,688,154	3,690,130	5,877
Colorado	2,021,955	432,283	4,677
Connecticut	2,810,930	506,169	5,553
Delaware	474,232	103,216	4,595
District of Columbia	1,206,754	77,271	15,617
Florida	16,046,099	2,654,681	6,044
Georgia	4,444,248	848,854	5,236
Hawaii	612,461	152,948	4,004
Idaho	522,788	152,673	3,424
Illinois	7,792,373	1,623,430	4,800
Indiana	3,770,224	829,586	4,545
Iowa	1,641,893	475,130	3,456
Kansas	1,630,982	385,357	4,232
Kentucky	2,610,256	595,583	4,383
Louisiana	3,937,599	585,918	6,720
Maine	791,042	205,132	3,856
Maryland	3,005,428	609,601	4,930
Massachusetts	5,884,023	942,272	6,245
Michigan	6,565,577	1,360,512	4,826
Minnesota	2,593,008	635,709	4,079
Mississippi	2,016,230	401,697	5,019
Missouri	4,122,022	838,377	4,917
Montana	469,724	131,847	3,563
Nebraska	933,547	250,284	3,730
Nevada	1,003,697	202,347	4,960
New Hampshire	652,613	159,275	4,097
New Jersey	5,958,095	1,177,159	5,061
New Mexico	799,360	215,930	3,702
New York	14,860,448	2,653,492	5,600
North Carolina	4,688,836	1,048,981	4,470
North Dakota	438,228	103,170	4,248
Ohio	7,870,293	1,676,437	4,695
Oklahoma	2,471,759	491,628	5,028
Oregon	1,801,354	472,197	3,815
Pennsylvania	11,468,028	2,077,870	5,519
Rhode Island	866,931	169,186	5,124
South Carolina	2,144,121	520,408	4,120
South Dakota	446,865	117,421	3,806
Tennessee	4,486,558	783,385	5,728
Texas	12,732,603	2,116,951	6,015
Utah	812,811	191,387	4,247
Vermont	306,150	84,454	3,625
Virginia	3,277,225	833,145	3,934
Washington	2,826,104	698,966	4,043
West Virginia	1,372,605	331,343	4,143

TABLE 2-4.—MEDICARE ESTIMATED BENEFIT PAYMENTS BY STATE, FISCAL YEAR 1996—Continued

State	Medicare estimated benefit payments ¹	HI and/or SMI Medicare enrollment ²	Estimated benefit payments per enrollee
Wisconsin	2,909,048	766,625	3,795
Wyoming	197,719	61,465	3,217
Puerto Rico	952,913	489,944	1,945
All other areas	36,142	321,269	112
Total all areas	191,176,132	37,979,904	5,034

¹ In thousands of dollars.² As of September 30, 1996.

Note.—Benefit payments for all areas represent actual Department of Treasury (DOT) disbursements. Distribution of benefit payments by State is based on a methodology which considered actual payments to HMOs and estimated payments for other providers of Medicare services. Estimated payments were determined by applying the relative weight of each State's share of total fee-for-service provider payments for fiscal year 1996 to the DOT disbursements net of managed care payments.

Source: Health Care Financing Administration.

ELIGIBILITY AND COVERAGE

AGED

Part A

Most Americans age 65 or older are automatically entitled to protection under part A. These individuals (or their spouses) established entitlement during their working careers by paying the HI payroll tax on earnings covered by either the Social Security or Railroad Retirement Systems.

The HI tax was extended to Federal employment with respect to wages paid on or after January 1, 1983. Beginning January 1, 1983, Federal employment is included in determining eligibility for protection under Medicare part A. A transitional provision allows individuals who were in the employ of the Federal Government both before and during January 1, 1983, to have their prior Federal employment considered as employment for purposes of providing Medicare coverage. Employees of State and local governments, hired after March 31, 1986, are also liable for the HI tax.

Persons age 65 or older who are not automatically entitled to part A may obtain coverage, providing they pay the full actuarial cost. The 1997 monthly premium is \$311 (\$187 for persons who have at least 30 quarters of covered employment). The 1998 monthly premium is \$309 (\$170 for persons who have at least 30 quarters of covered employment).

Part B

Part B of Medicare is voluntary. All persons age 65 or older (even those not entitled to part A) may elect to enroll in the SMI Program by paying the monthly premium. The 1997 and 1998 premium is \$43.80 per month. Persons who voluntarily enroll in part A are required to enroll in part B.

DISABLED

Part A

Part A also covers, after a 2-year waiting period, people under age 65 who are either receiving monthly Social Security benefits on the basis of disability or receiving payments as disabled Railroad Retirement System annuitants. (Dependents of the disabled are not eligible.) In addition, most people who need a kidney transplant or renal dialysis because of chronic kidney disease are entitled to benefits under part A regardless of age.

Part B

Persons eligible for part A by virtue of disability or chronic kidney disease may also elect to enroll in part B.

NUMBER OF BENEFICIARIES

In fiscal year 1996, 32.9 million aged and 4.8 million disabled had protection under part A. Of those, 7.2 million aged and 1.0 million disabled actually received reimbursed services. In fiscal year 1996, 31.9 million aged and 4.1 million disabled were enrolled in part B. About 27.0 million of the aged and 3.3 million of the disabled actually received reimbursed services (table 2-2).

BENEFITS AND BENEFICIARY COST SHARING

PART A

Part A coverage includes:

Inpatient hospital care.—The first 60 days of inpatient hospital services in a benefit period are subject to a deductible (\$760 in calendar year 1997; \$764 in 1998). A benefit period begins when a patient enters a hospital and ends when he has not been in a hospital or SNF for 60 days. For days 61–90 in a benefit period, a coinsurance amount (\$190 in calendar year 1997; \$191 in 1998) is imposed. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60-day lifetime reserve. A coinsurance amount (\$380 in calendar year 1997; \$382 in 1998) is imposed for each reserve day.

Skilled nursing facility care.—SNF care is up to 100 days (following hospitalization) in a skilled nursing facility for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance (\$95 in calendar year 1997; \$95.50 in 1998) amount.

Home health care.—Home health visits are provided to persons who need skilled nursing care on an intermittent basis, or physical therapy, or speech therapy. The Balanced Budget Act of 1997 gradually transfers from part A to part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF (that is, postinstitutional visits) and during a home health spell of illness. The transfer will be phased in over 6 years, between 1998 and 2003, with the Secretary transferring one-sixth of the aggregate expenditures associated with transferred visits in 1998; two-sixths in 1999; three-sixths in 2000; four-sixths in 2001; five-sixths in 2002; and six-sixths in 2003. Beginning January 1, 2003, part A will cover only postinstitutional home health

services for up to 100 visits during a home health spell of illness, except for those persons with part A coverage only, who will be covered for services without regard to the postinstitutional limitation.

Hospice care.—Hospice care services are provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team must recertify, at the beginning of 60-day periods, that the beneficiary is terminally ill.

PART B

Part B of Medicare generally pays 80 percent of the approved amount (fee schedule, reasonable charge, or reasonable cost) for covered services in excess of an annual deductible (\$100). Services covered include:

Doctor's services.—This category includes surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists, and chiropractors and for the treatment of mental illness.

Other medical and health services.—Laboratory and other diagnostic tests, x-ray and other radiation therapy, outpatient hospital services, rural health clinic services, DME, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services are also required.

Specified preventive services.—These services include a screening mammography once every 2 years for persons over age 65 and at specified intervals for the disabled; and effective January 1, 1998 annual mammograms for all women over age 40. A screening pap smear (and, effective January 1, 1998, a screening pelvic exam) is authorized once every 3 years, except for women who are at a high risk of developing cervical cancer. Effective January 1, 1998, coverage is provided for specified colorectal screening procedures. Effective July 1, 1998, coverage is authorized for diabetes self-management training services and bone mass measurements for high-risk persons. Prostate cancer screenings are covered beginning January 1, 2000.

Drugs and vaccines.—Generally Medicare does not pay for outpatient prescription drugs or biologicals. Part B pays for immunosuppressive drugs for 30 months following an organ transplant (extended to 36 months after 1997), erythropoietin for treatment of anemia for persons with chronic kidney failure, and certain specified oral cancer drugs. The program also covers flu shots, pneumococcal pneumonia vaccines, and hepatitis B vaccines for those at risk.

Home health services.—Home services include an unlimited number of medically necessary home health visits for persons not covered under part A. The 20-percent coinsurance and \$100 deductible do not apply for such benefits. As noted above, the Balanced Budget Act of 1997 gradually transfers some home health costs from part A to part B, beginning in 1998.

Table 2-5 illustrates the deductible, coinsurance and premium amounts for both part A and part B services from the inception of Medicare.

TABLE 2-5.—PART A AND PART B DEDUCTIBLE, COINSURANCE AND PREMIUMS, ¹ 1966–98

Calendar year	Inpatient hospital ²			Skilled nursing facility 21st–100th day coinsurance per day ⁵	HI monthly premium ⁶		SMI deductible	SMI premium	
	First 60 days deductible	61st–90th day coinsurance per day ³	60 lifetime reserve days (nonrenewable) coinsurance per day ⁴		Effective date	Full amount	Reduced amount	Effective date	Amount
1966		\$40	(7)	(7)	.....	.....	NA	7/66	\$3.00
1967		40	(7)	\$5.00	.....	.....	NA	.....	3.00
1968		40	\$20	5.00	.....	.....	NA	4/68	4.00
1969		44	22	5.50	.....	.....	NA	.....	4.00
1970		52	26	6.50	.....	.....	NA	.....	5.30
1971		60	30	7.50	.....	.....	NA	7/70	5.60
1972		68	34	8.50	.....	.....	NA	7/71	5.80
1973		72	36	9.00	.....	.....	NA	7/72	6.30
1974		84	42	10.50	7/73	\$33	NA	8 9/73	6.70
1975		92	46	11.50	7/74	36	NA	7/74	6.70
1976		104	52	13.00	7/75	40	NA	.....	7.20
1977		124	62	15.50	7/76	45	NA	7/76	7.70
1978		144	72	18.00	7/77	54	NA	7/77	8.20
1979		160	80	20.00	7/78	63	NA	7/78	8.70
1980		180	90	22.50	7/79	69	NA	7/79	9.60
1981		204	102	25.50	7/80	78	NA	7/80	11.00
1982		260	130	32.50	7/81	89	NA	7/81	12.20
1983		304	152	38.00	7/82	113	NA	7/82	12.20
1984		356	178	44.50	.....	113	NA	.....	14.60
1985		400	200	50.00	1/84	155	NA	1/84	15.50
1986		492	246	61.50	1/85	174	NA	1/85	15.50
1987		520	260	65.00	1/86	214	NA	1/86	17.90
1988		540	270	67.50	1/87	226	NA	1/87	24.80
1989		⁹ 560	NA	¹⁰ 25.50	1/88	234	NA	1/88	31.90
					1/89	156	NA	1/89	

1990	592	148	296	74.00	1/90	175	NA	75	1/90	28.60
1991	628	157	314	78.50	1/91	177	NA	100	1/91	29.90
1992	652	163	326	81.50	1/92	192	NA	100	1/92	31.80
1993	676	169	338	84.50	1/93	221	NA	100	1/93	36.60
1994	696	174	348	87.00	1/94	245	184	100	1/94	41.10
1995	716	179	358	89.50	1/95	261	183	100	1/95	46.10
1996	736	184	368	92.00	1/96	289	188	100	1/96	42.50
1997	760	190	380	95.00	1/97	311	187	100	1/97	43.80
1998	764	191	382	95.50	1/98	309	170	100	1/98	43.80

¹ For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

² For care in psychiatric hospital there is a 190-day lifetime limit.

³ Always equal to one-fourth of inpatient hospital deductible through 1988 and for 1990 and later; eliminated for 1989.

⁴ Always equal to one-half of inpatient hospital deductible through 1988 and for 1990 and later; eliminated for 1989.

⁵ Always equal to one-third of inpatient hospital deductible through 1988 and for 1990 and later. For 1989 it was equal to 20 percent of estimated Medicare covered average cost per day.

⁶ Not applicable prior to July 1973. Applies to aged individuals who are not fully insured, and to certain disabled individuals who have exhausted other entitlement. The reduced amount is available to aged individuals who are not fully insured but who have, or whose spouse has or had, at least 30 quarters of coverage under title II of the Social Security Act. The reduced amount is 75 percent of the full amount in 1994, 70 percent in 1995, 65 percent in 1996, 60 percent in 1997, and 55 percent in 1998 and thereafter.

⁷ Not covered.

⁸ For August 1973 the premium was \$6.10.

⁹ In 1989, the HI deductible was applied on an annual basis, not a benefit period basis (unlike the other years).

¹⁰ In 1989, the SNF coinsurance was on days 1–8 of the 150 days allowed annually; for the other years it is on days 21–100 of 100 days allowed per benefit period.

NA—Not available.

Note.—In addition to the deductible and coinsurance amounts shown in the table, the first three pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a \$60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physician services for mental illness; 50 percent of approved charges; up to a maximum of \$250 in benefits per year; July 1, 1966, through December 31, 1987; \$450 in benefits per year, January 1, 1988, through December 31, 1988; \$1,100 in benefits per year, January 1, 1989, through December 31, 1989; beginning January 1, 1990, the limit was removed; (2) physical and occupational therapy services furnished by physical therapists in independent practice: maximum annual approved charges July 1, 1973 through December 31, 1981, \$80 per year; January 1, 1982 through December 31, 1982, \$400 per year; January 1, 1983 through December 31, 1989, \$500 per year; January 1, 1990 through December 31, 1993, \$750 per year; and January 1, 1994 and thereafter, \$900 per year.

Source: Health Care Financing Administration, Office of the Actuary.

FINANCING

The Medicare Hospital Insurance Trust Fund (HI) finances services covered under Medicare part A. The Supplementary Medical Insurance Trust Fund (SMI) finances services covered under Medicare part B. The trust funds are maintained by the Department of the Treasury. Each trust fund is actually an accounting mechanism; there is no actual transfer of money into and out of the fund. Income to each trust fund is credited to the fund in the form of interest-bearing government securities. The securities represent obligations that the government has issued to itself. Expenditures for services and administrative costs are recorded against the fund.

HOSPITAL INSURANCE TRUST FUND—INCOME

The primary source of income to the HI fund is HI payroll taxes. This source accounted for \$106.9 billion (88.3 percent) of the total \$121.1 billion in income for fiscal year 1996. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.

Payroll taxes

The HI Trust Fund is financed primarily through Social Security payroll tax contributions paid by employees and employers. Each pays a tax of 1.45 percent on all earnings in covered employment. The self-employed pay 2.9 percent. Prior to 1994, there was an upper limit on earnings subject to the tax. An upper limit of \$68,400 in 1998 continues to apply under Social Security. Table 2-6 shows the history of the contribution rates and maximum taxable earnings base for the HI Programs.

Other income

The following are additional sources of income to the HI fund:

1. *Railroad retirement account transfers.*—In fiscal year 1996, \$401 million was transferred from the railroad retirement fund. This is the estimated amount that would have been in the fund if railroad employment had always been covered under the Social Security Act.
2. *Reimbursements for uninsured persons.*—HI benefits are provided to certain uninsured persons who turned 65 before 1968. Persons who turned 65 after 1967 but before 1974 are covered under transitional provisions. Similar transitional entitlement applies to Federal employees who retire before earning sufficient quarters of Medicare-qualified Federal employment provided they were employed before and during January 1983. Payments for these persons are made initially from the HI Trust Fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. In fiscal year 1996, \$419 million was transferred to HI on this basis.

TABLE 2-6.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES AND TAXABLE EARNINGS BASES, 1977-98

Calendar year	Employee and employer rates, each (percent)			HI taxable earnings base	Maximum HI tax
	OASDI combined	HI	OASDHI combined		
1977	4.95	0.90	5.85	\$16,500	\$148.50
1978	5.05	1.10	6.05	17,700	194.70
1979	5.08	1.05	6.13	22,900	240.45
1980	5.08	1.05	6.13	25,900	271.95
1981	5.35	1.30	6.65	29,700	386.10
1982	5.40	1.30	6.70	32,400	421.20
1983	5.40	1.30	6.70	35,700	464.10
1984	5.70	1.30	7.00	37,800	491.40
1985	5.70	1.35	7.05	39,600	534.60
1986	5.70	1.45	7.15	42,000	609.00
1987	5.70	1.45	7.15	43,800	635.10
1988	6.06	1.45	7.51	45,000	652.50
1989	6.06	1.45	7.51	48,000	696.00
1990	6.20	1.45	7.65	51,300	743.85
1991	6.20	1.45	7.65	¹ 125,000	1,812.50
1992	6.20	1.45	7.65	130,200	1,887.90
1993	6.20	1.45	7.65	135,000	1,957.50
1994	6.20	1.45	7.65	² none	no limit
1995	6.20	1.45	7.65	none	no limit
1996	6.20	1.45	7.65	none	no limit
1997	6.20	1.45	7.65	none	no limit
1998	6.20	1.45	7.65	none	no limit

¹Prior to 1991, the upper limit on tax earnings was the same as for Social Security. The Omnibus Budget Reconciliation Act of 1990 raised the limit in 1991 to \$125,000. Under automatic indexing provisions, the maximum was increased to \$130,200 in 1992 and \$135,000 in 1993.

²The Omnibus Budget Reconciliation Act of 1993 eliminated the indexing provision entirely beginning in 1994.

Source: Health Care Financing Administration.

3. *Premiums from voluntary enrollees.*—Certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described above may obtain protection by enrolling in the program and paying a monthly premium (\$311 in 1997; for persons who have at least 30 quarters of covered employment, \$187 in 1997). This accounted for an estimated \$1,107 million of financing in fiscal year 1996.
4. *Payments for military wage credits.*—Sections 217(g) and 229(b) of the Social Security Act, prior to modification by the Social Security Amendments of 1983, authorized annual reimbursement from the general fund of the Treasury to the HI Trust Fund for costs arising from the granting of deemed wage credits for military service prior to 1957, according to quinquennial determinations made by the Secretary of Health and Human Services. These sections, as modified by the Social Security Amendments of 1983, provided for a lump-sum transfer in 1983 for costs arising from such wage credits. In addition, the lump-sum transfer included combined employer-employee

HI taxes on the noncontributory wage credits for military service after 1965 and before 1984. After 1983, HI taxes on military wage credits are credited to the fund on July 1 of each year. The Social Security Amendments of 1983 also provided for: (1) quinquennial adjustments to the lump-sum amount transferred in 1983 for costs arising from pre-57 deemed wage credits; and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on non-contributory wage credits. In fiscal year 1996, this adjustment, including the quinquennial adjustment, was \$2.3 billion.

5. *Tax on Social Security benefits.*—Beginning in 1994, the trust fund acquired an additional funding source. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) increased the maximum amount of Social Security benefits subject to income tax from 50 to 85 percent and provided that the additional revenues would be credited to the HI Trust Fund. Revenue from this source totaled \$4.1 billion in fiscal year 1996.
6. *Interest.*—The remaining income to the trust fund consists almost entirely of interest on the investments of the trust fund. Interest amounted to an estimated \$10.5 billion in fiscal year 1996.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND—INCOME

Part B is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from general revenues. The premium rate is derived annually based on the projected costs of the program for the coming year. The monthly premium amount in calendar years 1997 and 1998 is \$43.80.

When the program first went into effect in July 1966, the part B monthly premium was set at a level to finance one-half of part B program costs. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which Social Security benefits were adjusted for changes in cost of living (that is, cost-of-living adjustments or COLAs). Under this formula, revenues from premiums soon dropped from 50 to below 25 percent of program costs because part B program costs increased much faster than inflation as measured by the Consumer Price Index on which the Social Security COLA is based.

Since the early 1980s, Congress has regularly voted to set part B premiums at a level to cover 25 percent of program costs, in effect overriding the COLA limitation. The 25-percent provisions first became effective January 1, 1984. General revenues covered the remaining 75 percent of part B program costs. Congress took this general approach again in OBRA 1990. However, OBRA 1990 set specific dollar figures, rather than a percentage, in law for 1991–95. These dollar figures reflected the Congressional Budget Office's (CBO) estimates of what 25 percent of program costs would be over the 5-year period. Program costs grew at a slower rate than anticipated, in part due to subsequent legislative changes. As a result, the 1995 premium of \$46.10 covered an estimated 31.5 percent of program costs.

OBRA 1993 extended the policy of setting the part B premium at a level to cover 25 percent of program costs for 1996–98. As was the case prior to 1991, a percentage rather than a fixed dollar fig-

ure was used. As a result, the 1996 premium was \$42.50, a full \$3.60 less than the 1995 premium. The 1997 and 1998 premiums are \$43.80. The Balanced Budget Act of 1997 permanently sets the part B premium equal to 25 percent of program costs.

FINANCIAL STATUS OF HOSPITAL INSURANCE TRUST FUND

The Hospital Insurance Trust Fund balance is dependent on total income to the HI Trust Fund exceeding total outlays from the fund. Tables 2-7 and 2-8 show historical information from the 1997 Trustees' Report on the operation of the trust fund. The Trustees' Report also included projections. However, the Congress subsequently passed the Balanced Budget Act of 1997 which substantially changed the expected operations of the fund. Tables 2-7, 2-8, and 2-9 show preliminary projections for the 1997-2007 period made following the enactment of the Balanced Budget Act.

The 1997 Trustees' Report (Board of Trustees, Hospital Trust Fund, 1997) stated that the program failed to meet both short-range and long-range tests of financial adequacy. Disbursements began to exceed income in 1995. Under the trustee's 1997 intermediate assumptions, the fund would have become insolvent in 2001. The Trustees' Report had projected that the fund's shortfall would be \$23.4 billion at the end of calendar 2001. The shortfall would continue to build each year, rising to \$429.8 billion at the end of fiscal year 2006 and \$471.6 billion at the end of calendar year 2006.

The projections included in the 1997 Trustees' Reports have been substantially modified as a result of the enactment of the Balanced Budget Act (table 2-9). This legislation provides for the transfer of a portion of home health spending (currently the fastest growing part A expenditure) from part A to part B. It also includes additional provisions designed to stem the growth in part A expenditures. These provisions include the implementation of prospective payment systems for home health services and skilled nursing facility services and limits on the increases in hospital payments. When the Balanced Budget Act of 1997 was enacted, CBO projected that the insolvency date would be postponed from 2001 to fiscal year 2007. Subsequently, the administration estimated that the year of exhaustion would be 2010 (see table 2-9).

Despite short-term improvements, the fund still faces insolvency. Beginning in fiscal year 1996, HI costs began to rise faster than income. The CBO expects this trend to continue, though at a somewhat slower pace as the result of the Balanced Budget Act of 1997. The administration projects that income will still slightly exceed costs over the short term and costs will again exceed income after 2007. Historically, the shortfall has been primarily attributable to the increase in hospital payments which have accounted for over 65 percent of HI benefit payments.

Beginning in 2011, the program will begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946 and 1964) begin turning age 65. Second, there will be a shift in the number of covered workers supporting each HI enrollee. In 1996, there were 3.9 workers for every beneficiary; in 2030 there will only be an estimated 2.3.

TABLE 2-7.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED FISCAL YEARS 1970–2007

Fiscal year ¹	Income					Disbursements			Trust fund				
	Payroll taxes	Income from taxation of benefits	Rail-road retirement account transfers	Reimbursement for uninsured persons	Pre-mi-ums from vol-untary enroll-ees	Payments for military wage cred-its	Interest and other in-come ²	Total in-come	Benefits pay-ments ³	Admin-istrative ex-penses ⁴	Total dis-burse-ments	Net increase in fund	Fund at end of year
Historical data (in millions of dollars):													
1970			\$64	\$617	.....	\$11	\$137	\$5,614	\$4,804	\$149	\$4,953	\$661	\$2,677
1975			132	481	\$6	48	609	12,568	10,353	259	10,612	1,956	9,870
1980			244	697	17	141	1,072	25,415	23,790	497	24,288	1,127	14,490
1985			371	766	38	86	3,182	50,933	47,841	813	48,654	⁵ 4,103	21,277
1986			364	566	40	⁶ —714	3,167	56,442	49,018	667	49,685	⁷ 17,370	38,648
1987			368	447	40	94	3,982	62,751	49,967	836	50,803	11,949	50,596
1988			364	475	42	80	5,148	68,010	52,022	707	52,730	15,281	65,877
1989			379	515	42	86	6,567	75,116	57,433	805	58,238	16,878	82,755
1990			367	413	113	107	7,908	79,563	65,912	774	66,687	12,876	95,631
1991			352	605	367	⁸ —1,011	8,969	83,938	68,705	934	69,638	14,299	109,930
1992			374	621	484	86	10,133	92,677	80,784	1,191	81,974	10,703	120,633
1993			400	367	622	81	⁹ 12,484	97,101	90,738	866	91,604	5,497	126,131
1994		\$1,639	413	506	852	80	10,676	106,195	101,535	1,235	102,770	3,425	129,555
1995		3,913	396	462	998	61	10,963	114,847	113,583	1,300	114,883	—36	129,520
1996		4,069	401	419	1,107	3	10,496	121,135	124,188	1,229	125,317	—4,182	125,338
Preliminary projections made following enactment of the Balanced Budget Act of 1997 (in billions of dollars):													
1997								128.8	.....	.....	138.1	—9.3	116.0
1998								125.6	.....	.....	131.5	—5.9	110.1
1999								129.3	.....	.....	131.5	—2.2	107.9
2000								137.6	.....	.....	134.3	3.3	111.2
2001								146.0	.....	.....	139.3	6.7	117.9

TABLE 2-8.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED CALENDAR YEARS 1970-2007

Calendar year	Income					Disbursements			Trust fund				
	Payroll taxes	Income from taxation of benefits	Rail-road retirement account transfers	Reimbursement for uninsured persons	Pre-miums from vol-untary enroll-ees	Payments for military wage cred-its	Interest and other income ¹	Total in- come	Benefits pay- ments ²	Admin- istrative ex- penses ³	Total dis- burse- ments	Net increase in fund	Fund at end of year
Historical data (in millions of dollars):													
1970	\$4,881	.....	\$66	\$863	.....	\$11	\$158	\$5,979	\$5,124	\$157	\$5,281	\$698	\$3,202
1975	11,502	.....	138	621	\$7	48	664	12,980	11,315	266	11,581	1,399	10,517
1980	23,848	.....	244	697	18	141	1,149	26,097	25,064	512	25,577	521	13,749
1985	47,576	.....	371	766	41	4 — 719	3,362	51,397	47,580	834	48,414	5 4,808	20,499
1986	54,583	.....	364	566	43	91	3,619	59,267	49,758	664	50,422	6 19,458	39,957
1987	58,648	.....	368	447	38	94	4,469	64,064	49,496	793	50,289	13,775	53,732
1988	62,449	.....	364	475	41	80	5,830	69,239	52,517	815	53,331	15,908	69,640
1989	68,369	.....	379	515	55	86	7,317	76,721	60,011	792	60,803	15,918	85,558
1990	72,013	.....	367	413	122	7 — 993	8,451	80,372	66,239	758	66,997	13,375	98,933
1991	77,851	.....	352	605	432	89	9,510	88,839	71,549	1,021	72,570	16,269	115,202
1992	81,745	.....	374	621	522	86	10,487	93,836	83,895	1,121	85,015	8,821	124,022
1993	84,133	.....	400	367	675	81	8 12,531	98,187	93,487	904	94,391	3,796	127,818
1994	95,280	\$1,639	413	506	907	80	10,745	109,570	103,282	1,263	104,545	5,025	132,844
1995	98,421	3,913	396	462	954	61	10,820	115,027	116,368	1,236	117,604	-2,577	130,267
1996	110,585	4,069	401	419	1,199	9 2,293	10,222	124,603	128,632	1,297	129,929	-5,325	124,942
Preliminary projections made following enactment of the Balanced Budget Act of 1997 (in billions of dollars):													
1997	.....	.....	.....	.....	.....	.....	.....	129.1	.....	.....	138.2	-9.1	115.8
1998	.....	.....	.....	.....	.....	.....	.....	124.5	.....	.....	128.2	-3.7	112.1
1999	.....	.....	.....	.....	.....	.....	.....	131.1	.....	.....	131.4	-0.3	111.8
2000	.....	.....	.....	.....	.....	.....	.....	139.6	.....	.....	134.6	5.0	116.8
2001	.....	.....	.....	.....	.....	.....	.....	148.8	.....	.....	140.2	8.6	125.5

TABLE 2-9.—PROJECTIONS MADE FOLLOWING PASSAGE OF THE BALANCED BUDGET ACT OF 1997 FOR THE HOSPITAL INSURANCE TRUST FUND OF INCOME AND OUTLAYS, FISCAL YEARS 1997–2007, UNDER CBO AND ADMINISTRATION ASSUMPTIONS

[In billions of dollars]

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
CBO projections:											
Income	\$127.7	\$131.0	\$136.5	\$142.3	\$147.9	\$154.2	\$160.6	\$166.9	\$173.6	\$180.4	\$187.2
Outlays	137.4	142.3	145.9	149.3	158.2	159.4	170.1	180.4	197.3	202.4	221.6
Net increase in fund	–9.7	–11.3	–9.4	–7.0	–10.3	–5.2	–9.5	–13.6	–23.7	–22.1	–34.4
Balance at end of year	115.6	104.3	94.9	87.9	77.6	72.4	62.9	49.3	25.7	3.6	–30.8
Administration projections:											
Income	128.8	125.6	129.3	137.6	146.0	155.4	165.5	173.8	183.6	191.4	200.9
Outlays	138.1	131.5	131.5	134.3	139.3	146.8	156.8	166.9	177.2	188.2	200.5
Net increase in fund	–9.3	–5.9	–2.2	3.3	6.7	8.6	8.7	6.9	6.3	3.2	0.4
Balance at end of year	116.0	110.1	107.9	111.2	117.9	126.5	135.2	142.1	148.4	151.6	152.1

Source: Congressional Budget Office, August 1997, and Social Security Administration, October 1997, unpublished tables.

The combination of expenditure and demographic factors is also reflected in the increasing size of the HI Program relative to other sectors of the economy. According to the 1997 Trustees' Report, the program's cost is expected to rise from 1.7 percent of gross domestic product (GDP) in 1996 to about 5 percent of GDP in 2070. This estimate was made prior to enactment of the Balanced Budget Act of 1997.

FINANCIAL STATUS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Because the SMI Trust Fund is financed through beneficiary premiums and Federal general revenues, it does not face the prospect of depletion, as does the HI Trust Fund. However, the rising cost of the program is placing a burden on the trust fund, and by extension on beneficiaries (in the form of premiums) and Federal general revenues. Table 2-10 shows historical information from the 1997 Trustees' Report (Board of Trustees, Federal Hospital Insurance Trust Fund, 1997).

COMPARISON OF MEDICARE LIFETIME BENEFITS WITH BENEFICIARY CONTRIBUTIONS

Medicare beneficiaries typically get back considerably more in Medicare benefits than they contribute in payroll taxes and premiums over their lifetimes. CBO has estimated (based on the 1996 Trustees' Report) the extent to which Medicare enrollees' contributions (through the HI payroll tax and the SMI premium) cover the expected value of their benefits under the program. Results are presented only for self-insured men and women (that is, those who obtain benefits on the basis of their own work history) who worked each year at an average wage from 1966 until retirement at age 65. Three groups of persons are shown—persons who reach 65 as of 1985, 1995, and 2005. All estimates, which were made prior to the enactment of the Balanced Budget Act of 1997, are dependent on uncertain projections of future health spending.

For a self-insured man who worked continuously at an average wage from 1966 (when Medicare began) until retirement in 1985, the present discounted value of their contributions is about 29 percent of the expected value of lifetime Medicare benefits. For men retiring in 1995, contributions represent about 37 percent of benefits; for those retiring in 2005, contributions represent about 41 percent. Contributions through HI payroll taxes increases relative to HI benefits for later retirees because the HI payroll tax (which began in 1966) was paid for a greater proportion of their working years. Conversely, contributions through SMI premiums relative to SMI benefits decline because, under the law in effect prior to the Balanced Budget Act of 1997, after 1998 annual premium increases were limited by the percentage increase in the Social Security COLA (see table 2-11).

TABLE 2-10.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), SELECTED FISCAL YEARS 1970-96

[In millions of dollars]

Fiscal year ¹	Income			Disbursements			Balance at end of year ⁴	
	Premium from enrollees	Government contributions ²	Interest and other income ³	Total income	Benefit pay- ments	Administra- tive expenses		Total dis- bursements
Historical data:								
1970	\$936	\$928	\$12	\$1,876	\$1,979	\$217	\$2,196	\$57
1975	1,887	2,330	105	4,322	3,765	405	4,170	1,424
1980	2,928	6,932	415	10,275	10,144	593	10,737	4,532
1985	5,524	17,898	1,155	24,577	21,808	922	22,730	10,646
1986	5,699	18,076	1,228	25,003	25,169	1,049	26,218	9,432
1987	6,480	20,299	1,018	27,797	29,937	900	30,837	6,392
1988	8,756	25,418	828	35,002	33,682	1,265	34,947	6,447
1989	⁵ 11,548	30,712	⁵ 1,022	⁵ 43,282	36,867	⁵ 1,450	⁵ 38,317	⁵ 11,412
1990	⁵ 11,494	33,210	⁵ 1,434	⁵ 46,138	41,498	⁵ 1,524	⁵ 43,022	⁵ 14,527
1991	11,807	34,730	1,629	48,166	45,514	1,505	47,019	15,675
1992	12,748	38,684	1,717	53,149	48,627	1,661	50,288	18,535
1993	14,683	44,227	1,889	60,799	⁶ 54,214	1,845	56,059	23,276
1994	16,895	38,355	2,118	57,368	58,006	1,718	59,724	20,919
1995	19,244	36,988	1,937	58,169	63,491	1,722	65,213	13,874
1996	18,731	61,702	1,392	82,025	67,176	1,771	68,946	26,953

¹ For 1970 and 1975, fiscal years cover the interval from July 1 through June 30; fiscal years 1980-2005 cover the interval from October 1 through September 30.

² General fund matching payments, plus certain interest-adjustment items.

³ Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.

⁴ The financial status of the program depends on both the total net assets and the liabilities of the program.

⁵ Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

⁶ Includes the impact of the transfer to the HI Trust Fund of the SMI catastrophic coverage reserve fund on March 31, 1993 as specified in Public Law 102-394. Actual benefit payments for 1993 were \$52,409 million and the amount transferred was \$1,805 million.

Source: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund (1997).

TABLE 2-11.—CONTRIBUTIONS AS A PERCENT OF EXPECTED LIFETIME BENEFITS UNDER MEDICARE FOR SELECTED SELF-INSURED ENROLLEES REACHING AGE 65 AS OF 1985, 1995, OR 2005

Category	Year		
	1985	1995	2005
Self-insured men who earned average wages:			
Hospital insurance	31.6	50.4	66.2
Supplementary medical insurance	24.3	17.8	11.5
Medicare total	28.9	37.3	41.0
Self-insured women who earned average wages:			
Hospital insurance	26.0	42.7	56.9
Supplementary medical insurance	24.5	16.9	11.8
Medicare total	25.5	31.8	36.0

Note.—Contributions include employers' and employees' hospital insurance (HI) payroll taxes, interest, and supplementary medical insurance (SMI) premiums. Any other taxes paid by enrollees are not included. Estimates are for beneficiaries with sufficient work history to qualify for benefits. However, up to 20 percent of Medicare beneficiaries qualify on the basis of their spouse's work history, not their own. For spouse-insured beneficiaries, contributions as a percent of benefits are lower because spouse-insured beneficiaries paid little or no HI payroll taxes. Estimates assume an expected lifetime at age 65 of 15 years for men (to age 80) and 19 years for women (to age 84). Present discounted values for expected benefits were obtained using the average interest rate projected for HI Trust Fund earnings over the same years.

Source: Congressional Budget Office.

Contributions by self-insured women as a percentage of expected benefits are smaller than they are for men. Actual contributions by men and women are the same in the illustrative calculations. However, a woman's lifetime benefits are larger because a woman's lifetime expectancy is 4 years longer at age 65 (table 2-11).

In 1995 dollars, the present discounted value of Medicare benefits net of contributions (that is the net transfer or subsidy value) is estimated at \$32,222 for men and \$41,355 for women who retired in 1985. For those retiring in 1995, the value is estimated at \$51,813 for men and \$68,777 for women. CBO projects that values will continue to increase in the future, reaching \$71,868 for men and \$91,594 for women by 2005 (table 2-12).

TABLE 2-12.—PRESENT DISCOUNTED VALUE OF LIFETIME BENEFITS, CONTRIBUTIONS, AND NET TRANSFER UNDER MEDICARE FOR SELECTED SELF-INSURED ENROLLEES REACHING AGE 65 IN 1985, 1995, OR 2005

[In constant 1995 dollars]

Category	Year		
	1985	1995	2005
Self-insured men who earned average wages:			
Benefits	\$45,305	\$82,599	\$121,898
Contributions	13,083	30,787	50,030
Net transfer	32,222	51,813	71,868
Self-insured women who earned average wages:			
Benefits	55,483	100,862	143,036
Contributions	14,128	32,084	51,442
Net transfer	41,355	68,777	91,594

Note.—Contributions include employers' and employees' HI payroll taxes, interest, and SMI premiums. Any other taxes paid by enrollees are included. Net transfer is benefits net of contributions. Estimates are for beneficiaries with sufficient work history to qualify for benefits. However, up to 20 percent of Medicare beneficiaries qualify on the basis of their spouse's work history, not their own. For spouse-insured beneficiaries qualify on the basis of their spouse's work history, not their own. For spouse-insured beneficiaries, contributions as a percent of benefits are lower and the net transfer is larger because spouse-insured beneficiaries paid little or no HI payroll taxes. Estimates assume an expected lifetime at age 65 to 15 years for men (to age 80) and 19 years for women (to age 84). Present discounted values for unexpected benefits were obtained using the average interest rate projected for HI Trust Fund earnings over the same years. The CPI-U was used to get constant 1995 dollars.

Source: Congressional Budget Office.

PART A SERVICES—COVERAGE AND PAYMENTS

INPATIENT HOSPITAL SERVICES

Medicare part A provides reimbursement for inpatient hospital care through the prospective payment system (PPS), established by Congress in the Social Security Amendments of 1983 (Public Law 98-21). Before the enactment of PPS, Medicare paid hospitals retrospectively for the full costs they incurred, subject to certain limits and tests of reasonableness. Congress had previously acted to contain growing hospital costs by placing certain limits on routine inpatient care operating costs. However, medical costs continued to grow faster than the rate of inflation in the early 1980s, so PPS was enacted to constrain the growth of Medicare's inpatient hospital costs by providing incentives for hospitals to provide care more efficiently (see appendix D for further information about hospital services).

Under PPS, fixed hospital payment amounts are established in advance of the provision of services on the basis of a patient's diagnosis. Hospitals that are able to provide services for less than the fixed PPS payment may keep the difference. Hospitals with costs that exceed the fixed PPS payment lose money on the case. The

system's fixed prices are determined in advance on a cost-per-case basis, using a classification system of over 500 diagnosis-related groups (DRGs). Each Medicare case is assigned to one of the DRGs based on the patient's medical condition and treatment. DRGs are assigned relative weights to reflect the variation in the costs of treating a particular diagnosis. The DRG-based payment rate is designed to represent the national average cost per case for treating a patient with a particular diagnosis. Payments for a particular DRG will vary among different hospitals depending on the hospital's location and certain other characteristics. In a particular hospital, all cases assigned to the same DRG are reimbursed at the same predetermined rate.

The PPS payment rates are updated each year using an update factor which is determined, in part, by the projected increase in the hospital market basket index (MBI). The hospital MBI measures the cost of goods and services that are purchased by hospitals, yielding one price inflator for all hospitals in a given year.

In addition to the basic DRG payment for each case, PPS hospitals may also receive certain supplemental Medicare payments. Additional hospital payments include indirect medical education costs, disproportionate-share hospital payments, outlier payments, and payments for inpatient dialysis provided to end-stage renal disease beneficiaries. Certain categories of hospital expenses are not included in the PPS rates and are reimbursed in some other way, including direct medical education costs and capital-related costs. Certain facilities receive special treatment under PPS, particularly certain types of isolated or essential hospitals in rural areas, including regional referral centers (RRCs), sole community hospitals (SCHs), and Medicare-dependent small rural hospitals.

Specialized facilities are excluded from PPS and are paid on the basis of reasonable costs subject to rate of increase limits. PPS-exempt facilities include psychiatric hospitals, rehabilitation hospitals, children's hospitals, cancer research centers, and long-term care hospitals. States are also allowed to apply for a waiver from PPS and establish a prospective system for setting hospital rates instead of what would be paid under PPS; Maryland is the only State that continues to operate under such a waiver.

Table 2-13 provides 1995 data on the utilization of inpatient hospital services by type of enrollee and type of hospital.

SKILLED NURSING FACILITY SERVICES

Coverage

The Medicare Program covers extended care services provided in nursing homes for beneficiaries who require additional skilled nursing care and rehabilitation services following a hospitalization. These extended care services, commonly known as skilled nursing facility (SNF) benefits, are covered under part A of the program for up to 100 days per spell of illness and must be provided in a skilled nursing facility certified to participate in Medicare. A spell of illness is that period which begins when a beneficiary is furnished

TABLE 2-13.—USE OF INPATIENT HOSPITAL SERVICES BY MEDICARE ENROLLEES, BY TYPE OF ENROLLEE AND TYPE OF HOSPITAL, CALENDAR YEAR 1995¹

Type of enrollee and type of hospital	Bills ²		Covered days of care		Reimbursement		
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per bill	Amount in millions	Per bill	Per enrollee
All enrollees:							
All hospitals	12,474	336	86,041	6.9	\$76,519	\$6,134	\$2,061
Short stay	11,260	303	72,124	6.4	69,261	6,151	1,865
Long stay	1,214	33	13,917	11.5	7,258	5,979	195
Psychiatric	302	8	2,688	8.9	937	3,103	25
All other	912	25	11,229	12.3	6,321	6,931	170
Aged:							
All hospitals	10,610	324	73,165	6.9	65,980	6,219	2,015
Short stay	9,848	301	63,695	6.5	60,572	6,151	1,850
Long stay	762	23	9,470	12.4	5,408	7,097	165
Psychiatric	90	3	902	10.0	342	3,800	10
All other	672	21	2,295	3.4	5,066	7,539	155
Disabled:							
All hospitals	1,864	424	12,876	6.9	10,539	5,654	2,399
Short stay	1,412	321	8,429	6.0	8,689	6,154	1,978
Long stay	452	103	4,447	9.8	1,850	4,093	421
Psychiatric	213	48	1,787	8.4	596	2,798	136
All other	239	54	2,660	11.1	1,254	5,247	285

¹ Preliminary data. Totals may not add due to rounding.

² Discharges not available by type of hospital.

Note.—Only services rendered by inpatient hospitals are included.

Source: Health Care Financing Administration, Bureau of Management and Strategy.

inpatient hospital or SNF care and ends when the beneficiary has been neither an inpatient of a hospital nor an SNF for 60 consecutive days. A beneficiary may have more than one spell of illness per year.

In order to be eligible for SNF care, the beneficiary must have been an inpatient of a hospital for at least 3 consecutive days and must be transferred to a SNF, usually within 30 days of discharge from the hospital. Furthermore, a physician must certify that the beneficiary is in need of skilled nursing care or other skilled rehabilitation services, which as a practical matter can only be provided on an inpatient basis and which are related to the condition for which the beneficiary was hospitalized.

Covered SNF services include the following:

- Nursing care provided by or under the supervision of a registered nurse;
- Room and board;
- Physical or occupational therapy or speech-language pathology;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment ordinarily furnished by a SNF for the care of patients;
- Medical services of interns and residents in training under an approved teaching program of a hospital with which the SNF has a transfer agreement; and
- Other services necessary to the health of patients that are generally provided by SNFs.

Reimbursement

Medicare has reimbursed the great bulk of skilled nursing facility (SNF) care on a retrospective cost-based basis. This has meant that SNFs have been paid after services were delivered for the reasonable costs (as defined by program) they incurred for the care they provided. For these purposes, the costs SNFs incurred for providing services to beneficiaries were divided into three major categories: (1) routine service costs—nursing, room and board, administrative, and other overhead costs; (2) ancillary services, such as therapy services, laboratory, radiology procedures, supplies and other equipment; and (3) capital-related costs, including net depreciation expense, taxes, lease and rental payments, improvements that extend the life of or increase productivity of assets, net interest expense, and so forth.

Routine costs have been subject to national average per diem limits, adjusted to reflect differences in wage levels from area to area. Ancillary service and capital costs have been paid on the basis of reasonable costs and neither have been subject to limits.

Beginning July 1, 1998, the Balanced Budget Act of 1997 phases in a prospective payment system for SNFs that will pay a Federal per diem rate for covered SNF services. Covered services will include part A SNF as well as all services for which payment may be made under part B during the period when the beneficiary is provided covered SNF care (excluding, however, physician services, certain nurse practitioner and physician assistant services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, certain dialysis serv-

ices and drugs, and in 1998 only, the transportation costs of electrocardiogram equipment).

The Federal per diem payment will cover routine service costs, ancillary costs, and capital-related costs, but will not include costs associated with approved educational activities. The actual per diem rate received by a facility will include adjustments for case mix based on a resident classification system established by the Secretary to account for relative resource utilization of different patient types. The labor-related portion of the rate will also include budget-neutral adjustments to reflect the relative levels of wages and wage-related cost for the geographic area in which the facility is located.

The resident classification system used by the Secretary for the new SNF prospective payment system is expected to be similar to that developed under a Health Care Financing Administration demonstration known as resource utilization groups (RUGs)—III. Under RUGs—III, classification is based on residents' clinical conditions; extent of services needed, such as nursing care, rehabilitation, respiratory/ventilator care of tube feedings; and functional status, such as the amount of support needed to eat or toilet. This new system pays, for example, three times more for bedridden, severely ill patients needing a variety of therapies than for ambulatory patients who need only posthospital monitoring and surgical wound treatment.

For a beneficiary residing in a SNF (or a part of a facility that includes a SNF) but no longer eligible for part A SNF care, payments for part B covered services will have to be made to the facility whether or not the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. This requirement is often referred to as the "consolidated billing" provision of the new law. Payment for part B items and services must include a code identifying the items or services delivered. In addition, bills submitted by physicians must include the SNFs provider number.

Growth in payments

For the past several years, SNF care has been one of Medicare's fastest growing benefits. SNF spending in calendar year 1990 stood at \$2.5 billion; by calendar year 1996 it had increased to \$11.7 billion, for an average annual growth rate of 29 percent (see table 2-14). Because spending for SNF care has been growing at a faster rate than other benefits, both its share of total Medicare spending as well as its share of total part A expenditures have increased significantly, actually doubling during this same period. Table 2-14 presents historical SNF spending data on a calendar year basis.

Table 2-15 shows that since 1990 the number of Medicare beneficiaries receiving SNF care grew from 638,000 to 1,145,000 in 1996 or by 79.5 percent; the number of covered days grew from 25.1 million to 40.2 million or by 60 percent. Payment per day, however, tripled, increasing by 198 percent during the period, and reached \$292 per day.

TABLE 2-14.—ESTIMATED MEDICARE PAYMENTS FOR SKILLED NURSING FACILITY CARE BY TYPE OF SERVICE, 1983–96 ¹

Calendar year:	Payments (in billions)	Percent change ²
1983	\$0.5	.....
1984	0.6	6.9
1985	0.6	2.9
1986	0.6	0.2
1987	0.6	8.8
1988	0.9	47.1
1989	3.5	275.7
1990	2.5	– 29.0
1991	2.9	18.4
1992	4.5	55.3
1993	6.5	44.4
1994	8.4	29.2
1995 ¹	10.4	23.8
1996 ¹	11.7	12.5

¹ Estimated.² Rounding in payments may not reflect actual change.

Note.—Payments reported here are incurred expenditures, net of beneficiary copayments.

Source: Health Care Financing Administration, Office of the Actuary, and Prospective Payment Assessment Commission (1995, 1996).

TABLE 2-15.—MEDICARE SKILLED NURSING FACILITY UTILIZATION AND PAYMENTS PER PERSON SERVED, 1983–96

Calendar year	People served		Days		Payment per day	
	Number	Per 1,000 enrollees	Number (in millions)	Per person served	Amount	Percent change
1983	265,000	9	9.3	35.1	\$56	.....
1984	299,000	10	9.6	32.2	58	3.2
1985	314,000	10	8.9	28.4	65	11.1
1986	304,000	10	8.2	26.8	71	9.6
1987	293,000	9	7.4	25.4	84	19.3
1988	384,000	12	10.7	27.8	87	2.6
1989	636,000	19	29.8	46.8	117	34.6
1990	638,000	19	25.1	39.5	98	– 16.1
1991	671,000	20	23.7	35.3	123	25.9
1992	785,000	22	29.0	36.9	157	27.1
1993	908,000	25	34.4	37.9	188	20.1
1994	1,068,000	29	37.1	39.7	226	20.1
1995	1,110,000	30	39.8	35.1	267	18.1
1996 ¹	1,145,000	30	40.2	35.1	242	9.3

¹ Estimated.

Source: Health Care Financing Administration, Office of the Actuary.

Tables 2-14 and 2-15 also show that SNF utilization and spending first began to increase significantly in 1988 and 1989. These increases can be traced to significant changes that occurred in the benefit at that time. First HCFA issued new coverage guidelines that became effective early in 1988. The guidelines provided SNFs a great deal more information than had previously existed about criteria that must be met for a beneficiary to receive Medicare coverage. Prior to this time, studies had pointed to a lack of adequate written guidance on coverage criteria that led to inconsistencies in coverage decisions for a benefit that was intended to be uniform across the country. As a result, many SNFs were reluctant to accept Medicare beneficiaries because of the possibility that a submitted claim would be retroactively denied. The 1988 guidelines clarified coverage criteria by providing numerous examples of covered and noncovered care. Furthermore, the guidelines explained that even when a patient's full or partial recovery is not possible, care could be covered if it were needed to prevent deterioration or to maintain current capabilities. Previously, some care had been denied because patients' health status was not expected to improve.

The second major, though temporary, change in Medicare's SNF benefit came in 1988 with the enactment of the Medicare Catastrophic Coverage Act (MCCA). Effective beginning in 1989, this legislation: eliminated the SNF benefit's prior hospitalization requirement; revised the coinsurance requirement to be equal to 20 percent of the national average estimated per diem cost of SNF services for the first 8 days of care; and authorized coverage of up to 150 days of care per calendar year (rather than 100 days per spell of illness). These changes were repealed in 1989, and the SNF benefit's structure assumed its prior form. Table 2-14 shows that spending for SNF care decreased by 29 percent between 1989 and 1990, but did not drop back to 1988 levels. Studies have suggested that the coverage guidelines and MCCA changes together might have caused a long-run shift in the nursing home industry toward Medicare patients that would not end with the repeal of MCCA. This trend is reflected in data showing a 65-percent increase, from 8,638 to 14,219, in facilities participating in Medicare between 1989 and 1996.

As noted above, large average annual rates of growth in Medicare SNF spending can be explained not only by increases in volume of services covered, but also by significant increases in reimbursements per day of care. Prospective Payment Assessment Commission analysis has shown that Medicare reimbursement policies may explain this increase. While routine care costs are subject to per diem limits, ancillary services are not. Higher ancillary service use, therefore, results in greater Medicare payments. In addition, a SNF may claim high ancillary service use as a justification for an exemption from routine service cost limits, thereby increasing those payments. In 1990, charges for physical, occupational, speech, and respiratory therapy services were approximately 15 percent of total Medicare SNF charges. By 1994, these services represented over 30 percent of charges. Although final payments for therapy and other ancillary services are based on costs rather than charges, these estimates reveal the relative importance of these services in the overall growth of Medicare Program payments for

SNF services. This growth is expected to be controlled in the future by the new SNF prospective payment system mandated by the Balanced Budget Act of 1997.

HOME HEALTH SERVICES

Coverage

Both parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Persons must also be homebound and under the care of a physician who establishes and periodically reviews a plan of care for the patient. While a beneficiary cannot become eligible for home health on the basis of needing only occupational therapy, this need can continue eligibility for home health care coverage, even if intermittent skilled nursing care or physical or speech therapy are no longer needed.

Medicare's home health benefit is intended to serve beneficiaries needing acute medical care that must be provided by skilled health care personnel, and was never envisioned as providing coverage for the nonmedical supportive care and personal care assistance needed by chronically impaired persons. If beneficiaries meet the required eligibility criteria, they become entitled to an unlimited number of home health visits. Home health visits are not subject to deductibles or coinsurance.

For beneficiaries meeting the qualifying criteria, Medicare's home health benefit covers the following services:

- Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
- Physical or occupational therapy or speech-language pathology services;
- Medical social services;
- Part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;
- Medical supplies (excluding drugs and biologicals) and durable medical equipment;
- Medical services provided by an intern or resident in training under an approved training program with which the agency may be affiliated; and
- Certain other outpatient services which involve the use of equipment that cannot readily be made available in the beneficiary's home.

In 1989, as a result of an agreement reached in a class action lawsuit, *Duggan v. Bowen*, HCFA published new manual instructions that clarified the criteria which must be met for Medicare coverage of home health services. The coverage guidelines, for example, specify that to meet the requirement of needing "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. This need can be met in most instances if the individual requires these services at least once every 60 days. The guidelines further provide that a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse; instead the inherent complexity of the service, the condition

of the patient, and accepted standards of medical and nursing practice must be considered. Skilled nursing services may be justified for such purposes as treatment of illness or injury; observation and assessment of a patient's condition when only the specialized skills of a medical professional can determine a patient's status; management and evaluation of a patient care plan to ensure that essential nonskilled care is achieving its purpose; and teaching and training activities for the patient and the patient's family or care givers.

The Balanced Budget Act included several provisions which clarified coverage criteria for home health care:

- Persons will no longer be able to qualify for Medicare's home health benefit on the basis of needing skilled nursing care for venipuncture for the purpose of obtaining a blood sample.
- Effective for services furnished on or after October 1, 1997, the Medicare statute includes definitions for part-time and intermittent skilled nursing and home health aide services. For purposes of receiving skilled nursing and home health aide services, "part-time or intermittent" is defined as skilled nursing and home health aide services furnished any number of days per week as long as they were furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, "intermittent" is defined as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).
- The Secretary of Health and Human Services is required to conduct a study on the criteria that should be applied for determining whether an individual should be considered homebound for purposes of qualifying for Medicare's home health benefit. The criteria should include the extent and circumstances under which a person may be absent from the home but nonetheless qualify. The Secretary is required to report to Congress by October 1, 1998, and make specific recommendations on such criteria.
- Effective for services furnished on or after October 1, 1997, the Secretary is required to establish normative guidelines for the frequency and duration of home health services. Payments will be denied for visits that exceed the normative standards. The Secretary is also authorized to establish a process for notifying a physician when the number of home health visits furnished according to a prescription or certification of the physician significantly exceeds the threshold normative guidelines. The Secretary may adjust the thresholds to reflect demonstrated differences in the need for home health services among different beneficiaries.

Reimbursement

Home health care agencies have been reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined

separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Cost limits, however, have been applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency.

The Balanced Budget Act reduces the per visit cost limits from 112 percent of the mean labor-related and nonlabor per visit cost to 105 percent of the national median of labor-related and nonlabor costs for freestanding home health agencies, effective for cost-reporting periods beginning October 1, 1997 (in effect, delaying the cycle for updating the limits).

In addition, home health agencies, for cost-reporting periods beginning on or after October 1, 1997, will be paid the lesser of: (1) their actual costs (that is, allowable reasonable costs); (2) the per visit limits, reduced to 105 percent of the national median, applied in the aggregate; or (3) a new blended agency-specific per beneficiary annual limit applied to the agency's unduplicated census count of patients. The blended per beneficiary limit will be based 75 percent on an agency's own costs per beneficiary and 25 percent on the average cost per beneficiary for agencies in the same census region (adjusted for differences in labor costs). These costs will be calculated from cost reports for cost-reporting periods ending in fiscal year 1994, recognizing 98 percent of reasonable costs for that period and updating them by the home health market basket. The costs associated with nonroutine medical supplies would be included in this calculation. For new providers and those providers without a 12-month cost-reporting period ending in fiscal year 1994, the per beneficiary limit will equal the median of these limits (or the Secretary's best estimates) applied to home health agencies. Home health agencies that have altered their corporate structure or name will not be considered new providers for these purposes. For beneficiaries using more than one home health agency, the per beneficiary limitation will be prorated among the agencies.

The Secretary is required to establish the per visit limits in effect for fiscal year 1998 by January 1, 1998, and the per beneficiary limits by April 1, 1998. For subsequent fiscal years (beginning October 1), the Secretary will be required to establish limits by the prior August 1.

Prospective payment for home health care

Beginning October 1, 1999, the Secretary is required to establish a prospective payment system (PPS) for home health and implement the system. All services covered and paid on a reasonable cost basis at the time of enactment of the Balanced Budget Act including medical supplies, must be paid on a prospective basis. For the new prospective system, the Secretary will consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services. In implementing the system, the Secretary can provide for a transition of

not longer than 4 years during which a portion of the payment will be based on agency-specific costs, but only if aggregate payments are not greater than they would have been if a transition had not occurred.

Under the new system, the Secretary will compute a standard prospective payment amount (or amounts) that will initially be based on the most current audited cost report data available to the Secretary. For fiscal year 2000, payment amounts under the prospective system must be computed in such a way that total payments will equal amounts that would have been paid had the system not been in effect, but will also reflect a 15-percent reduction in cost limits and per beneficiary limits in effect September 30, 1999. To assure savings from this reduction, the Secretary will be required to reduce cost limits and per beneficiary limits in effect September 30, 1999, by 15 percent, even if the Secretary is not prepared to implement the new system on October 1.

The payment amount for a unit of home health service will be adjusted by a case-mix adjustor factor established by the Secretary to explain a significant amount of the variation in the cost of different units of service. The labor-related portion of the payment amount will be adjusted by an area wage adjustment factor that reflects the relative level of wages and wage-related costs in a particular geographic area as compared to the national average.

Claims for home health services furnished on or after October 1, 1998, will have to contain an appropriate identifier for the physician prescribing home health services or certifying the need for care. Claims will also be required to include information on the length of time of a service unit, as measured in 15-minute increments. The categories of services for which time information must be included on a claim are skilled nursing care; physical and occupational therapy and speech-language pathology; medical social services; and home health aide services.

In order for home health services to be considered covered care, home health care agencies will be required to submit claims for all services, and all payments will have to be made to a home health agency without regard to whether the item or service was furnished by the agency, by others under arrangement, or under any other contacting or consulting arrangement.

Transfer of some home health payments to part B

Under current law, both parts A and B of Medicare cover home health. Neither part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments under part B for covered services to the extent that individuals are also covered under part A for the same services. As a result, the comparatively few persons who have no part A coverage are the only beneficiaries for whom payments have been made under part B.

The Balanced Budget Act of 1997 gradually transfers from part A to part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF (that is, postinstitutional visits) and during a home health spell of illness.

The transfer will be phased in over a period of 6 years, between 1998 and 2003, with the Secretary transferring one-sixth of the aggregate expenditures associated with transferred visits in 1998 and an additional one-sixth each year thereafter until fully implemented in 2003. Beginning January 1, 2003, part A will cover only postinstitutional home health services for up to 100 visits during a home health spell of illness, except for those persons with part A coverage only, who will be covered for services without regard to the postinstitutional limitation.

The increase in the part B premium attributable to transferred expenditures will be phased in over a period of 7 years, between 1998 and 2004. For 1998, the part B premium will be increased by one-seventh of the extra costs due to the transfer; for 1999, the part B premium will be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001, four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer.

Postinstitutional home health services are defined for these purposes as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least 3 consecutive days, initiated within 14 days after discharge; or (2) after a stay in a SNF, initiated within 14 days after discharge. Home health spell of illness is defined as the period beginning when a patient first receives postinstitutional home health services and ending when the beneficiary had not received inpatient hospital, SNF, or home health services for 60 days.

Claims administration for transferred visits will continue to be done by part A fiscal intermediaries.

In related Medicaid provisions, States will receive allotments to cover under their Medicaid Programs that portion of the Medicare part B premium attributable to the transfer of visits to part B for Medicare beneficiaries with incomes between 135 and 175 percent of poverty. The Federal Government will pay 100 percent of these costs, just so long as a State does not exceed its allotment. (See Specified Low-Income Beneficiaries, below.)

The Balanced Budget Act also includes a provision requiring the Secretary, not later than October 1, 1997, to report to the Commerce, Ways and Means, and Finance Committees on an estimate of Medicare home health outlays under parts A and B during each of fiscal years 1998–2002. Not later than the end of each of the years 1999–2002, the Secretary is also required to submit a report that compares actual outlays with estimated outlays. If the Secretary finds for a fiscal year that actual outlays were greater than estimated outlays, the report is also required to include recommendations regarding beneficiary copayments or such other methods as will reduce the growth in outlays for Medicare home health services.

Growth in payments

For the past several years, the home health benefit has been Medicare's fastest growing benefit. As table 2–16 indicates, spending for home health began to increase in 1989 when the total stood at \$2.5 billion. By 1996, spending had increased to \$18.1 billion, for an average annual rate of growth of 33 percent. Because spending

for home health has been growing at a faster rate than other benefits, its share of total net Medicare spending has also increased. Almost all home health claims have been paid out of the Medicare Part A Hospital Insurance Trust Fund, but beginning with fiscal year 1998, this will change as explained above.

TABLE 2-16.—MEDICARE PAYMENTS FOR HOME HEALTH, 1983-96 ¹

Calendar year	Payments (in billions)	Percent change ²
1983	\$1.6	NA
1984	1.8	17.5
1985	1.9	4.0
1986	1.9	-0.5
1987	1.9	-1.2
1988	2.0	8.3
1989	2.5	23.3
1990	3.9	53.2
1991	5.6	43.6
1992	7.9	41.1
1993	10.3	30.4
1994	13.3	30.1
1995	16.2	21.8
1996 ³	18.1	11.7

¹ Includes both part A and part B expenditures.

² Rounding in payments may not reflect actual change.

³ Estimated.

NA—Not applicable.

Note.—Payments reported here are incurred expenditures rather than outlays.

Source: Health Care Financing Administration, Office of the Actuary and Prospective Payment Assessment Commission (1995, 1996).

Table 2-17 shows that most of the growth in home health spending has been the result of an increasing volume of services being covered under the program, both in terms of increasing numbers of users and an increasing number of covered visits per user. The number of persons served per 1,000 enrollees increased from 50 in 1989 to 99 in 1996, an increase of 98 percent over the period. Average number of visits per person served increased from 27 in 1989 to 76 in 1996, an increase of 181 percent.

Increasing per-visit costs for home health services have accounted for comparatively little spending growth. Payments per visit increased at a relatively low rate, from \$54 per visit in 1989 to \$62 in 1996, a 14.8-percent increase for the period.

Some portion of growth in the volume of covered visits may represent a delayed response to an increasing need for skilled home care resulting from incentives, contained within Medicare's hospital prospective payment system, to discharge patients more quickly to their homes. During early years of hospital prospective payment, HCFA had in place medical review and claims processing policies that had resulted in high denial rates for home health care. These policies were relaxed by 1989. In addition, the 1989 revised home health guidelines are believed to have liberalized coverage policies,

increasing the number of allowed visits per week and duration of eligibility. Furthermore, the revised guidelines may have opened the door to eligibility for persons who have ongoing medical problems that require personal care assistance associated more with long-term care rather than acute care. Other factors that explain growth in spending include aging of the population, technological advances that have made possible a level of care in the home that previously was only available in hospitals and other institutions, and increased supply of services because of the expanding number of agencies participating in Medicare (9,939 in 1996 compared to 5,686 in 1989).

TABLE 2-17.—MEDICARE HOME HEALTH CARE UTILIZATION AND PAYMENTS PER VISIT, 1983-96

Calendar year of service	People served		Visits			Payment per visit	Percent change ¹
	Number	Per 1,000 enrollees	Number (in millions)	Per 1,000 enrollees	Per person served		
1983	1,318,000	45	36.9	1,234	28	\$43	NA
1984	1,498,000	50	40.4	1,330	27	46	7.3
1985	1,549,000	50	39.4	1,274	25	49	6.5
1986	1,571,000	50	38.0	1,204	24	50	3.4
1987	1,544,000	48	35.6	1,104	23	53	5.2
1988	1,582,000	48	37.1	1,130	23	55	3.8
1989	1,685,000	50	46.2	1,379	27	54	-0.9
1990	1,940,000	57	69.5	2,038	36	56	2.2
1991	2,223,000	64	100.2	2,875	45	56	-1.8
1992	2,523,000	72	134.9	3,863	54	58	3.8
1993	2,868,000	80	169.1	4,742	59	61	4.1
1994	3,175,000	87	220.7	6,090	70	60	-0.3
1995	3,570,000	96	266.4	7,158	75	61	0.7
1996 ²	3,735,000	99	285.7	7,578	76	62	3.8

¹ Rounding in payments may not reflect actual change.

² Estimated.

NA—Not applicable.

Source: Health Care Financing Administration, Office of the Actuary and Prospective Payment Assessment Commission (1995, 1996).

HOSPICE SERVICES

Coverage and benefits

Medicare covers hospice care, in lieu of most other Medicare benefits, for terminally ill beneficiaries. Hospice care emphasizes palliative medical care, that is, relief from pain, and supportive social and counseling services for the terminally ill and their families. Services are provided primarily in the patient's home. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248, first authorized Medicare part A coverage for hospice care (for the period November 1, 1983 to October 1, 1986); in 1986, Congress made the hospice benefit a permanent part of the Medicare Program, effective April 7, 1986.

For a person to be considered terminally ill and eligible for Medicare's hospice benefit, the beneficiary's attending physician and the medical director of the hospice (or physician member of the hospice team) must certify that the individual has a life expectancy of 6 months or less. As a result of an amendment in the Balanced Budget Act, persons electing hospice are covered for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice team must recertify at the beginning of each new election period that the beneficiary is terminally ill. Services must be provided under a written plan of care established and periodically reviewed by the individual's attending physician and by the medical director of the hospice.

Covered hospice services include the following: (1) nursing care provided by or under the supervision of a registered nurse; (2) physical or occupational therapy or speech-language pathology services; (3) medical social services; (4) services of a home health aide who has successfully completed a training program approved by the Secretary of DHHS; (5) homemaker services; (6) medical supplies (including drugs and biologicals) and the use of medical appliances; (7) physician services; (8) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); (9) counseling, including dietary counseling, for care of the terminally ill beneficiary and for adjustment to the patient's death (bereavement counseling is not a reimbursable service); and (10) any other item or service which is specified in a patient's plan of care and which Medicare may pay for (effective April 1, 1998).

Medicare's hospice benefit is intended to be principally an in-home benefit. For this reason, Medicare law prescribes that respite care, or relief for the primary care giver of the terminally ill patient, may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than 5 days. In addition, the aggregate number of inpatient care days provided in any 12-month period to Medicare beneficiaries electing hospice care can not exceed 20 percent of the total number of days of hospice coverage provided to these persons.

Only two covered hospice services—outpatient drugs or biologicals and respite care—are subject to coinsurance. Outpatient drugs and biologicals are subject to a coinsurance amount that approximates 5 percent of the cost of the drug to the hospice program, except that the amount may not exceed \$5 per prescription. For respite care, coinsurance equals 5 percent of program payments for respite, but may not exceed Medicare's inpatient hospital deductible during a hospice coinsurance period (defined as the period when hospice election is not broken by more than 14 days).

Covered services must be provided by a Medicare-certified hospice. Certified hospices must be either public agencies or private organizations primarily engaged in providing covered hospice services and must make services available on a 24-hour basis, in individuals' homes, on an outpatient basis, and on a short-term inpatient basis. Hospices must routinely directly provide substantially all of the following "core" services: nursing care, medical social services, and counseling services. The remaining hospice services

may be provided either directly by the hospice or under arrangements with others. If services are provided through arrangements with other providers, the hospice must maintain professional management responsibility for all such services, regardless of the facility in which the services are furnished.

The hospice program must also have an interdisciplinary group of personnel which includes at least one registered professional nurse and one social worker employed by the hospice; one physician employed by or under contract with the hospice; plus at least one pastoral or other counselor.

Reimbursement

In implementing Medicare's hospice benefit, HCFA established a prospective payment methodology. Under this methodology, hospices are paid one of four prospectively determined rates, which correspond to four different levels of care, for each day a Medicare beneficiary is under the care of the hospice. Reimbursement will thus vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary.

The four rate categories for reimbursing hospices are:

1. *Routine home care day.*—Routine home care day is a day on which an individual is at home and is not receiving continuous home care. The routine home care rate is paid for every day a patient is at home and under the care of the hospice regardless of the volume or intensity of the services provided on any given day as long as less than 8 hours of care are provided. This rate is \$95.77 for services provided between October 1, 1997 and September 30, 1998.
2. *Continuous home care day.*—A continuous home care day is a day on which an individual receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. Home care must be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care. Payment for continuous home care will vary depending on the number of hours of continuous services provided. Currently this rate is \$558.99 for 24 hours or \$23.29 per hour.
3. *Inpatient respite care day.*—An inpatient respite care day is one on which the individual who has elected hospice care receives care in an approved facility on a short-term (not more than 5 days at a time) basis for the respite of his caretakers. Currently this rate is \$99.07.
4. *General inpatient care day.*—A general inpatient care day is one on which an individual receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. Care may be provided in a hospital, skilled nursing facility, or inpatient unit of a freestanding hospice. Currently this rate is \$426.05.

To reflect differences in wage levels from area to area, each of these four payment rates is adjusted by the hospital area wage index used by Medicare for adjusting payments to hospitals, skilled nursing facilities, and home health agencies. HCFA separates each of the national payment rates for hospice care into components which reflect the estimated proportion of the rate attributable to wage and nonwage costs. The wage component of each rate is then adjusted by the index applicable to the area in which the hospice is located.

The Omnibus Budget Reconciliation Act (OBRA) of 1989 required that the payment rates be increased by the hospital market basket percentage increase each fiscal year. OBRA 1993, however, reduced the updates for the prospective rates as follows: for fiscal year 1994, the hospital market basket percentage increase minus 2.0 percentage points; for fiscal years 1995 and 1996, the hospital market basket minus 1.5 percentage points; and for fiscal year 1997, market basket minus 0.5 percentage points.

The Balanced Budget Act of 1997 reduces the hospice payment update to market basket minus 1 percentage point for each of fiscal years 1998–2002.

Medicare law requires that payments to a hospice for care furnished over the period of a year be limited to a “cap amount.” The cap amount is applied on an aggregate rather than a case-by-case basis. Therefore, each individual hospice’s cap amount is calculated by multiplying the yearly cap amount by the number of Medicare beneficiaries who received hospice care from the hospice during the cap period. Medicare defines a cap year as the period from November 1 through October 31 of the following year. The cap amount for the period November 1, 1996 through October 31, 1997, is \$14,394. Cap amounts are updated annually by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for Urban Consumers.

Hospice program data

Table 2–18 shows that the number of hospices participating in Medicare has grown from 553 in 1988 to 2,090 in 1996. Table 2–19 indicates that spending for the benefit has increased signifi-

TABLE 2–18.—NUMBER OF HOSPICES BY PROVIDER TYPE WITH PERCENTAGE OF TOTAL, 1988–96

Provider type	Month and year								
	7/88	7/89	5/90	9/91	1/92	5/93	8/94	6/95	10/96
Freestanding	191	220	260	394	404	499	608	656	762
Hospital based	138	182	221	282	291	341	401	447	507
Skilled nursing facility based	11	13	12	10	10	10	12	18	21
Home health agency based	213	286	313	325	334	438	583	674	800
Total	553	701	806	1,011	1,039	1,288	1,604	1,795	2,090

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE 2—19.—SELECTED MEASURES OF MEDICARE HOSPICE CARE, FISCAL YEARS 1988–95

Measure	Fiscal year							
	1988	1989	1990	1991	1992	1993	1994	1995
Cash outlays by provider type:								
Freestanding	\$52.1	\$87.1	\$130.7	\$219.2	\$444.2	\$620.4	\$724.2	\$977.1
Hospital based	13.5	33.0	57.0	92.0	168.0	205.3	226.1	319.3
Skilled nursing facility based	4.8	5.9	7.6	8.6	17.1	22.6	17.7	26.0
Home health agency based	47.8	79.3	113.5	125.7	224.3	303.7	348.7	508.1
Total	118.4	205.4	308.8	445.4	853.6	1,151.9	1,316.7	1,830.5
Cash outlays by care type:								
Routine home care	95.7	175.2	262.8	376.6	720.0	1,004.9	1,158.6	1,611.6
Continuous home care	2.5	2.6	3.1	3.9	10.4	12.2	14.5	25.6
Inpatient respite care	0.3	0.6	0.9	1.3	2.5	2.6	2.7	4.4
General inpatient care	18.9	25.5	39.6	59.7	114.0	125.5	134.1	179.1
Physicians	0.9	1.4	2.4	3.9	6.7	6.7	6.8	9.8
Total	118.4	205.4	308.8	445.4	853.6	1,151.9	1,316.7	1,830.5
Average dollar amount per beneficiary:								
Freestanding	2,837	3,436	4,237	4,121	5,668	6,085	6,355	6,451
Hospital based	3,129	3,217	3,832	4,234	5,296	5,361	5,631	5,740
Skilled nursing facility based	3,247	3,260	3,231	4,198	5,538	5,344	5,426	6,079
Home health agency based	2,965	3,395	3,994	3,993	5,169	5,239	5,408	5,509
Total	2,935	3,378	4,037	4,108	5,452	5,681	5,935	8,049
Number of beneficiaries:								
Freestanding	18,396	25,351	30,861	53,194	78,374	102,283	113,959	151,466

TABLE 2-19.—SELECTED MEASURES OF MEDICARE HOSPICE CARE, FISCAL YEARS 1988-95—Continued
[By claim approved]

Measure	Fiscal year							
	1988	1989	1990	1991	1992	1993	1994	1995
Hospital based	4,315	10,269	14,870	21,717	31,734	38,295	40,156	55,631
Skilled nursing facility based	1,494	1,818	2,353	2,040	3,084	4,221	3,262	4,272
Home health agency based	16,151	23,364	28,407	31,472	43,391	57,969	64,472	91,238
Total	40,356	60,802	76,491	108,413	156,583	202,768	221,849	302,608
Average number of days a beneficiary elects hospice care:								
Freestanding	39.26	48.40	52.41	46.15	59.11	62.0	63.7	62.9
Hospital based	37.70	41.24	45.85	44.19	54.57	53.8	55.4	56.7
Skilled nursing facility based	31.05	37.10	34.51	37.59	44.45	42.7	45.5	49.3
Home health agency based	35.26	43.14	46.46	42.45	52.59	52.2	53.3	63.8
Total ¹	37.19	44.83	48.38	44.52	56.09	57.2	58.9	68.3
Number of units by care type:								
Routine home care—days	1,460,414	2,677,170	3,600,407	4,667,703	8,564,904	11,324,524	12,699,617	17,257,734
Continuous home care—hours	154,989	160,056	166,039	199,309	442,968	565,903	654,667	1,129,697
Inpatient respite care—days	4,223	8,398	12,573	14,867	28,495	27,887	28,769	45,932
General inpatient care—days	58,346	83,750	117,989	161,211	297,190	303,245	299,823	418,093
Physicians—procedures	19,257	24,442	39,587	53,491	111,716	115,560	110,790	165,066

¹ Weighted by the number of beneficiaries in each hospice type.

Note.—Totals may not add due to rounding.

Source: Health Care Financing Administration.

cantly, rising from \$118.4 million in fiscal year 1988 to \$1.8 billion in fiscal year 1995. The number of beneficiaries electing Medicare's hospice benefit has increased from about 40,000 in fiscal year 1988 to almost 303,000 in fiscal year 1995. The average number of days a beneficiary spends in hospice care has risen from 37 to 68 days during this period, and the average amount spent per beneficiary has increased from \$2,935 to \$8,049. The vast majority of care paid for by the program is routine home care.

PART B SERVICES—COVERAGE AND PAYMENTS

PHYSICIANS SERVICES

Medicare pays for physicians services on the basis of a fee schedule which went into effect in 1992. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are then converted into a dollar payment amount by a dollar figure known as the conversion factor. In 1997, there are three conversion factors—one for surgical services, one for primary care services, and one for other services. The conversion factors in 1997 are \$40.96 for surgical services, \$35.77 for primary care services, and \$33.85 for other services (for a further discussion of physician payment issues, see appendix E).

The conversion factors have been updated each year by a formula called the default formula. However, Congress may elect to reduce the update that would otherwise apply. The default formula has been based on two factors: (1) inflation as measured by the Medicare economic index (MEI); and (2) a comparison of actual physician spending in a base period compared to an expenditure goal known as the Medicare volume performance standard (MVPS). Specifically, the update has been equal to the MEI, plus or minus the difference between the MVPS for the second preceding fiscal year and actual expenditures for that year. (Thus fiscal year 1995 data were used in determining the calendar year 1997 update.) However, regardless of actual performance during the base period, there has been a limit on the actual reduction (but not increase).

The Balanced Budget Act of 1997 specified that there will be a single conversion factor beginning in 1998. The 1998 amount—\$36.69 is the 1997 primary care conversion factor, updated to 1998 by the average of the three separate updates that would occur in the absence of the legislation. Beginning in fiscal year 1998, the MVPS is replaced with a cumulative “sustainable growth rate” based on real GDP growth. The 1998 rate is 1.5 percent. This new target will begin affecting updates in 1999. An upper limit is placed on allowable fee increases—3 percentage points above inflation. The lower limit on decreases is changed from inflation minus 5 percentage points to inflation minus 7 percentage points.

Anesthesiologists are paid under a separate fee schedule which uses base and time units. A separate conversion factor (\$16.68 in 1997) applies. The Balanced Budget Act of 1997 specifies that beginning in 1998, the conversion factor equals 46 percent of the single conversion factor, except as adjusted for changes in work, prac-

tice expense, or malpractice relative value units. The 1998 factor is \$16.88.

Medicare payments are made for physicians' services after the annual deductible requirement of \$100 has been satisfied. Payment is set at 80 percent of the fee schedule with beneficiaries responsible for the remaining 20 percent, which is referred to as coinsurance.

Medicare payment is made either on an "assigned" or "unassigned" basis. By accepting assignment, physicians agree to take the Medicare fee schedule amount as payment in full. Thus, if assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge, subject to limits. This procedure is known as balance billing.

Medicare's Participating Physician Program was established to provide beneficiaries with the opportunity to select physicians (designated as "participating physicians") who have agreed to accept assignment on all services provided during a 12-month period. Nonparticipating physicians continue to be able to accept or refuse assignment on a claim-by-claim basis. There are a number of incentives for physicians to become participating physicians, the chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95 percent of the recognized amount paid to participating physicians. Additional incentives include more rapid claims payment and widespread distribution of participating physician directories.

Nonparticipating physicians may not charge more than 115 percent of Medicare's allowed amount for any service. Medicare's allowed amount for nonparticipating physicians is set at 95 percent of that for participating physicians. Thus, nonparticipating physicians are only able to bill 9.25 percent (115 percent times 95 percent) over the approved amount for participating physicians.

SERVICES OF NONPHYSICIAN PRACTITIONERS

The physician fee schedule is also used for calculating payments made for certain services provided by nonphysician practitioners.

Physician assistants and nurse practitioners

Currently, separate payments are made for physician assistant services, when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility; (2) as an assistant at surgery; or (3) in a rural area designated as a health manpower shortage area. Payments equal a percentage of what would be paid if the services were performed by a physician, namely 65 percent of the fee schedule amount for services performed as an assistant-at-surgery, 75 percent for other hospital services, and 85 percent for other services, including services "incident to" physicians services.

Currently, separate payments are made for nurse practitioner services, provided in collaboration with a physician, which are furnished in a nursing facility. Payments equal 85 percent of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists are paid directly for services provided in collaboration

with a physician in a rural area. Payments equal 75 percent of the physician fee schedule amount for services furnished in a hospital and 85 percent of the fee schedule amount for other services.

The Balanced Budget Act of 1997 removes the restriction on settings for these practitioners, effective January 1, 1998. Payment for services can only be made if no facility or other provider charges are paid in connection with the service. Payment will equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment will equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would have been recognized for a physician serving as an assistant-at-surgery. The physician assistant may be in an independent contractor relationship with the physician.

Certified nurse midwife services

Certified nurse midwife services are paid at 65 percent of the physician fee schedule amount.

Certified registered nurse anesthetists (CRNAs)

CRNAs are paid under the same fee schedule used for anesthesiologists (see above). Payments for services furnished by an anesthesia care team composed of an anesthesiologist and a CRNA are capped at a percentage of the amount that would be paid if the anesthesiologist were practicing alone. The percentage is 105 percent in 1997 and 100 percent in 1998 and thereafter. The payments are evenly split between each practitioner.

Clinical psychologists and clinical social workers

Diagnostic and therapeutic services provided by clinical psychologists are paid under the physician fee schedule. Payments for services provided by clinical social workers are equal to 75 percent of the amount allowed for clinical psychologists. Some services are subject to the psychiatric services limitation which limits Medicare payments for some services to 50 percent of incurred expenses.

Physical or occupational therapists

Payments for physical or occupational therapists in independent practice are made under the physician fee schedule, subject to an annual limit of \$900 per patient in billed charges for each type of therapist. Beginning in 1999, BBA places a \$1,500 per patient limit on all physical therapy services and a separate \$1,500 limit on all occupational therapy services. The limits do not apply to services provided by hospitals.

CLINICAL LABORATORY SERVICES

Medicare provides coverage for diagnostic clinical laboratory services. These services may be provided by an independent laboratory, a physician's office laboratory, or a hospital laboratory to outpatients. Since 1984, Medicare has paid for clinical laboratory services on the basis of a fee schedule. Fee schedules have been established on a carrier service area basis. The law set the initial payment amount for services performed in physicians' offices or independent laboratories at the 60th percentile of the prevailing charge

established for the fee screen year beginning July 1, 1984. Similarly, the initial fee schedule payment amount for services provided by hospital-based laboratories serving hospital outpatients was set at the 62d percentile of the prevailing charge level. Subsequent amendments to the payment rules limited application of the hospital fee schedule to "qualified hospitals." A qualified hospital is a sole community hospital (as that term is used for payment purposes under Medicare's hospital prospective payment system) which provides some clinical diagnostic tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day, 7 days a week.

The fee schedule payment amounts have been increased periodically since 1984 to account for inflation. The updates have generally occurred on January 1 of each year. Allowable increases in 1991, 1992, and 1993 were limited to 2 percent per year. There were no increases in 1994 and 1995. The increase in 1996 was 2.9 percent. The increase in 1997 is 2.7 percent. The Balanced Budget Act of 1997 freezes the fee schedule for the 1998–2002 period.

Beginning in 1988, the law established national ceilings on payment amounts. Initially the ceiling was set at 115 percent of the median for all fee schedules for that test. This percentage has been lowered several times. In 1997, the ceiling is 76 percent of the median. The Balanced Budget Act sets the ceiling at 74 percent of the median beginning in 1998.

As of January 1, 1998, HCFA is eliminating the use of old codes for certain automated panel/profile tests and replacing them with revised codes. The Balanced Budget Act of 1997 makes several changes with respect to the administration of the lab benefit. It requires the Secretary to divide the country into no more than five regions and designate a single carrier for each region to process lab claims (excluding those for services provided to inpatients of hospitals and skilled nursing facilities) no later than July 1, 1999. The allocation of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen is collected or other method selected by the Secretary. The requirement will not apply to those physicians office labs that the Secretary determines would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

The Balanced Budget Act also requires the Secretary, by January 1, 1999, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rulemaking process. The policies would be designed to eliminate variation among carriers and to simplify administrative requirements. The use of interim regional policies are permitted in cases where a uniform national policy has not been established.

Payment for clinical laboratory services (except for those provided by a rural health clinic) may only be made on the basis of assignment. The law specifically applies the assignment requirement to clinical laboratory services provided in physicians' offices. Payment for clinical laboratory services equals 100 percent of the fee schedule amount; no beneficiary cost sharing is imposed.

Laboratories must meet the requirements of the Clinical Laboratory Improvement Amendments of 1988. This legislation, which focused on the quality and reliability of medical tests, expanded Fed-

eral oversight to virtually all laboratories in the country, including physician office laboratories.

DURABLE MEDICAL EQUIPMENT AND PROSTHETICS AND ORTHOTICS

Medicare covers a wide variety of durable medical equipment (DME). Medicare law specifies that DME includes, but is not limited to, iron lungs, oxygen tents, hospital beds, and wheelchairs used in a patient's home. A patient's home can include an institution, such as a home for the aged, so long as the institution is not a hospital or skilled nursing facility. Health Care Financing Administration (HCFA) guidelines implementing the law provide a definition for DME that allows additional items to be covered. The guidelines define DME as equipment which: (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. Each of these requirements must be met before an item can be considered covered DME. Medicare also covers related supplies that are necessary for the effective use of DME; such supplies include drugs and biologicals which must be put directly into equipment in order for it to achieve its therapeutic benefit or to assure its proper functioning. With these definitions, HCFA has issued coverage guidelines for numerous DME items.

Medicare law defines prosthetic devices as items that replace all or part of an internal body organ (including colostomy bags and intraocular lenses) and prosthetics and orthotics such as leg, arm, back and neck braces, and artificial legs, arms and eyes. Program guidelines give additional examples of covered prosthetic devices. These include cardiac pacemakers, breast prostheses for postmastectomy patients, and a urinary collection and retention system that replaces bladder function. Examples of prosthetics and orthotics include rigid and semirigid back braces, special corsets, and terminal limb devices, such as artificial hands and hooks.

Reimbursement for durable medical equipment

Medicare pays for DME on the basis of a fee schedule originally enacted in the Omnibus Budget Reconciliation Act (OBRA) of 1987 and modified on several occasions since then. Prior to OBRA 1987, reimbursement for DME was generally made on the basis of reasonable charges. The fee schedule first became effective January 1, 1989.

Under the DME fee schedule, reimbursement is the lesser of either 80 percent of the actual charge for the item or the fee schedule amount. Covered DME items are classified into five groups for determining the fee schedule amounts: (1) inexpensive or other routinely purchased durable medical equipment (defined as equipment costing less than \$150 or which is purchased at least 75 percent of the time); (2) items requiring frequent and substantial servicing; (3) customized items (defined as equipment constructed or modified substantially to meet the needs of an individual patient); (4) other items of durable medical equipment (frequently referred to as the "capped rental" category); and (5) oxygen and oxygen equipment.

In general, the fee schedules establish national payment limits for DME. The limits have floors and ceilings. The floor is equal to

85 percent of the weighted median of local payment amounts and the ceiling is equal to 100 percent of the weighted median of local payment amounts.

Prosthetics and orthotics are also paid according to a fee schedule that is based on principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of regional payment amounts; the ceiling is 120 percent. Fee schedule amounts are updated annually by the Consumer Price Index for all Urban Consumers.

The Balanced Budget Act freezes payments for DME at the 1997 level for 1998–2002. It limits the update for prosthetics and orthotics to 1 percent for those years.

In addition, under the Balanced Budget Act, payments for oxygen are reduced in 1998 to 75 percent of the 1997 payment limits. Beginning in fiscal year 1999 and continuing through subsequent years, oxygen payments are limited to 70 percent of the 1997 levels. The Secretary is also authorized to establish separate classes of oxygen and oxygen equipment and establish separate national monthly payment limits for each class, as long as expenditures are neither more nor less than what would have been made without the separate classes. In addition, the Secretary is required to establish service standards for home oxygen providers. The General Accounting Office is required to submit a report to Congress, including recommendations for legislation, by February 1999 regarding beneficiary access to home oxygen equipment.

The Balanced Budget Act of 1997 also permits the Secretary to establish fee schedules for certain items of medical equipment which are currently paid on a reasonable charge basis.

Medicare payments for DME are intended to pay for items which are reasonable and medically necessary. Upgraded or deluxe items of DME purchased or rented for a beneficiary's convenience or other purposes do not meet these criteria. A beneficiary who wants an upgraded item must purchase it from the supplier and then seek Medicare reimbursement. The reimbursement will be based on the amount paid for the kind of item normally used to meet the intended purpose. The Balanced Budget Act authorizes (but does not require) the Secretary to publish regulations allowing reimbursement for upgraded DME. The regulations must include consumer protection safeguards and a determination of fair market prices for upgraded items of DME. If the regulations are released, a beneficiary could rent or purchase an upgraded item and Medicare would pay the supplier the standard fee for the item; the beneficiary would be responsible for paying the additional cost of the upgrade. The supplier's charge for the upgraded item could not exceed the established fee schedule amount (if any).

Table 2–20 shows total Medicare allowed payment amounts in calendar year 1995 for DME, prosthetics and orthotics, and other covered items that are not paid according to the fee schedule, as well as non-DME items that are paid according to the fee schedule.

TABLE 2-20.—ALLOWED AMOUNTS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND CERTAIN OTHER ITEMS, CALENDAR YEAR 1994

[In millions of dollars]

Category	Allowed amounts
Inexpensive/routinely purchased ¹	\$367.0
Items with frequent maintenance ²	71.4
Customized items ³	0.2
Capped rental ⁴	886.1
Oxygen ⁵	1,654.9
Prosthetics/orthotics ⁶	802.6
Other ⁷	922.0
Total	4,704.2

¹Inexpensive defined as equipment for which the purchase price does not exceed \$150. Routinely purchased defined as equipment that is acquired 75 percent of the time by purchase. These items include commode chairs, electric heat pads, bed rails, and blood glucose monitors.

²Paid on a rental basis until medical necessity ends; includes such items as ventilators and continuous and intermittent positive breathing machines.

³Includes such items as wheelchairs adapted specifically for an individual. Payment based on individual determination.

⁴Items of DME on a monthly rental basis not to exceed a period of continuous use of 15 months. Includes such items as hospital beds and wheelchairs.

⁵Payment for oxygen and oxygen equipment based on a monthly rate per beneficiary. Payment not made for purchased equipment except where installment payments continue.

⁶These items include covered prosthetic and orthotic devices (except for items included in the categories "customized items" and "items requiring frequent maintenance," and transcutaneous electrical nerve stimulators, parenteral/enteral nutritional supplies and equipment, and intraocular lenses).

⁷This category includes other covered items, such as enteral formulae and enteral medical supplies, that are not paid according to the fee schedules. It also includes non-DME items that are paid according to the DME fee schedule, such as surgical dressings.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from the part B Medicare Annual Data System.

Administration of the fee schedule

Consolidation of administration.—On June 18, 1992, the Health Care Financing Administration (HCFA) published a final rule regarding DME claims payments. The rule established four regional carriers to process all claims for DME and prosthetics and orthotics. HCFA argued that, as a result of this consolidation, greater efficiency in claims processing would be achieved, and variance in coverage policy and utilization parameters would be greatly reduced.

In addition, the rule also required that the responsibility for processing claims for beneficiaries residing within each regional area would fall to the regional carrier for that area. This change was made in order to eliminate "carrier shopping," that is, filing claims in those carrier areas that have higher payment rates.

Overused items.—OBRA 1990 required the Secretary to develop a list of DME items frequently subject to unnecessary utilization; the list must include seat-lift mechanisms; transcutaneous electrical nerve stimulators (TENS); and motorized scooters. Carriers are directed to determine, in advance, whether payment will be made for items on the Secretary's list. DME suppliers must obtain

carriers' approval before providing items on the list to Medicare beneficiaries.

Certificates of medical necessity.—All DME must be prescribed by a physician in order to be reimbursed by Medicare. Instead of a physician's prescription, carriers may require the physician to submit a certificate of medical necessity to document that an item is reasonable and medically necessary. OBRA 1990 prohibited DME suppliers from distributing completed or partially completed certificates and established penalties for suppliers who knowingly and willfully distribute forms in violation of the prohibition. The purpose of this provision was to prohibit DME suppliers from directly marketing items to Medicare beneficiaries by providing them with completed certificates that could then be submitted to their physicians. It was hoped that requiring physicians to complete the certificates would encourage them to take a more active role in considering their patients' needs for DME, while simultaneously reducing suppliers' ability to influence DME acquisition.

The Social Security Amendments of 1994 modified this prohibition to allow suppliers to distribute forms to physicians or beneficiaries with some limited information such as the supplier's identification number, a description of the item, or payment information.

Inherent reasonableness.—The Secretary is permitted to increase or decrease Medicare payments in cases where the payment amount is "grossly excessive or grossly deficient and not inherently reasonable." The Secretary's authority to make these payment adjustments is generally referred to as "inherent reasonableness authority."

In order to make a payment adjustment, the Secretary must demonstrate that the payment meets several criteria of inherent reasonableness specified by law. In addition, the Secretary must publish a notice in the *Federal Register* outlining his proposal to reduce or increase payment amounts, the proposed methodology for adjusting the payment amount, and the potential impact of the payment adjustment. The Secretary is also required to meet with representatives of the affected suppliers, to provide a 60-day public comment period, and to publish a final determination in the *Federal Register*. The final determination must include an explanation of the factors and data the Secretary took into consideration in making the determination.

According to HCFA, the Secretary rarely uses inherent reasonableness authority because the requirements are too stringent and the notice requirements too burdensome.

Competitive bidding

Investigations have shown that Medicare pays higher prices for certain medical supplies than those paid by other health care insurers and other government agencies, including the Department of Veterans Affairs (VA). In order to lower payments, the Secretary currently must initiate the inherent reasonableness process or rely on congressional legislation. Thus, critics suggested granting the Secretary the authority to engage in a competitive bidding arrangement similar to the one used by the VA. The Balanced Budget Act provided such authority on a limited basis by authorizing not more

than five 3-year competitive bidding demonstration projects. Within established competitive acquisition areas, providers of part B services (excluding physician services) will compete for contracts to supply items or services. At least one of the projects must include oxygen and oxygen equipment. The Secretary may limit the number of suppliers within an area to that number necessary to meet the projected demand for items and services covered under the contract. The Secretary will evaluate the effect of these projects on Medicare payments, access, quality, and diversity of product selection and report these evaluations annually to Congress. All projects must terminate by December 31, 2002.

Requirements for participation in Medicare

The Social Security Amendments of 1994 established requirements for suppliers of medical equipment. Some of the requirements codified regulations proposed by HCFA in 1992. In order to be paid under Medicare, suppliers must be issued a supplier number. To obtain this number, the supplier must receive and fill orders from its own inventory or inventory in other companies with which it has contracted. Suppliers must also deliver Medicare covered items to beneficiaries, honor any warranties, answer any questions or complaints, maintain and repair rental items, and accept returns of substandard or unsuitable items. The law further required that the supplier must comply with all State and Federal regulations, must maintain an appropriate physical plant, and must have proof of insurance coverage.

The Secretary is not permitted, except under specific circumstances, to issue multiple supplier numbers to one supplier.

The law also addressed marketing and sales activities of suppliers. Except under specified conditions, a supplier is prohibited from making unsolicited telephone calls to Medicare beneficiaries to sell them equipment. If such a sale is made, the supplier will not be paid by Medicare and costs paid by the beneficiary must be refunded by the supplier. Penalties were established for suppliers that violate this provision.

HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Medicare hospital outpatient department (OPD) services are reimbursed under Medicare part B. Services provided in outpatient hospital settings and included in expenditure data for this service setting are: emergency room services, clinic, laboratory, radiology, pharmacy, physical therapy, ambulance, operating room services, end-stage renal disease services, durable medical equipment, and other services such as computer axial tomography and blood. Services rendered by physicians in OPD settings are not included in these expenditure data.

Prior to 1983, hospital outpatient services, excluding physicians' services, were paid for on a reasonable cost basis. Some services, such as emergency services, are still reimbursed on a reasonable cost basis. However, Congress has enacted a number of provisions that have altered the ways hospital OPDs are paid for many of their services and has placed limits on payments for others. For example, outpatient dialysis services are paid on the basis of a fixed composite rate; clinical laboratory services are paid on the basis of

a fee schedule; x-ray services are subject to a limit on payments; and ambulatory surgical facility fees for surgeries performed in hospital outpatient departments are based on a weighted average of the hospital's costs and the prevailing fee that would be paid to a freestanding ambulatory surgical facility in the area.

The aggregate payment to hospital OPDs and hospital-operated ambulatory surgical centers (ASCs) for covered ASC procedures is equal to the lesser of the following two amounts: (1) the lower of the hospital's reasonable costs or customary charges less deductibles and coinsurance; or (2) the amount determined based on a blend of the lower of the hospital's reasonable costs or customary charges, less deductibles and coinsurance, and the amount that would be paid to a freestanding ASC in the same area for the same procedures. For cost-reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 and 58 percent, respectively.

Payments for services delivered in hospital OPDs were \$12.9 billion in calendar year 1995. Payments to hospital OPDs constituted approximately 20 percent of all Medicare part B payments in 1995 and about 8 percent of total parts A and B Medicare payments. Table 2-21 provides information on the number of part B enrollees, covered charges, aggregated reimbursements and reimbursements per enrollee for hospital outpatient services from 1974 to 1995. Table 2-22 shows the percent distribution of Medicare hospital OPD charges, by type of service, for 1995.

The law provides for a reduction in payment for services paid on a cost-related basis, other than capital costs, by 5.8 percent of the recognized costs for payments. The Balanced Budget Act of 1997 extends the reduction through cost-reporting periods, occurring through January 1, 2000. The reduction also applies to cost portions of blended payment limits for ambulatory surgery and radiology services. The Balanced Budget Act also extends the reduction in reimbursement for capital costs for OPDs by 10 percent for cost-reporting periods occurring through January 2000. Sole community hospitals and rural primary care hospitals are exempt from these reductions.

The Balanced Budget Act requires the Secretary to establish a prospective payment system for covered OPD services furnished beginning in 1999. The Secretary is required to develop a classification system for covered OPD services, such that services within each group are comparable clinically and with respect to the use of resources. The Secretary is also required to establish relative payment rates for covered OPD services using 1996 hospital claims and cost report data, and to determine projections of the frequency of use of each service or group of services in 1999. In addition, she must determine a wage adjustment factor to adjust for relative geographic differences in labor and labor-related cost that must be applied in a budget-neutral manner and establish other adjustments as necessary, including adjustments to account for variations in coinsurance payments for procedures with similar resource costs, and to ensure equitable payments under the system. Finally, the Secretary must develop a method for controlling unnecessary increases in the volume of covered OPD services.

TABLE 2-21.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974-95

Type of enrollment and year of service	Number of SMI ¹ enrollees in thousands	Covered charges in thousands	Program payments		
			Amount in thousands	Per enrollee	Percent of charges
All beneficiaries:					
1974	23,166,570	\$535,296	\$323,383	\$14	60.4
1976	24,614,402	974,708	630,323	26	64.7
1978	26,074,085	1,384,067	923,658	35	66.7
1980	27,399,658	2,076,396	1,441,986	52	69.4
1982	28,412,282	3,164,530	2,203,260	78	69.6
1983	28,974,535	3,813,118	2,661,394	92	69.8
1984	29,415,397	5,129,210	3,387,146	115	66.0
1985	29,988,763	6,480,777	4,082,303	136	63.0
1986	30,589,728	8,115,976	4,881,605	160	60.1
1987	31,169,960	9,794,832	5,690,786	183	58.2
1988	31,617,082	11,833,919	6,371,704	202	53.8
1989	32,098,770	14,195,252	7,160,586	223	50.4
1990	32,635,800	18,346,471	8,171,088	250	44.5
1991	33,239,840	22,016,673	8,612,320	259	39.1
1992	33,956,460	26,799,501	9,941,391	293	37.1
1993	34,642,500	32,026,576	10,938,545	315	34.2
1994	35,178,600	36,323,649	11,813,522	336	32.6
1995 ²	31,806,740	40,476,180	12,933,358	407	31.9
Average annual rate of growth:					
1974-95	1.5	22.9	19.2	17.4	—
1974-83	2.5	24.4	26.4	23.3	—
1984-95	0.7	20.7	13.0	12.2	—
Aged:					
1974	21,421,545	394,680	220,742	10	55.9
1976	22,445,911	704,569	432,971	19	61.5
1978	23,530,893	1,005,467	648,249	28	64.5
1980	24,680,432	1,517,183	1,030,896	42	69.9
1982	25,706,792	2,402,462	1,645,064	64	68.5
1983	26,292,124	2,995,784	2,066,207	79	69.0
1984	26,764,150	4,122,859	2,679,571	100	65.0
1985	27,310,894	5,210,762	3,211,744	118	61.6
1986	27,862,737	6,529,273	3,809,992	137	58.4
1987	28,382,203	7,859,038	4,522,841	159	56.4
1988	28,780,154	9,790,273	5,098,546	177	52.1
1989	29,216,027	11,855,127	5,767,589	197	48.7
1990	29,691,180	15,384,510	6,563,454	221	42.7
1991	30,183,480	18,460,835	6,842,329	227	37.1
1992	30,722,080	22,253,657	7,741,774	252	34.8
1993	31,162,480	26,556,415	8,522,089	273	32.1
1994	31,443,800	29,768,892	9,116,610	290	30.6
1995 ²	28,020,760	33,110,441	9,900,199	353	29.9
Average annual rate of growth:					
1974-95	1.3	23.5	19.9	18.5	—

TABLE 2-21.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974-95—Continued

Type of enrollment and year of service	Number of SMI ¹ enrollees in thousands	Covered charges in thousands	Program payments		
			Amount in thousands	Per enrollee	Percent of charges
1974-83	2.3	25.3	28.2	25.8	—
1984-95	0.4	20.9	12.6	12.1	—
Disabled:					
1974	1,745,019	140,617	102,641	59	73.0
1976	2,168,467	270,139	197,352	91	73.1
1978	2,543,162	378,600	275,409	108	72.7
1980	2,719,226	559,213	411,090	152	73.5
1982	2,705,490	762,068	558,195	206	73.2
1983	2,682,411	817,335	595,187	222	72.8
1984	2,651,247	1,006,351	707,575	267	70.3
1985	2,677,869	1,270,015	870,560	325	68.5
1986	2,726,991	1,586,703	1,071,613	393	67.5
1987	2,787,757	1,773,664	1,167,945	417	65.8
1988	2,836,928	2,043,646	1,273,158	449	62.3
1989	2,882,743	2,340,124	1,392,897	483	59.5
1990	2,944,620	2,961,961	1,607,634	546	54.3
1991	3,056,360	3,555,838	1,769,991	579	49.8
1992	3,234,380	4,545,843	2,199,617	680	48.4
1993	3,480,020	5,470,161	2,416,456	694	44.2
1994	3,734,800	6,463,757	2,696,912	722	41.7
1995 ²	3,785,980	7,465,739	3,033,158	801	40.6
Average annual rate of growth:					
1974-95	3.8	20.8	17.5	13.2	—
1974-83	4.9	21.6	21.6	15.9	—
1984-95	3.3	20.0	14.1	10.5	—

¹ 1974 is the first full year of coverage for disabled beneficiaries under Medicare; SMI = supplementary medical insurance.

² Beginning in 1995, the utilization rates per 1,000 enrollees do not reflect managed care enrollment; that is, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

Note.—Numbers may not add to totals because of rounding. Hospital outpatient services include clinics or hospital-based renal dialysis facility services, and surgical facility or hospital-based ambulatory surgical center services provided to hospital outpatient.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from the Medicare Decision Support System; data developed by the Office of Research and Demonstrations.

The Secretary is authorized to periodically review and revise the groups, relative payment weights, wages, and other adjustments to take into account changes in medical practice, medical technology, the addition of new services, new cost data, and other relevant information. Any adjustments made by the Secretary must be made in a budget-neutral manner. If the Secretary determines that the volume of services increased beyond amounts established through those methodologies, the Secretary is authorized to adjust the update to the conversion factor in a subsequent year.

TABLE 2-22.—PERCENT DISTRIBUTION OF HOSPITAL OUTPATIENT CHARGES UNDER MEDICARE BY TYPE OF SERVICE, 1995

Service category	Percent of charges
Radiology	20.5
Laboratory	13.0
Operating room	11.4
End-stage renal disease	7.9
Pharmacy	6.2
Emergency room	3.2
Clinic	1.7
Physical therapy	2.5
Medical supplies	9.3
All other ¹	20.4

¹ Includes computerized axial tomography, durable medical equipment, and blood.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy; Data from the Medicare Decision Support System.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient services provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. As a result, the amount the beneficiary pays in coinsurance does not equal 20 percent of the program's allowable payment. On average, beneficiaries pay 37 percent of the total payment.

The Balanced Budget Act provides for a new method for determining beneficiary coinsurance beginning in 1999. Hospital OPD coinsurance payments are limited to 20 percent of the national median of the charges for the service (or services within the group) furnished in 1996 updated to 1999 using the Secretary's estimate of charge growth. The Secretary is required to develop rules for the establishment of a coinsurance payment amount for a covered OPD service not furnished during 1996, based on its classification within a group of such services. In addition, the Balanced Budget Act provides for the entire fee schedule amount (program payments plus beneficiary coinsurance payments) to be updated by the market basket increase minus 1 percentage point for years 2000 through 2002, and by the market basket percentage increase in subsequent years. Beneficiary coinsurance payments are to be subtracted from the fee schedule amount to determine Medicare Program payments. Over time, beneficiary cost sharing will move closer to the 20 percent of Medicare's recognized amount applicable for most part B services.

The Secretary must establish a procedure under which a hospital, before the beginning of a year (starting with 1999), can elect to reduce the coinsurance payment for some or all covered OPD services to an amount that is not less than 20 percent of the total amount (Medicare Program plus beneficiary coinsurance payment) for the service involved, adjusted for relative differences in labor costs and other factors. A reduced coinsurance payment can not be

further reduced or increased during the year involved, and hospitals can disseminate information on the reduction of coinsurance amounts.

AMBULATORY SURGICAL CENTER SERVICES

Medicare reimburses ambulatory surgical centers (ASCs) for performing surgical procedures on an ambulatory basis. ASCs are paid a prospectively determined rate for use of an operating room associated with covered surgical procedures. Excluded are the physicians charge for professional services performed and other medical items and services (for example, durable medical equipment for the patient's home use) for which separate payment is authorized under Medicare. Participating ASCs are paid 80 percent of the prospectively determined rate for facility services, adjusted for regional wage variations. The rate is intended to represent HCFA's estimate of a fair payment, taking into account the costs incurred by ASCs generally in providing services that are furnished in connection with performing a surgical procedure.

For payment purposes, ASC services are divided into nine groups, and the ASC facility payment for all procedures in each group is established at a single rate adjusted for geographic variation. The ASC payment groups for fiscal year 1998 range from \$314 for a procedure in payment group one, to \$928 for a procedure in payment group eight. Payment for group nine, allotted exclusively to extracorporeal shockwave lithotripsy services, was established and published in the *Federal Register* on December 31, 1991 (vol. 56, no. 251, 67666); however, a court decision in *American Lithotripsy Society v. Sullivan*, 785 F.Supp. 1034 (D.D.C. 1992), currently prohibits payment for these services under the ASC benefit. The Secretary is required to review and update standard overhead amounts annually. The ASC facility payment rates are required to result in substantially lower Medicare expenditures than would have been paid if the same procedure had been performed on an inpatient basis in a hospital.

Medicare also requires that payment for insertion of an intraocular lens include an allowance that is reasonable and related to the cost of acquiring the class of lens involved. OBRA 1993 also reduced the amount of payment for an intraocular lens inserted during or subsequent to cataract surgery in an ASC on or after January 1, 1994 and before January 1, 1999, to \$150.

OBRA 1993 eliminated inflation updates in the payment amounts for ASCs for fiscal years 1994 and 1995. The Social Security Act Amendments of 1994 (Public Law 103-432) required the Secretary to survey, not later than January 1, 1995, and every 5 years thereafter, the actual audited costs incurred by ASCs, based on a representative sample of procedures and facilities. In addition, the 1994 legislation provides for an automatic application of an inflation adjustment during a fiscal year when the Secretary does not update ASC rates based on survey data of actual audited costs. The act also provides that ASC payment rates be increased by the percentage increase in the Consumer Price Index for Urban Consumers (CPI-U), as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved, if the Secretary has not updated rates during a fiscal year, beginning with fiscal year

1996. The update for 1996 was 2.9 percent; the update for 1997 was 2.6 percent.

The Balanced Budget Act sets the annual update for ASC fees at the CPI-U minus 2 percentage points for fiscal years 1998–2002, specifying that the update cannot be less than zero. The update for fiscal year 1998 was 0.6 percent. In 1997, there were 2,433 ASCs, a 400-percent increase over the 485 facilities which were participating in Medicare in 1985. As shown in table 2–23, payments for ASC services totaled \$688.9 million in 1996. Table 2–24 shows the top 10 procedures performed in ASCs in 1996.

TABLE 2–23.—MEDICARE-CERTIFIED AMBULATORY SURGICAL CENTERS: UTILIZATION AND PROGRAM BENEFIT PAYMENTS FOR FACILITY SERVICES, 1993–96

Year	Number of services	Allowed charges for ASC facility services	Program payments for ASC facility services
1993	1,059,644	\$625,005,465	\$495,313,388
1994	1,298,740	721,315,789	572,001,981
1995	1,497,934	836,270,472	659,726,047
1996 ¹	1,527,130	867,629,247	688,910,712

¹ Short file, as of December 1996 (89 percent complete).

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from part B Extract and Summary System.

TABLE 2–24.—HIGH VOLUME PROCEDURES PERFORMED AT MEDICARE-CERTIFIED AMBULATORY SURGICAL CENTERS, 1996

Current procedural terminology code	Short descriptor	Volume of Medicare cases
66984	Remove cataract, insert lens	525,520
66821	After cataract laser surgery	165,281
43239	Upper GI endoscopy, biopsy	78,391
45378	Diagnostic colonoscopy	59,972
45385	Colonoscopy, lesion removal	41,699
62289	Lumbar or caudal epidural	35,340
45380	Colonoscopy and biopsy	34,744
43235	Upper GI endoscopy, diagnosis	24,055
45384	Colonoscopy	22,537
52000	Cystourethroscopy	19,048

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Data from the National Claims History Procedure Summary File.

OTHER PART B SERVICES

Preventive services

Screening mammograms.—In 1997, Medicare covered a screening mammography once every 2 years for persons over age 65. The program covers mammographies for the disabled according to the following schedule: age 35–39—one baseline screening; age 40–50—one every 2 years, except one every year for women at high risk;

and age 50–64—one every year. The Balanced Budget Act authorizes coverage for annual mammograms for all women over age 40 beginning January 1, 1998. The deductible is waived for these services.

Payment for a mammogram is based on the lesser of the actual charge, the amount established for the global procedure under Medicare's fee schedule, or the payment limit established for the procedure. The 1997 limit is \$63.34; the 1998 limit is \$64.73.

Screening Pap smears; pelvic exams.—In 1997, a screening pap smear was authorized once every 3 years, except for women who were at a high risk of developing cervical cancer. Beginning in 1998, coverage is authorized every 3 years for screening pelvic exams; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule (see above).

Prostate cancer screening tests.—The Balanced Budget Act authorizes coverage, beginning January 1, 2000, for an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer.

Colorectal screening.—The Balanced Budget Act authorizes coverage of and establishes frequency limits for colorectal cancer screening tests, effective January 1, 1998. A covered test is any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than one every 4 years); (3) screening colonoscopy for high-risk individuals (limited to one every 2 years); and (4) such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer. Payment limits are established for the tests.

The Balanced Budget Act requires the Secretary, within 90 days of enactment, to publish a determination on the coverage of screening barium enema. The Secretary has determined that barium enema tests, as an alternative to either a screening flexible sigmoidoscopy or a screening colonoscopy, will be covered in accordance with the same screening parameters specified for those tests.

Diabetes screening tests.—The Balanced Budget Act specifies that, effective July 1, 1998, Medicare's covered benefits will include diabetes outpatient self-management training services. These services are defined as including educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting. They will be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of their own condition. Certified providers for these purposes are defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare.

Providers must meet quality standards established by the Secretary. They are deemed to meet the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations that participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services.

In addition, beginning January 1, 1998, Medicare will cover blood glucose monitors and testing strips for type I or type II diabetics (without regard to a person's use of insulin, as determined under standards established by the Secretary in consultation with appropriate organizations). The national payment limit for testing strips is reduced by 10 percent beginning in 1998.

Bone mass measurements.—The Balanced Budget Act authorizes coverage, beginning July 1, 1998, for bone mass measurement for the following high risk persons: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess osteoporosis drug therapy. The Secretary would be required to establish frequency limits.

Drugs/vaccines

Medicare generally does not cover outpatient prescription drugs. Despite the general limitation, Medicare law specifically authorizes coverage for the following drugs:

- Immunosuppressive drugs.*—Drugs used in immunosuppressive therapy (such as cyclosporin) during the first 30 months following a covered organ transplant. The coverage period is extended to 3 years beginning in 1998.
- Erythropoietin (EPO).*—EPO for the treatment of anemia for persons with chronic kidney failure.
- Osteoporosis drugs.*—Injectable drugs approved for the treatment of postmenopausal osteoporosis provided to an individual by a home health agency. A physician must certify that the individual suffered a bone fracture related to postmenopausal osteoporosis and that the individual is unable to self-administer the drug.
- Oral cancer drugs.*—Oral drugs used in cancer chemotherapy when identical to drugs which would be covered if not self-administered.

The Balanced Budget Act also authorizes coverage, effective January 1, 1998, for oral antinausea drugs used as part of an anticancer chemotherapeutic regimen, subject to specified conditions.

Generally, Medicare payment for drugs has been based on the lower of the estimated acquisition cost or the national average wholesale price. These provisions do not apply when payment is based on reasonable costs. Special limits apply in the case of erythropoietin; the limit is \$10 per 1,000 units. Osteoporosis drugs can only be paid on the basis of reasonable costs.

The Balanced Budget Act specifies that, effective January 1, 1998, in any case where payment is not made on a cost or prospective payment basis, the payment will equal 95 percent of the aver-

age wholesale price. The Secretary is authorized to pay a dispensing fee to pharmacies. Further, the Secretary is required to study the effect of this provision on average wholesale prices.

Medicare also pays for influenza virus vaccines (flu shots), pneumococcal pneumonia vaccine, and hepatitis B vaccine for persons at risk of contracting hepatitis B. Cost-sharing charges do not apply for pneumococcal pneumonia or influenza virus vaccines; cost-sharing charges do apply for hepatitis B vaccines.

Ambulance services

Medicare pays for ambulance services provided certain conditions are met. The services must be medically necessary and other methods of transportation must be contraindicated. Ambulance services are currently paid on the basis of reasonable costs when such services are provided by a hospital; otherwise the payment is based on reasonable charge screens developed by individual carriers based on local billings (which may take a variety of forms). Based on these local billing methods, carriers develop screens for one or more of the following four main billing methods: (1) a single all inclusive charge reflecting all services, supplies, and mileage; (2) one charge reflecting all services and supplies, with separate charge for mileage; (3) one charge for all services and mileage, with separate charges for supplies; and (4) separate charges for services, mileage, and supplies. Within each broad payment method, additional distinctions are made based on whether the service is basic life support service or advanced life support, whether emergency or non-emergency transport was used, and whether specialized advanced life services were rendered.

The Balanced Budget Act of 1997 specifies that the reasonable cost and charge limits will apply through 1999, with annual increases equal to the CPI minus 1 percentage point. A fee schedule will be implemented in 2000. The aggregate amount of payments in 2000 cannot exceed what would be paid if the interim reductions remained in effect in that year. Annual increases in subsequent years will equal the CPI increase, except that in 2001 and 2002 there will be a 1-percentage point reduction. The act specifies that coverage is provided for advanced life support services provided by paramedic intercept service providers in rural areas under contract with one or more volunteer ambulance services.

END-STAGE RENAL DISEASE SERVICES

COVERAGE

The Medicare Program covers individuals who suffer from end-stage renal disease if they are: (1) fully insured for old age and survivor insurance benefits; (2) entitled to monthly Social Security benefits; or (3) spouses or dependents of individuals described in (1) or (2). Such persons must be medically determined to be suffering from end-stage renal disease and must file an application for benefits. In 1996, 8.4 percent of the population suffering from end-stage renal disease (ESRD) who needed renal dialysis and 11.6 percent who needed kidney transplants did not meet any of these requirements and thus were not eligible for Medicare renal benefits.

Benefits for qualified end-stage renal disease beneficiaries include all part A and part B medical items and services. ESRD beneficiaries are automatically enrolled in the part B portion of Medicare and must pay the monthly premium for such protection.

Table 2–25 shows estimates of expenditures, number of beneficiaries, and the average expenditure per person for all persons with ESRD (including the aged and disabled) from 1974 through 2002. Total projected program expenditures for the Medicare End-Stage Renal Disease Program for fiscal year 1998 are estimated at \$11.0 billion. In fiscal year 1998, there are an estimated 287,169 beneficiaries, including successful transplant patients and persons entitled to Medicare on the basis of disability who also have ESRD.

TABLE 2–25.—END-STAGE RENAL DISEASE MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES, 1974–2002

[Expenditures in millions of dollars]

Fiscal year	Expenditures (HI & SMI)	HI beneficiaries	Per person cost
1974	\$229	15,993	\$4,319
1975	361	22,674	15,921
1976	512	28,941	17,691
1977	641	35,889	17,861
1978	800	43,482	18,398
1979	1,009	52,636	19,169
1980	1,245	54,725	22,750
1981	1,464	61,487	23,810
1982	1,640	69,267	23,676
1983	1,984	78,361	25,319
1984	2,325	87,609	26,538
1985	2,835	96,965	29,237
1986	3,165	106,568	29,699
1987	3,490	117,020	29,824
1988	3,998	128,075	31,216
1989	4,653	140,324	33,159
1990	5,251	154,575	33,971
1991	5,634	170,718	33,003
1992	6,433	186,729	34,451
1993	7,192	202,988	35,429
1994	7,877	220,359	35,747
1995	8,652	237,469	36,436
1996	9,560	254,157	37,614
1997	10,252	270,672	37,875
1998	11,008	287,169	38,334
1999	11,849	303,765	39,007
2000	12,795	320,593	39,909
2001	14,121	337,774	41,806
2002	15,606	355,387	43,914

Note.—Estimates for 1979–2001 are subject to revision by the Office of the Actuary, Office of Medicare and Medicaid Cost Estimates; projections for 1994–2001 are under the fiscal year 1996 budget assumptions.

Source: Health Care Financing Administration, Office of the Actuary.

When the ESRD Program was created, it was assumed that program enrollment would level out at about 90,000 enrollees by 1995. That mark was passed several years ago, and no indication exists that enrollment will stabilize soon.

Table 2-26 shows that new enrollment for all Medicare beneficiaries receiving ESRD services grew at an average annual rate of 7.4 percent from 1989 to 1994. Most of the growth in program participation is attributable to growth in the numbers of elderly people receiving services and growth in the numbers of more seriously ill people entering treatment. Table 2-26 shows the greatest rate of growth in program participation is in people over age 75, at 12.0 percent, followed by people of ages 65-74 with a growth rate of 9.1 percent. The largest rate of growth in primary causes of people entering ESRD treatment was diabetes. People with diabetes frequently have multiple health problems, making treatment for renal failure more difficult.

The rates of growth in older and sicker patients entering treatment for end-stage renal disease indicate a shift in physician practice patterns. In the past, most of these people would not have entered dialysis treatment because their age and severity of illness made successful treatment for renal failure less likely. Although the reasons that physicians have begun treating older and sicker patients are not precisely known, it is clear that these practice patterns have resulted, and will continue to result, in steady growth in the number of patients enrolling in Medicare's End-Stage Renal Disease Program.

End-stage renal disease is invariably fatal without treatment. Treatment for the disease takes two forms: transplantation and dialysis. Although the capability to perform transplants had existed since the 1950s, problems with rejection of transplanted organs limited its application as a treatment for renal failure. The 1983 introduction of a powerful and effective immunosuppressive drug, cyclosporin, resulted in a dramatic increase in the number of transplants being performed and the success rate of transplantation.

Table 2-27 indicates that the number of kidney transplants in 1995 was more than double the number performed in 1980. Despite the significant increases in the number and success of kidney transplants, transplantation is not the treatment of choice for all ESRD patients. A chronic, severe shortage of kidneys available for transplantation now limits the number of patients who can receive transplants. Even absent a shortage of organs, some patients are not suitable candidates for transplants because of their age, severity of illness, or other complicating conditions. Finally, some ESRD patients do not want an organ transplant.

For all of these reasons, dialysis is likely to remain the primary treatment for end-stage renal disease. Dialysis is an artificial method of performing the kidney's function of filtering blood to remove waste products. There are two types of dialysis: hemodialysis and peritoneal dialysis. In hemodialysis, still the most common form of dialysis, blood is removed from the body, filtered and cleansed through a dialyzer, sometimes called an artificial kidney machine, before being returned to the body. There are three types

TABLE 2-26.—MEDICARE END-STAGE RENAL DISEASE PROGRAM INCIDENCE BY AGE, SEX, RACE, AND PRIMARY DIAGNOSIS, 1989-94

Age, sex, race, and primary diagnosis	1989	1990	1991	1992	1993	1994	Average annual percent change	Percent change 1993-94
Age:								
Under 15 years	417	462	465	419	444	437	0.9	-1.6
15-24 years	1,327	1,282	1,289	1,362	1,315	1,268	-0.9	-3.6
25-34 years	3,442	3,459	3,556	3,580	3,628	3,496	0.3	-3.6
35-44 years	4,718	5,174	5,590	5,954	5,825	5,986	4.9	2.8
45-54 years	5,947	6,275	6,859	7,642	8,019	8,756	8.0	9.2
55-64 years	9,230	9,973	10,796	11,430	11,631	12,426	6.1	6.8
65-74 years	11,554	12,964	14,499	16,007	16,542	17,851	9.1	7.9
75 years and over	6,845	7,765	8,932	10,275	10,813	12,046	12.0	11.4
Sex:								
Male	23,569	25,708	27,958	30,251	31,289	33,259	7.1	6.3
Female	19,911	21,646	24,028	26,418	26,928	29,007	7.8	7.7
Race:								
Asian	831	1,032	1,117	1,266	1,318	1,456	11.9	10.5
Black	12,608	13,538	14,962	16,520	16,976	17,638	6.9	3.9
White	28,983	31,564	34,669	37,477	38,072	40,532	6.9	6.5
American Indian	540	580	633	792	618	689	5.0	11.5
Other/unknown	518	640	605	614	1,233	1,951	30.4	58.2
Primary diagnosis:								
Diabetes	14,456	16,219	18,715	20,792	20,368	23,417	10.1	15.0
Glomerulonephritis	5,701	5,852	5,944	6,161	5,953	6,256	1.9	5.1
Hypertension	12,408	13,544	15,014	16,831	15,839	17,705	7.4	11.8
Polycystic-kidney disease	1,268	1,400	1,484	1,548	1,359	969	-5.2	-28.7
Interstitial nephritis	1,389	1,397	1,538	1,569	1,392	1,585	2.7	13.9
Obstructive nephropathy	980	945	1,019	1,091	960	944	-0.7	-1.7

TABLE 2-26.—MEDICARE END-STAGE RENAL DISEASE PROGRAM INCIDENCE BY AGE, SEX, RACE, AND PRIMARY DIAGNOSIS, 1989-94—Continued

Age, sex, race, and primary diagnosis	1989	1990	1991	1992	1993	1994	Average an- nual percent change	Percent change 1993-94
Other	2,678	2,866	3,588	3,931	4,157	5,030	13.4	21.0
Unknown	2,506	2,481	2,760	3,018	2,594	2,453	-0.4	-5.4
Not reported	2,094	2,650	1,924	1,728	5,595	3,907	13.3	-30.2
Total number of new enrollees	43,480	47,354	51,986	56,669	58,217	62,266	7.4	7.0

Source: Health Care Financing Administration, Bureau of Data Management and Strategy; data from the Program Management and Medical Information System, September 1996 update.

TABLE 2-27.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE-CERTIFIED U.S. HOSPITALS, 1979-95

Calendar year	Total transplants	Living donor		Cadaveric donor	
		Number	Percent	Number	Percent
1979	4,189	1,186	28	3,003	72
1980	4,697	1,275	27	3,422	73
1981	4,883	1,458	30	3,425	70
1982	5,358	1,677	31	3,681	69
1983	6,112	1,784	29	4,328	71
1984	6,968	1,704	24	5,364	76
1985	7,695	1,876	24	5,819	76
1986	8,976	1,887	21	7,089	79
1987	8,967	1,907	21	7,060	79
1988	8,932	1,816	20	7,116	80
1989	8,899	1,893	21	7,006	78
1990	9,796	2,091	21	7,705	79
1991	10,026	2,382	24	7,644	76
1992	10,115	2,536	25	7,579	75
1993	10,934	2,828	26	8,106	74
1994	11,312	3,000	26	8,312	73
1995	11,902	3,416	29	8,426	71

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

of peritoneal dialysis. Intermittent peritoneal dialysis (IPD) and continuous cycling peritoneal dialysis (CCDP) requires the use of a machine while continuous ambulatory peritoneal dialysis (CAPD) does not require the use of a machine. Under peritoneal dialysis, filtering takes place inside the body by inserting dialysate fluid through a permanent surgical opening in the peritoneum (abdominal cavity). Toxins filter into the dialysate fluid and are then drained from the body through the surgical opening. Hemodialysis is usually performed three times a week, IPD is performed once or twice a week, while CAPD and CCPD require daily exchanges of dialysate fluid.

REIMBURSEMENT

Medicare reimbursement for facility-based dialysis services provided by hospital-based and independent facilities are paid at prospectively determined rates for each dialysis treatment session. The rate, referred to as a composite rate, is derived from area wage differences and audited cost data adjusted for the national proportion of patients dialyzing at home versus in a facility. Adjustments are made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs.

Beneficiaries electing home dialysis may choose either to receive dialysis equipment, supplies, and support services directly from the facility with which the beneficiary is associated (method I) or to make independent arrangements for equipment, supplies, and support services (method II). Under method I, the equipment, supplies, and support services are included in the facility's composite rate. Under method II, payments are made on the basis of reasonable

charges and limited to 100 percent of the median hospital composite rate, except for patients on continuous cycling peritoneal dialysis, in which case the limit is 130 percent of the median hospital composite rate.

Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the prospective payment system. However, kidney acquisition costs are paid on a reasonable cost basis.

The composite rate is not routinely updated, nor are method II reasonable charge payments. There is no specific update policy for reasonable costs of kidney acquisition; 100 percent of reasonable costs are reimbursed. In fiscal year 1998, the composite rate is \$130 for hospitals and \$126 for freestanding facilities.

PRIVATE HEALTH PLANS IN MEDICARE

The Medicare Risk Contract Program in its current form (section 1876 of the Social Security Act) was authorized as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). It gives Medicare beneficiaries the option to enroll in a private health plan, typically a health maintenance organization (HMO). (An HMO is a type of managed care plan that acts as both insurer and provider of health care services to an enrolled population.) The program receives a predetermined, per capita payment from Medicare for each enrolled beneficiary and is at risk for providing each enrollee Medicare-covered items and services. The Risk Contract Program built upon an earlier Medicare provision, originating in the 1970s, which authorized private plans to contract with Medicare on a cost-reimbursement basis.

The Balanced Budget Act of 1997 made several major changes to underlying Medicare law dealing with private health plans. First, it replaces the risk program (and most other Medicare managed-care options, such as plans with cost contracts) with a program called Medicare+Choice (new part C of Medicare). Second, it creates a new set of private plan options for Medicare beneficiaries. Third, it establishes a new method for paying participating private health plans. Under the Balanced Budget Act of 1997, every individual entitled to Medicare part A and enrolled in part B will be able to elect the existing package of Medicare benefits through either the existing Medicare fee-for-service program (traditional Medicare) or through a Medicare+Choice plan.

This section describes the rules and standards under which both the old and new program operate. The Risk Contract Program is characterized as the "current" program; the new program is generally referred to as Medicare+Choice.

PLAN OPTIONS AND RULES FOR ENROLLMENT BEFORE THE BALANCED BUDGET ACT OF 1997

Prior to the implementation of Medicare+Choice, which should be fully in place by 1999, persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Alternatively, under section 1876 of the Social Security Act, they may elect to enroll with a managed

care organization which has entered into a payment agreement with Medicare.

Three types of managed care organizations are authorized under section 1876 to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, and a health care prepayment plan (HCPP) that has a cost contract to provide Medicare part B services. Risk contracts are frequently referred to as TEFRA risk contracts and cost contracts are frequently referred to as TEFRA cost contracts because the TEFRA legislation established the rules governing these types of contracts.

Risk contracts

Both HMOs and competitive medical plans (CMPs) are permitted to sign risk contracts with Medicare. (A CMP is a health plan that is not a federally qualified HMO but that meets specific Medicare requirements.) By contrast, provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs) that are not organized under the laws of a State and are neither a federally qualified HMO or CMP are not eligible to contract with Medicare under the Risk Contract Program. Allowing PSOs and PPOs to compete for Medicare beneficiaries is one of the major changes made by the Balanced Budget Act of 1997.

Medicare makes a single monthly capitation payment for each of its enrollees. This payment has been called the adjusted average per capita cost (AAPCC). The Balanced Budget Act of 1997 changed the capitation payment methodology, as discussed below. In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers.

In general, a beneficiary in an area served by an HMO or CMP with a risk contract may voluntarily choose to enroll in the organization. With a few exceptions, the beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. Typically, the beneficiary is not responsible for many of the cost-sharing charges associated with traditional Medicare. In some cases, the beneficiary may be charged a monthly premium by the organization. In 1995, risk plans were authorized to offer point-of-service (POS) options in which enrollees can go out of plan for services, with cost-sharing responsibilities varying with the choice of provider (higher cost sharing is associated with the use of nonnetwork providers).

Cost-based plans

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost sharing).

The other type of cost-based arrangement is the health care prepayment plan. A HCPP arrangement is similar to a TEFRA cost contract except that it provides only part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract.

Enrollment

With certain exceptions, any Medicare beneficiary residing in the area served by a risk plan or cost plan may enroll. Under the rules in effect until Medicare+Choice is implemented, the plans must have an annual open enrollment period of at least 30 days duration. During this period, they must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless doing so would lead: (a) to violation of the rule requiring HMOs to have no more than 50 percent of their enrollees as Medicare-Medicaid beneficiaries, or (b) to an enrolled population unrepresentative of the population in the area served by the HMO. As of January 1, 1997, the Secretary is authorized to waive this “50–50 rule” if she finds it in the public interest. This provision was included in the Balanced Budget Act of 1997, which also repeals the 50–50 rule as of January 1, 1999.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly with the HMO or at the local Social Security Office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to reenroll a beneficiary on the basis of health status or need for health services.

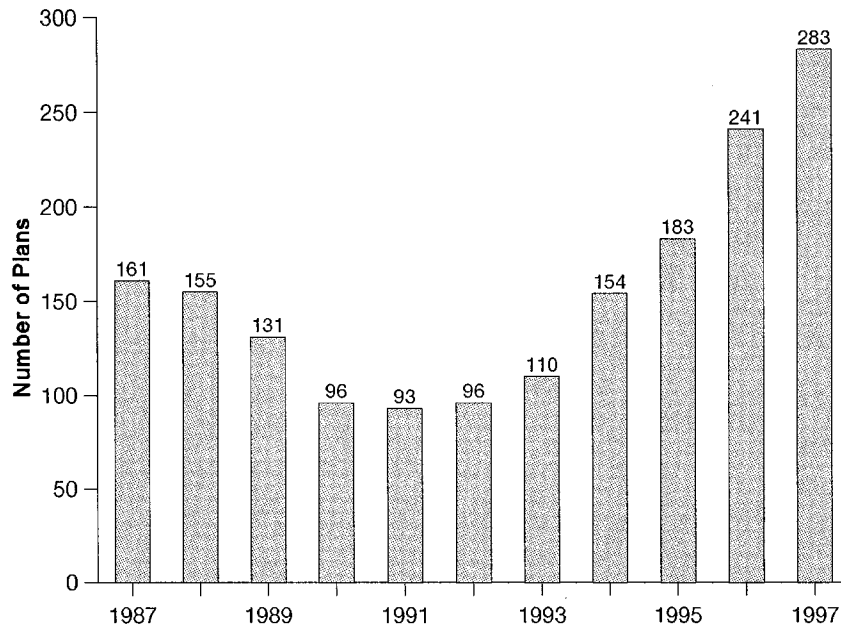
The Secretary is authorized to prescribe procedures and conditions under which eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, application forms, or other promotional or informational material may be distributed only after review and approval by the Secretary of Health and Human Services (DHHS). HMOs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A terminating HMO must arrange for supplementary coverage for Medicare enrollees to pay for certain cost-sharing charges during any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period.

TRENDS IN PLAN AVAILABILITY AND ENROLLMENT

As of 1997, a small but growing portion of Medicare beneficiaries are enrolled in managed care plans. Recent growth in enrollment reflects increases in both the number of plans with Medicare risk contracts and the number of Medicare enrollees per plan.

Availability of Medicare risk plans

In the 1980s, many large HMOs did not participate in Medicare. Participation by health plans, however, has grown rapidly in the past 5 years, especially since 1993 (chart 2–1).

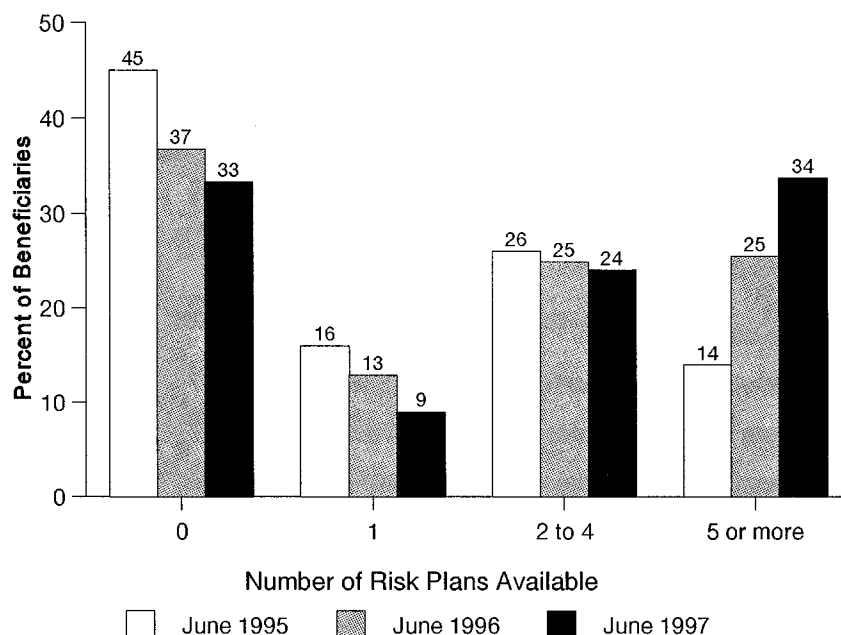
CHART 2-1. NUMBER OF RISK PLANS PARTICIPATING IN MEDICARE, 1987-97

Note: All data are for December, except that June data are used for 1997.

Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of data from Health Care Financing Review, 1996 Statistical Supplement and Medicare Managed Care Contract Reports.

By law, each risk plan is available for a specific service area. Plans define their service areas as a set of counties and partial counties (partial counties are identified by ZIP code). Typically, a plan serves some portion of a single State or a multistate metropolitan area. Analysis by the Physician Payment Review Commission (PPRC; 1997) shows that, in June 1997, 67 percent of all Medicare beneficiaries had at least one risk plan available to them (chart 2-2). (PPRC has now merged with the Prospective Payment Assessment Commission to become the Medicare Payment Advisory Commission or MedPAC.) Almost 60 percent of all beneficiaries had a choice of plans, and one-third had five or more available to them. In 2 years, the proportion of all beneficiaries without access to at least one risk plan had dropped 12 percent, while the number with access to at least five plans had more than doubled.

CHART 2-2. DISTRIBUTION OF MEDICARE BENEFICIARIES BY NUMBER OF RISK PLANS AVAILABLE IN THEIR AREA, 1995-97



Note: Area is defined as the ZIP codes in a risk plan's service area.

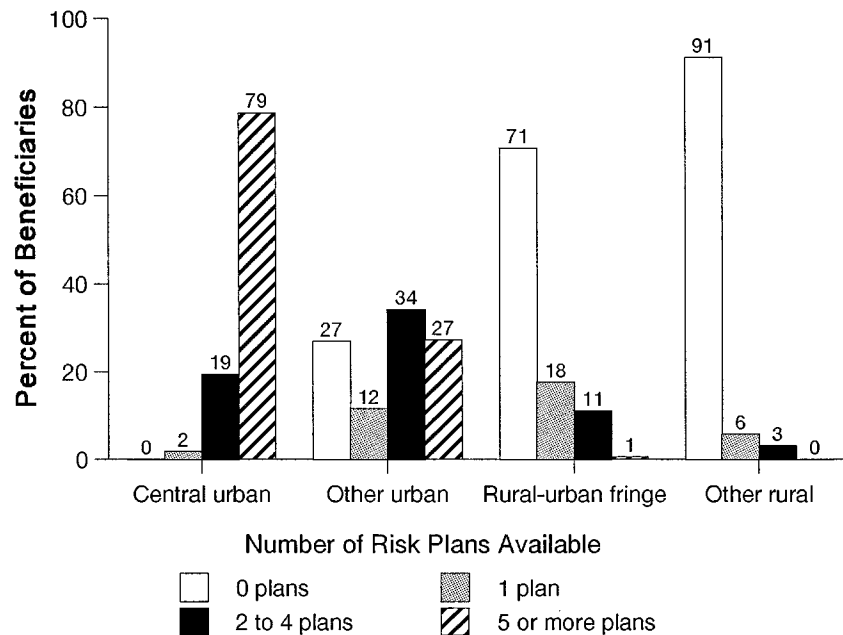
Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Health Care Financing Administration enrollment data.

Access to risk plans, however, is much greater in urban areas than in rural areas (chart 2-3). All residents of central urban areas have at least one plan available, and most have more. By contrast, rural beneficiaries rarely have even one plan available.

Enrollment trends for Medicare managed care

Historically, few Medicare beneficiaries have enrolled in HMOs, but the numbers have risen steadily to 14.2 percent of all beneficiaries in mid 1997 (chart 2-4). The largest numbers and all of the growth have been in risk plans, in which enrollment increased from 3.3 percent in 1990 to 12.6 percent in June 1997. By contrast, enrollment in cost contracting plans fell to a low of 1.6 percent in 1997. Nationally, enrollment in risk plans grew about 30 percent from June 1996 to June 1997.

CHART 2-3. DISTRIBUTION OF MEDICARE BENEFICIARIES IN URBAN AND RURAL LOCATIONS BY NUMBER OF AVAILABLE PLANS, JUNE 1997



Note: Urban counties are divided into central counties and others; rural counties are divided into urban fringe counties and others.

Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Health Care Financing Administration enrollment data.

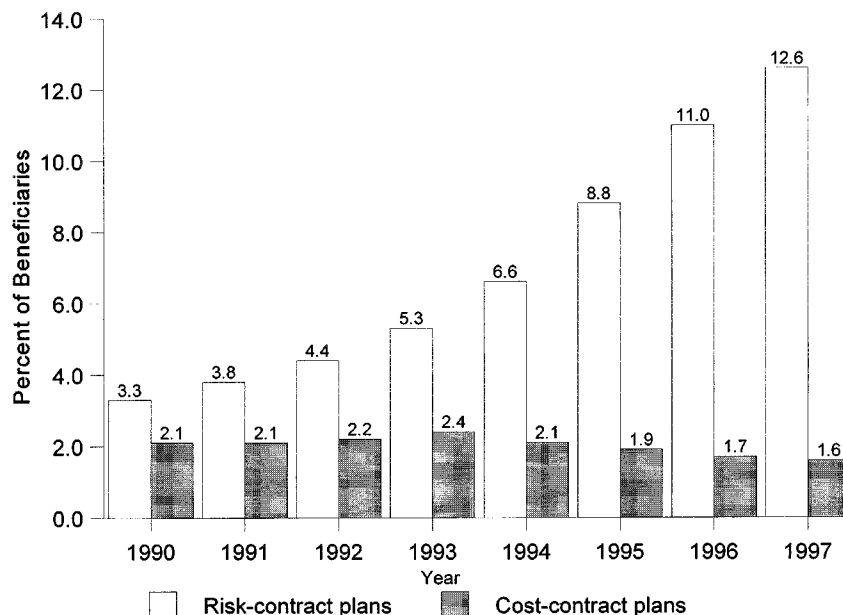
In addition to enrollment in risk and cost plans, over 16,000 beneficiaries had enrolled in plans offered through the Medicare Choices Demonstration Project as of mid 1997. This project was established to give Medicare beneficiaries expanded choices among types of managed care plans and test new ways to pay for managed care.

Patterns of enrollment differ across urban and rural locales. Risk plan enrollment in central urban areas (cities at the core of metropolitan areas) was about 24 percent in June 1997, about twice the level in outlying urban areas. That level was up from 17 percent 2 years earlier. Risk plan enrollment in rural areas was about 1.8 percent. Although low, it has been rising rapidly over the past 2 years. Enrollment in cost contract plans is more evenly distributed.

Enrollment patterns are not uniform around the country, with risk plan enrollment higher generally in western States (chart 2-5). In particular, over one-third of the beneficiaries in Arizona (37 percent) and California (37 percent) were in risk plans in June 1997. The highest levels of enrollment in eastern States were in

Florida (24 percent), Massachusetts (17 percent), Pennsylvania (19 percent), and Rhode Island (16 percent).

CHART 2-4. PERCENT OF MEDICARE BENEFICIARIES ENROLLED IN RISK AND COST PLANS, 1990-97



Note: All data are for December, except that 1997 data are from June.

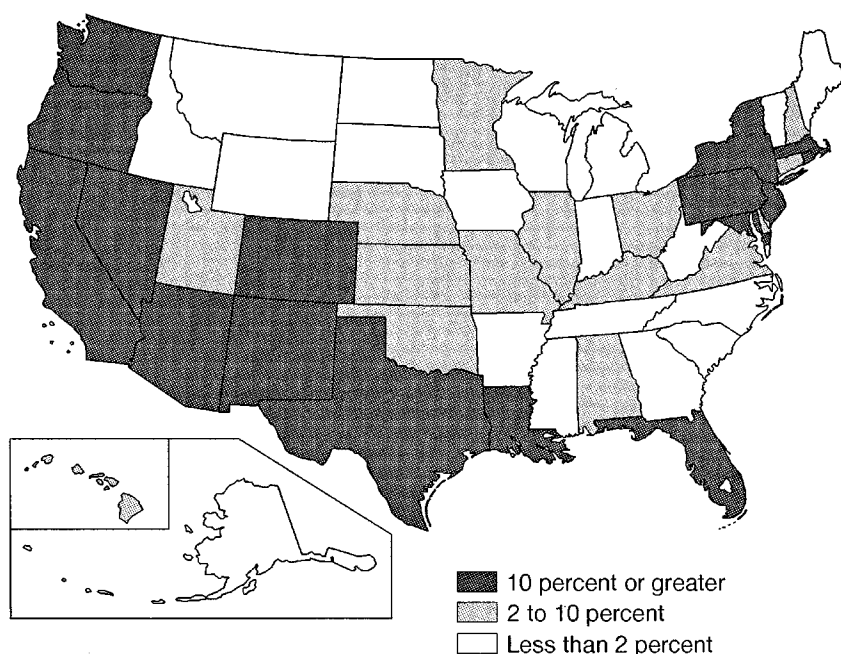
Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Medicare Managed Care Contract Reports.

Further evidence of the degree of concentration is that five States account for just over two-thirds of all risk enrollees but just over one-third of all Medicare beneficiaries. Almost half of all risk enrollees live in California and Florida. New enrollees, however, come from a somewhat different mix of States than do current risk enrollees. Beneficiaries in California and Florida represent under one-fourth of net new enrollment between June 1996 and June 1997, whereas Pennsylvania has the largest share of new enrollees (14 percent).

Although enrollment in the risk program initially was concentrated on the west coast and Florida, other areas, especially in the East and Midwest, have seen rapid rises in risk plan enrollment over the last 2 years. Urban areas with the greatest share of national enrollment growth tend to be those where Medicare payments are high. New competition has entered many of these markets, but the newer entrants do not necessarily attract the most new enrollees.

Although nearly 300 risk plans participate in Medicare, risk contracts are concentrated among a few large national firms. Just 12 large national firms enroll over three-fourths of all risk plan enrollees (chart 2-6). The largest firm is Pacificare (including its recent merger partner, FHP) with 21 percent of risk plan enrollees nationwide. Kaiser Permanente, the Blue Cross Blue Shield companies, and Humana are the next largest firms participating in Medicare. The concentration of enrollment appears to be declining, possibly because of the large number of recent new entrants into the program. Countering this trend, however, may be corporate mergers, which tend to increase enrollment concentration.

CHART 2-5. PERCENT OF MEDICARE BENEFICIARIES ENROLLED IN RISK PLANS, BY STATE, JUNE 1997

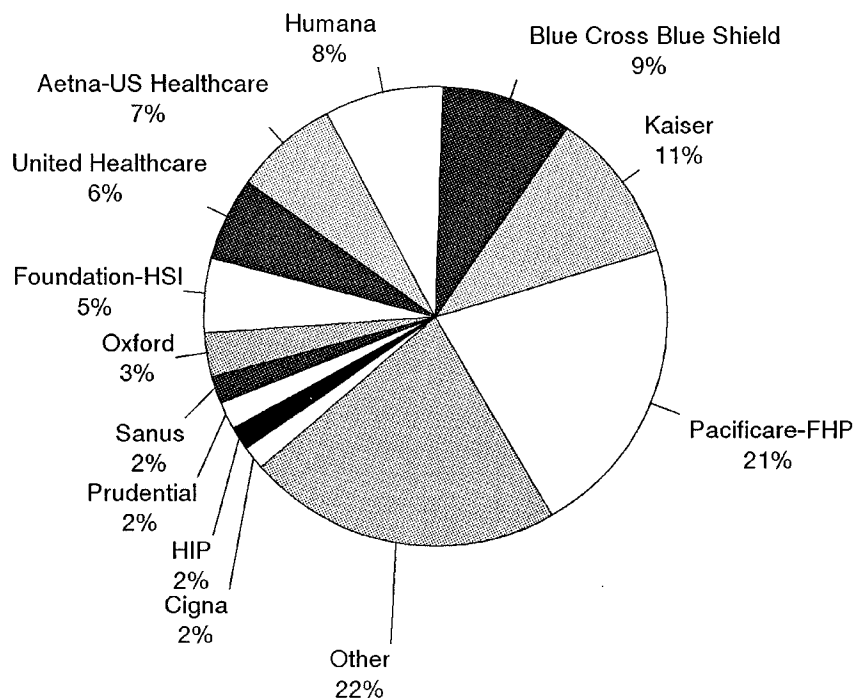


Note: Enrollment in eight States falls in a different category than it would based on HCFA's monthly reports because certain plans serve beneficiaries in States other than where they are located.

Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Health Care Financing Administration enrollment data.

Projections of enrollment show continued growth. Forecasts by the Congressional Budget Office (CBO) suggest enrollment will reach about 34 percent by 2005, modestly above the 29-percent rate projected under prior law.

CHART 2-6. PERCENT OF PLAN ENROLLEES WHO ARE IN RISK PLANS AFFILIATED WITH NATIONAL FIRMS, JUNE 1997



Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Health Care Financing Administration enrollment data.

PLAN OPTIONS AND RULES FOR ENROLLMENT IN MEDICARE+CHOICE

The Balanced Budget Act establishes Medicare+Choice, which will give beneficiaries an expanded array of private plan alternatives to traditional Medicare. Each Medicare+Choice plan will have to provide the same benefits as required under traditional Medicare. Standards for Medicare+Choice plan organization and performance are discussed below. Also discussed below are beneficiary and provider protections.

Plan options

A Medicare+Choice plan can be: (1) a coordinated care plan, (2) a private fee-for-service plan, or (3) on a limited demonstration basis, a combination of a medical savings account (MSA) plan and contributions to a Medicare+Choice MSA.

Coordinated care plans may be offered by an HMO (with or without a point-of-service plan), a PPO, or a PSO. PPOs are generally groups of physicians and hospitals who contract with an insurer or employer to serve a group of enrollees on a fee-for-service basis at

negotiated rates that are lower than those charged to nonenrollees. PPOs do not traditionally have primary care gatekeepers. A PSO is generally a cooperative venture of a group of providers who control its delivery and financial arrangements.

The Balanced Budget Act defines a private fee-for-service plan as a plan that: reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary rates for a provider based on the utilization relating to the provider; and does not restrict the selection of providers among those who are lawfully authorized to provide the covered services, and who agree to accept the terms and conditions of payment established by the plan.

The Balanced Budget Act defines an MSA plan as a plan that reimburses Medicare-covered services after a specified deductible (up to \$6,000) is met. The difference between the premium for the high-deductible plan and applicable Medicare+Choice capitation payment would be placed into an account for the beneficiary to use in meeting his or her expenses below the deductible. The MSA option is offered on a demonstration basis. Up to 390,000 individuals can enroll in MSA plans (specific rules for MSA plans are described below).

As Medicare+Choice begins operation, probably late in 1998, most existing risk and cost-based contracts will be phased out. No new risk contracts may be initiated after Medicare+Choice standards are released, and no risk contracts may be renewed after January 1999. Existing risk-contract plans will be able to convert to Medicare+Choice if they meet the new program requirements. Effective immediately, no new cost-based contracts may be initiated, and most cost-based contracts may not be renewed beyond December 2002.

Enrollment rules for Medicare+Choice

With two exceptions, beneficiaries will be able to enroll in any Medicare+Choice plan that serves their area. The first exception applies to beneficiaries not enrolled in part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the plan.

After a transition period (through 2001) in which individuals are able to make and change elections on an ongoing basis, elections will be made and changed only during an annual coordinated election period. There will also be a 3-month period after making an election in which individuals can change their election (except for a 6-month period in 2002). Additional election periods (called special election periods) will apply for newly eligible Medicare beneficiaries (based on age, but not disability) and beneficiaries who experience certain events; for example, the individual is no longer eligible to participate in a plan because she moves or because the plan has terminated its contract with Medicare. Table 2-28 summarizes the enrollment schedule for Medicare+Choice.

TABLE 2–28.—TRANSITION TO ANNUAL COORDINATED ELECTION OF MEDICARE+CHOICE PLANS

Date	Event
June 1, 1998	Secretary of DHHS must issue regulations implementing standards (other than those for solvency) for Medicare+Choice plans. Medicare+Choice contracts cannot be signed until such standards are in place. Upon signing a contract with DHHS, Medicare+Choice plans begin accepting Medicare beneficiaries on a continuous open enrollment and continuous disenrollment basis.
November 1998	Medicare+Choice Information Fair nationwide coordinated educational and publicity campaign. Individuals can begin enrolling in Medicare+Choice MSAs (with coverage becoming effective January 1, 1999).
January 1, 1999	Current risk contract enrollees are hereafter considered to be enrolled in Medicare+Choice plans. MSA plans begin providing coverage.
November 1999	First coordinated annual election period for Medicare+Choice plans (for coverage becoming effective January 1, 2000) and first mailing of informational materials to all Medicare beneficiaries.
December 31, 2001 ..	Last day of continuous open enrollment/disenrollment during which an individual can change elections an unlimited number of times.
January 1, 2002	First year in which elections become locked in. First 6 months of 2002 is a transition period when an individual can change election only once (other than an election during the coordinated annual election period or in the case of an event qualifying for a special election). Limited exceptions are provided.
December 31, 2002 ..	New elections end for Medicare+Choice MSA plans (unless 390,000 cap is reached prior to this date).
January 1, 2003	New elections become effective the first day of January following each election period. Each year there is a 3-month period when an individual can change election one time. Otherwise, elections cannot be changed until the next annual coordinated election period (unless individual qualifies for special enrollment period). Limited exceptions are provided.

Source: Congressional Research Service analysis of provisions in the Balanced Budget Act of 1997.

Marketing rules

Medicare+Choice organizations and the plans they offer to Medicare beneficiaries must meet certain marketing rules. They will have to submit marketing material to the Secretary at least 45 days before distribution. The material can then be distributed if it is not disapproved by the Secretary (whereas in the previous rules active approval was required). The Secretary is required to disapprove such material if it is inaccurate or misleading. Each organization must conform to fair marketing standards, and must not permit an organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise. The Secretary is permitted to prohibit an organization or its agent from completing any portion of any election form on behalf of any individual.

Information to beneficiaries

The Secretary is required to provide for activities to disseminate broadly information on traditional Medicare and Medicare+Choice plans to current and prospective Medicare beneficiaries. The information has to be comparative in order to help beneficiaries make informed choices among available options. The Secretary is required to conduct an educational and publicity campaign during November 1998 to inform Medicare+Choice individuals about the identity of Medicare+Choice plans and risk contract plans offered in different areas and the election process. As shown in table 2-28, the Secretary is required to provide comprehensive information, including plan comparisons, to beneficiaries every November, beginning with 1999.

Specifically, the Secretary is required to mail to all individuals eligible for Medicare+Choice general and comparative plan information. This mailing must occur at least 15 days before each annual, coordinated election period. (Such information will also be sent to newly eligible beneficiaries in advance of their initial enrollment period.)

The general information is to include: (1) benefits and cost-sharing requirements under the traditional Medicare Program; (2) the procedures for electing traditional Medicare and Medicare+Choice; (3) a general description of procedural rights (including grievance and appeals procedures) for both traditional Medicare and Medicare+Choice; (4) information on benefits and other features of supplemental coverage, including Medigap and Medicare Select; and (5) notice that a Medicare+Choice organization may terminate its contract with Medicare or otherwise cease to be available to an enrolled individual and what would happen in that event.

The comparative plan information for Medicare+Choice will have to include: (1) benefits, cost-sharing requirements, and the extent to which an enrollee may obtain benefits through out-of-network providers; (2) plan premiums; (3) plan service areas; (4) quality and performance information, including disenrollment rates, enrollee satisfaction, health outcomes, and compliance data; (5) supplemental benefits, if any, and their premiums.

The Secretary is required to maintain a toll-free number and internet site to facilitate access to information on Medicare+Choice plans. Nonfederal entities may be used to carry out information activities required under the Balanced Budget Act. The Medicare+Choice organizations will be required to furnish the Secretary with the information needed to enable the Secretary to comply with these requirements.

Medicare+Choice organizations will be required to pay a "user fee" to offset HCFA's costs of providing beneficiaries with comparative plan information, conducting annual information fairs, maintaining the toll-free information number and internet site, and conducting the other activities designed to inform Medicare beneficiaries about their insurance options. This user fee must equal the organization's share (as determined by the Secretary) of the aggregate amount of fees which are appropriated for a fiscal year. The amounts collected are authorized to be appropriated, and are capped at \$200 million in fiscal year 1998; \$150 million in fiscal year 1999; and \$100 million in fiscal year 2000 and subsequent

years. However, Public Law 105–78, providing for appropriations for the Departments of Labor, Health and Human Services, and Education, provides for only \$95 million in user fees for fiscal year 1998. Report language accompanying the legislation suggests that HCFA should give priority in using these funds to: (1) publishing a comparative booklet to be mailed to beneficiaries describing the new Medicare+Choice plans; (2) contracting for a toll-free number and maintaining an internet site for questions about Medicare+Choice options; and (3) operating Medicare+Choice information fairs and funding future dissemination of information through local information centers and other forms of public relations.

Nondiscrimination

Medicare+Choice organizations are required to accept eligible individuals without restriction during election periods (also referred to as open enrollment periods). In general, organizations and plans cannot deny enrollment on the basis of health status related factors. These include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. These provisions do not apply if they will result in enrollment misrepresentative of the Medicare population in the service area. An organization can deny enrollment in the event it has reached the limits of its capacity. Organizations also cannot terminate an enrollee's election except for failure to pay premiums on a timely basis, disruptive behavior, or because the plan ends for all Medicare+Choice enrollees.

PAYMENTS TO PLANS THROUGH 1997

There are two basic components of the risk program payment methodology used through 1997. The first is the actuarial method used to calculate risk plan payment rates each year. The second is the adjusted community rate (ACR) mechanism through which risk contracting plans determine the amount of Medicare noncovered benefits that they will provide to Medicare enrollees and the premiums they are permitted to charge for those benefits. As described below, the Balanced Budget Act made substantial changes in the calculation of plan payment rates, but only modest changes in the ACR mechanism.

Capitation payments to risk contracting plans

Under the old system, Medicare paid risk plans 95 percent of an actuarial projection, at the county level, of what the program would have paid if the beneficiary had remained in the traditional fee-for-service sector. This payment rate was known as the adjusted average per capita cost (AAPCC). The Health Care Financing Administration (HCFA) recalculated AAPCCs every calendar year based on estimates of national average spending, county spending, and beneficiary characteristics.

National Medicare per capita expenditures.—In the first stage of the AAPCC calculation, HCFA actuaries used historical program expenditures to project national per capita program expenditures

for the coming calendar year. These U.S. per capita costs (USPCC) were needed to update historical spending at the county level. Separate projections were made for part A services and part B services for the aged, the disabled, and people with ESRD. These projections took into account expected inflation and changes in utilization patterns and services covered by the Medicare Program. The USPCC was reported in terms of monthly per capita expenditures because risk plans are paid on a monthly basis.

County level Medicare per capita expenditures.—In the second stage, HCFA estimated expected per capita program expenditures for the aged and the disabled in each county, and for people with ESRD in each State. County level per capita spending differed from the national average because of differences in input prices, practice patterns, health status, utilization, and Medicare payments for special purposes such as graduate medical education and support for disproportionate-share hospitals. Risk adjusters were applied to these data to approximate what Medicare per capita spending in the fee-for-service sector would have been in each year if a county had the same demographic characteristics as the nation as a whole. These projected risk-weighted per capita payments are the AAPCC.

Enrollee-level payment to plans.—Finally, HCFA calculated what it would pay a risk plan for each individual enrollee. This payment was based on 95 percent of the AAPCCs for the enrollee's county of residence and was adjusted by national risk adjusters to reflect each enrollee's demographic characteristics, such as age, sex, and whether the person is in a nursing home (see section below on risk adjustment). Medicare also paid plans 95 percent of the State level end-stage renal disease AAPCCs for enrollees with end-stage renal disease.

Payment issues

For several years, certain issues have been raised about the AAPCC-based payment methodology. Payment rates varied widely across the country and from year to year. Risk plans also were paid for graduate medical education and disproportionate-share hospital (DSH) payments that they may not actually have incurred.

Geographic variation and volatility.—Certain policies in place under the old system led to significant variation in risk payments across the country. Nationally, in 1997, AAPCCs ranged from \$221 to \$767. AAPCCs for central urban counties (\$546) and other urban counties (\$436) were higher on average than AAPCCs for rural counties adjacent to urban areas (\$393) or the most rural counties (\$371). Furthermore, because Medicare risk payments were county based, neighboring counties often had substantially different AAPCCs that could not be explained by differences in plan costs. For example, the AAPCC varied by over \$200 per month among the counties adjacent to Chicago or to Washington, DC. These geographic variations in AAPCCs resulted from local differences in fee-for-service Medicare expenditures that in turn reflected service use patterns (both volume and intensity), provider input prices (for example, cost of wages or supplies), and Medicare payments for special purposes (for example, payments for graduate medical education).

In addition, many counties experienced substantial changes in the AAPCC from year to year, despite the use of multiple years of expenditure data to smooth changes in per capita spending. Per capita costs for counties with small Medicare populations fluctuated more over time than per capita costs for counties with larger Medicare populations.

Both the levels of AAPCC-based payment rates and their volatility over time have influenced Medicare risk plan enrollment rates. PPRC's analysis indicated that, in urban counties, the level of payments is one of the important factors influencing enrollment rates, with higher enrollment rates where payment rates are high. Payment volatility appears to have had a weaker but measurable effect, with lower enrollment rates where volatility is high.

Medical education and disproportionate-share payments.—Medicare fee-for-service payments for inpatient hospital stays include payments for direct and indirect medical education costs incurred by teaching hospitals and extra payments to hospitals that serve a disproportionate share of low-income beneficiaries. Under the old payment system, these payments were retained in the expenditures used to calculate the AAPCCs. As a result, an AAPCC reflected a county's average monthly per capita cost for fee-for-service medical education and disproportionate share hospitals. These amounts may not correspond with actual risk plan costs, however, because not all plans have medical education programs or use teaching or disproportionate-share hospitals. Each type of payment averaged about 3 percent of the AAPCC rates overall. The shares of total payments, however, varied across the country.

Payments for services in VA or defense facilities.—In some areas, many Medicare enrollees obtain services from Veterans Administration or Department of Defense facilities. As a result, Medicare expenditures are reduced in these areas. Because the AAPCCs were based on Medicare fee-for-service expenditures, the exclusion of these services meant that the AAPCC did not represent the average service use of Medicare beneficiaries in the fee-for-service sector. The value of the services provided by these non-Medicare Programs averaged about 3 percent of total Medicare per enrollee costs across all States, although it varied substantially across individual States.

MEDICARE+CHOICE PAYMENTS TO PLANS

The Balanced Budget Act substantially restructured the system for setting the rates by which Medicare pays plans. While Medicare+Choice is not yet in place, the Balanced Budget Act requires HCFA to determine 1998 payments to risk plans using the new capitation payment methodology. The rates for 1998, the first to be so calculated, were issued in September 1997.

In general, the program makes monthly payments in advance to each participating health plan for each covered individual in a payment area (typically a county). The Secretary is required to determine annually, and announce by March 1 before the calendar year concerned, the annual Medicare+Choice capitation rate for each payment area, and the risk and other factors to be used in adjusting such rates.

Payments to Medicare+Choice organizations and payments to Medicare+Choice MSAs are made from the Medicare Trust Funds in proportion to the relative weights that benefits under parts A and B represent of Medicare's actuarial value of the total benefits.

Calculation of the payment rate

The major factors for determining Medicare's annual Medicare+Choice capitation rates are summarized in table 2–29. The annual Medicare+Choice capitation rate, for a payment area (for a contract for a calendar year) is set at the highest of three amounts calculated for each county:

- a rate calculated as a blend of an area-specific (local) rate and a national rate,
- a minimum or floor rate, and
- a rate reflecting a minimum increase from the previous year's rate.

Each year, the two components of the blended rate and the floor rate will be updated by a national growth percentage. Each part of the system is described in more detail below.

Blended rates.—The blended capitation rate is designed to shift county rates gradually away from local rates, which reflect the wide variations in fee-for-service costs discussed above, toward a national average rate. Blending is designed to reduce payments in counties where AAPCCs historically have been higher than the national average rate, and to increase payments in counties where AAPCCs have been lower. The blended rate is defined as the sum of:

- a percentage of the annual area-specific Medicare+Choice capitation rate for the year for the payment area, and
- a percentage of the input-price adjusted annual national Medicare+Choice capitation rate for the year.

The area-specific (local) rate is based on the 1997 AAPCC for the payment area with two adjustments. First, the area-specific rate is reduced to remove an amount corresponding to graduate medical education (GME) payments (described below). Second, rates are updated each year by the national growth percentage (described below).

The national rate is the weighted average of all local area-specific rates. This component of the blend is adjusted to reflect differences in certain input prices, such as hospital labor costs, by a formula stated in the law. The Balanced Budget Act allows the Secretary to change the method for making input-price adjustments in the future.

The percentage applied to the area-specific rate will be reduced in increments over 6 years from 90 percent in 1998 to 50 percent in 2003, while the corresponding percentage for the national rate is increased over the same 6 years from 10 percent to 50 percent (table 2–29). In 2003, the blended rate will be based on 50 percent of area-specific costs and 50 percent of national, input-price adjusted costs. Each year, the blended rates may be raised or lowered to achieve budget neutrality (described below).

TABLE 2-29.—MAJOR FACTORS FOR DETERMINING MEDICARE PAYMENTS TO
MEDICARE+CHOICE PLANS

Factor	Rule established in the Balanced Budget Act of 1997	
Blended counties (blend of local and national rates).	General	Transition over 6 years to 50–50 blend of local and national rates. National rates are adjusted for differences in input prices.
	1998	90 percent local, 10 percent national.
	1999	82 percent local, 18 percent national.
	2000	74 percent local, 26 percent national.
	2001	66 percent local, 34 percent national.
	2002	58 percent local, 42 percent national.
	2003 and after	50 percent local, 50 percent national.
Minimum payment ("floor") rate.	1998	Minimum of \$367 or 150 percent of 1997 payment outside the United States.
	1999 and after	Previous year's payment times annual percentage increase.
Minimum percent increase.	1998	102 percent of 1997 payment rate.
Treatment of pay- ments for graduate medical education (GME) and dis- proportionate-share hospitals (DSH).	1999 and after	102 percent of prior year's rate.
		GME payments excluded in equal inter- vals over 5 years. DSH payments not ex- cluded.
Budget neutrality		Total Medicare+Choice payments may not exceed what would have been spent if payments were entirely based on local rates.
Annual percentage increase.	1998	Increase in Medicare per capita expend- itures minus 0.8 percentage points.
	1999–2002	Increase in Medicare per capita expend- itures minus 0.5 percentage points.
	After 2002	Increase in Medicare per capita expend- itures.
Risk adjustment		Payments are adjusted by Secretary to reflect demographic and other factors. Study is to be done of risk adjusters based on health status. Starting 2000, payments are risk adjusted based on Secretary's recommendations.

Source: Congressional Research Service analysis of provisions in the Balanced Budget Act of 1997.

Minimum (floor) rates.—Each county is also subject to a floor rate, designed to raise payment in certain counties more quickly than would occur through the blend alone. The minimum rate is set at \$367 for 1998 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the 1997 payment rate). For subsequent years, this payment amount will be increased by the national growth percentage (described below). In about one-third of all counties, the 1998 payment rate had to be raised to meet the floor.

Minimum percentage increase.—The minimum increase rule protects counties that would otherwise receive only a small (if any) increase. In 1998, the minimum rate for any payment area is 102 percent of its 1997 AAPCC. For subsequent years, it will be 102 percent of its annual Medicare+Choice capitation rate for the previous year.

Exclusion of payments for graduate medical education.—Payments (direct and indirect) for GME are excluded or “carved out” of the payments to Medicare+Choice plans over 5 years. Specifically, in determining the local rate prior to determining the blended rate, amounts attributable to payments for the indirect costs of medical education and for direct graduate medical education costs are deducted from the 1997 payment amount. The amount excluded begins at 20 percent in 1998, rising in equal amounts until it reaches 100 percent in 2002. Payments for disproportionate-share hospitals are not carved out.

National growth percentage.—The national per capita Medicare+Choice growth percentage is defined as the projected per capita increase in total Medicare expenditures minus a specific reduction set in law. In 1998, the reduction is 0.8 percentage points; from 1999 through 2002, it is 0.5 percentage points. There is no reduction after 2002. (Starting with the 1999 rates, adjustments will be made for errors in the previous year’s projection of spending.) The actual national growth percentage for 1998, after the reduction, is 2.6 percent. Estimated growth percentages for the period 1999–2002 have been estimated by CBO to range from about 4–6 percent.

Budget neutrality.—Once the rates are calculated for each county, based on the greatest of the blended rate, floor, and minimum increase, total payments are compared to a budget-neutral amount. A budget neutrality adjustment is applied as necessary to the blended rates to ensure that the aggregate of payments for all payment areas equals that which would have been made if the payment were based on 100 percent of the area-specific capitation rates for each payment area. In no case may rates be reduced below the floor or minimum increase amounts for the particular county. In some years, it may not be possible to achieve budget neutrality because no county rate may be reduced below its floor or minimum increase. The law makes no provision for achieving budget neutrality after all county rates are at the floor or minimum increase. When this situation occurred for the 1998 rates, HCFA chose to waive the budget-neutrality rule rather than one of the other rules.

Rates for disabled and ESRD beneficiaries.—Payment rates for disabled and ESRD beneficiaries are set using a similar method as that for aged beneficiaries except that ESRD rates are calculated on a statewide basis. In particular, the same floor rates also apply to both groups of beneficiaries, even though payments for disabled beneficiaries have been historically 15 percent lower than for aged beneficiaries.

Geographic basis for payment rates.—A Medicare+Choice payment area is defined as a county or equivalent area specified by the Secretary. (In the case of individuals determined to have ESRD, the Medicare+Choice payment area is each State, or other payment

areas as the Secretary specifies.) Upon request of a State for a contract year (beginning after 1998), the Secretary will redefine Medicare+Choice payment areas in all or a portion of the State to: (1) a single statewide payment area; (2) a metropolitan system; or (3) a single payment area consolidating noncontiguous counties (or equivalent areas) within a State.

Special rules for MSA plans.—Special rules will apply for payments to MSA plans. If the monthly premium for an MSA plan (that is, a high deductible plan) for a Medicare+Choice payment area is less than the monthly capitation rate for the area and year involved, the Secretary is required to deposit the difference in a Medicare+Choice MSA established by the individual. For cases when an MSA election was terminated before the end of the year, the Secretary will have to establish a procedure to recover deposits attributable to the remaining months.

Risk adjustment

Actual payments to plans depend on the characteristics of the beneficiaries who enroll. The rate for an enrollee's county of residence (or State in the case of ESRD enrollees) is adjusted by national risk adjusters to reflect each enrollee's demographic characteristics (table 2–30).

TABLE 2–30.—CALCULATION OF RISK PLAN MONTHLY PAYMENT ON BEHALF OF SELECTED BENEFICIARIES, LOS ANGELES COUNTY, CALIFORNIA, 1998

	(Part A rate	×	Part A risk ad- juster)	+	(Part B rate	×	Part B risk ad- juster)	=	Total pay- ment
Male ¹	(\$364.81	×	0.65)	+	(\$270.19	×	0.80)	=	\$453.28
Female ²	(\$364.81	×	2.10)	+	(\$270.19	×	1.65)	=	\$1,211.91

¹ Age 68, non-Medicaid, noninstitutionalized, nonworking.

² Age 87, non-Medicaid, institutionalized, nonworking.

Note.—The monthly payment for an average beneficiary in Los Angeles County is \$635.00.

Source: Medicare Payment Advisory Commission analysis.

The risk adjusters currently in use reflect the relative level of program spending for groups defined on the basis of age, sex, institutional status, Medicaid enrollment, and working aged with employment-based insurance coverage (table 2–31). Disability and ESRD status are handled through separate rates for each county (or State, in the case of ESRD), rather than as a national risk adjuster.

The Physician Payment Review Commission, among others, has presented evidence of significant risk selection in the Medicare managed care program. For the 6 months before enrolling in managed care plans, beneficiaries' costs were 37 percent below those of a fee-for-service comparison group. In the 6 months after disenrolling, beneficiaries' costs were 60 percent above the fee-for-service average (chart 2–7). The current system does a poor job of risk adjustment because the risk adjusters used provide little infor-

mation about beneficiaries' health and explain only 1 percent of the variation in their health case costs.

TABLE 2-31.—MEDICARE RISK ADJUSTERS FOR AGED BENEFICIARIES, 1998

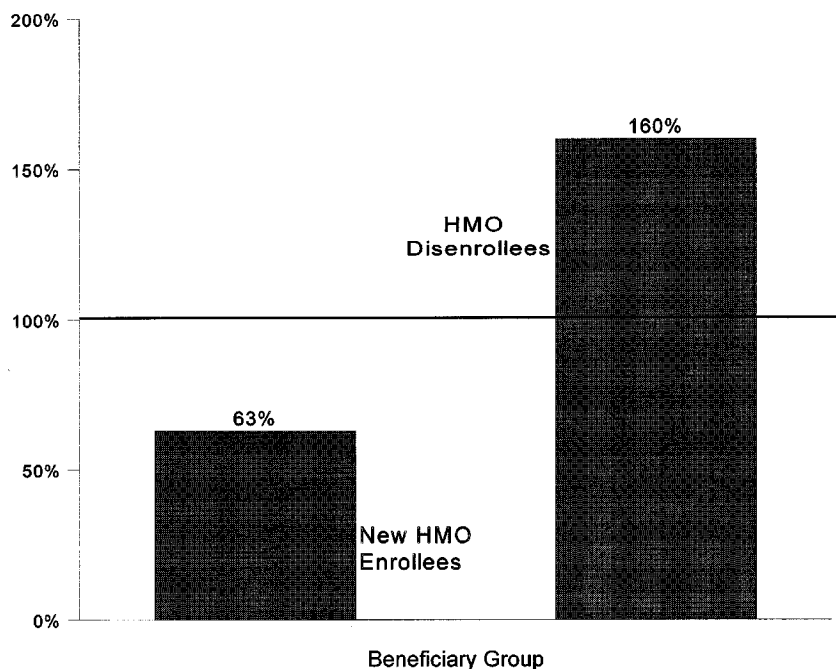
Sex and age group	Institu- tional	Noninstitutional			
		Medicaid	Non- Medicaid	Working aged	
Part A—hospital insurance:					
Male:					
85 and over	2.25	2.60	1.35	0.90	
80–84	2.25	2.35	1.20	0.80	
75–79	2.25	1.95	1.05	0.70	
70–74	2.25	1.50	0.85	0.45	
65–69	1.75	1.15	0.65	0.40	
Female:					
85 and over	2.10	2.10	1.20	0.80	
80–84	2.10	1.70	1.05	0.70	
75–79	2.10	1.45	0.85	0.55	
70–74	1.80	1.05	0.70	0.45	
65–69	1.45	0.80	0.55	0.35	
Part B—supplementary medical insur- ance:					
Male:					
85 and over	1.95	1.70	1.15	1.00	
80–84	1.95	1.70	1.15	0.90	
75–79	1.95	1.55	1.10	0.80	
70–74	1.80	1.35	0.95	0.65	
65–69	1.60	1.10	0.80	0.45	
Female:					
85 and over	1.65	1.25	1.00	0.85	
80–84	1.65	1.25	0.95	0.75	
75–79	1.65	1.25	0.95	0.70	
70–74	1.65	1.15	0.85	0.55	
65–69	1.50	1.05	0.70	0.40	

Note.—Values indicate the multiplier used for a beneficiary with a particular set of characteristics; average beneficiary has a multiplier of 1.00. A separate set of risk adjusters is used for disabled beneficiaries.

Source: Health Care Financing Administration.

By March 1, 1999, the Secretary must submit to Congress a report on a method of risk adjustment of payment rates that accounts for variations in per capita costs based on health status. The Balanced Budget Act calls for the new risk adjustment methodology to be in effect for payments to plans as of January 1, 2000.

CHART 2-7. COSTS AS A PERCENTAGE OF AVERAGE MEDICARE SPENDING PER BENEFICIARY



Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of 1989-94 Medicare claims and denominator files, 5-percent sample.

Unresolved issues for plan payment

As policy changes in the method of paying plans are implemented, several unresolved issues remain. Some issues are relatively technical, such as the absence of any alternative mechanism to achieve budget neutrality in a situation where all rates are reduced to floors or minimum updates. Other issues, among those described above, were not resolved by the Balanced Budget Act of 1997. They include adjustments to local rates for Medicare payments to disproportionate-share hospitals or for services beneficiaries receive from Veterans Administration and Department of Defense facilities, and basing payment on geographic areas larger than counties. Longer range issues include determining whether adequate progress toward reducing variation in rates will result from the rules in the Balanced Budget Act.

COUNTY PAYMENT RATES, 1997-2003

The payment rates used in 1998 are the first to be calculated under the new rules established by the Balanced Budget Act. Based on HCFA's projection of overall Medicare growth, the national growth percentage for 1998 is set to be 2.6 percent for aged

beneficiaries. This amount results from an estimated 3.4 percent Medicare spending growth, less the 0.8-percent reduction required by the Balanced Budget Act. The carve-out for graduate medical education spending for an average county is about 0.8 percent, so the effective average increase in county payment rates, before floors and minimum increases are applied, is 1.8 percent.

After applying the floors and minimum increases, the average county payment rate (weighted by beneficiaries) is \$484, about a 3-percent increase over 1997. The difference between this average and the 1.8-percent increase expected from the formula results from the Balanced Budget Act requirement to create floor rates and minimum increases. The fact that the 1.8-percent increase is below the minimum increase of 2 percent also illustrates why the budget-neutrality requirement could not be met for 1998 rates.

The increases from 1997 to 1998 would have been even lower under the policy that was replaced by the Balanced Budget Act. This is because the Balanced Budget Act did not provide for a correction for HCFA's overprojection of 1997 spending a year earlier. Had such a correction been applied, the 1997 base rates used as the starting point for the calculation of 1998 monthly county rates would have been lower by an average of about \$10. After the statutory reduction, the effective national growth percentage would then have been 0.3 percent instead of 2.6 percent.

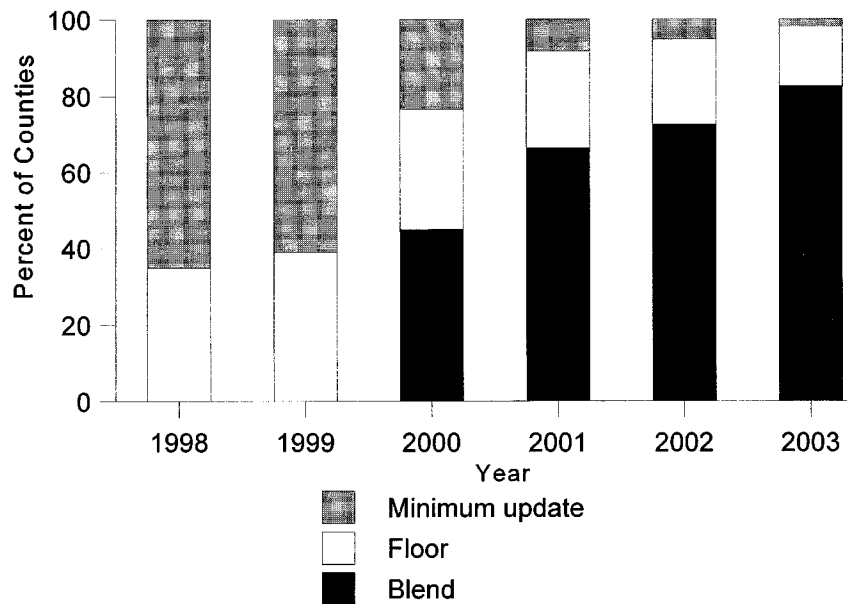
As noted above, each county rate is set at the greatest of the amounts calculated under three rules—its blended rate, minimum increase, and floor. Because of the low national growth percentage in 1998, no county rate will be set by the blended rate rule. About one-third of all counties are set at the floor, with the rest receiving the minimum 2-percent increase (chart 2-8).

Sample calculations show how the rates are determined (table 2-32). After the initial calculation of rates under the three rules (blended, floor, and minimum increase) but before budget neutrality, the rates are set simply at the highest of these three amounts. Among the sample counties shown in the table, there are two counties whose rates are determined by each rule. The budget-neutrality adjustment only applies to the counties whose rates are set by the blended-rate rule (Hennepin and Fairfax Counties in table 2-32) because rates may never fall below the rates set by the other two rules. The 1998 rates for such counties were reduced below where they would have been by about 1-2 percent because of this adjustment. Had the budget-neutrality adjustment been smaller, then rates for these counties would have been set between the blended and minimum-increase amounts.

Geographic variations

Large variation in county payment rates was one of the motivating forces behind some of the changes enacted in the Balanced Budget Act. The establishment of a floor rate removed some of the greatest variation. The combination of the low national growth percentage and the budget-neutrality rule, however, delayed the application of the blended-rate rule. Only when county rates are more heavily based on the national component of the blend will more of the county variation be reduced.

CHART 2-8. RULE USED TO DETERMINE COUNTY PAYMENT RATES, BY YEAR, 1998–2003



Note: Analysis based on actual rates for 1998 and simulated rates for 1999–2003, using dynamic enrollment growth assumptions.

Source: Medicare Payment Advisory Commission simulations of payment rates under the Balanced Budget Act of 1997.

TABLE 2-32.—CALCULATION OF MONTHLY PAYMENT RATES FOR SAMPLE COUNTIES, 1998

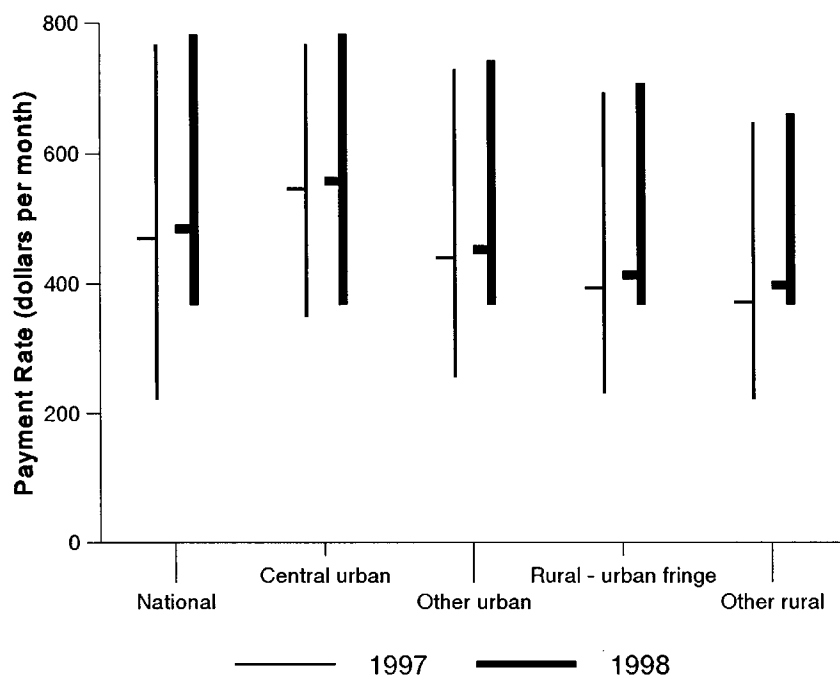
County	1997 actual rate	Calculation under separate rule			Determination of rate	
		Minimum update	Floor	Blend (90:10)	Before budget neutrality adjustment	Actual rate (after budget neutrality adjustment)
Los Angeles, CA ..	622.55	635.00	367.00	625.92	635.00	635.00
Dade, FL	748.23	763.19	367.00	737.10	763.19	763.19
Hennepin, MN	405.63	413.74	367.00	419.34	419.34	413.74
Fairfax, VA	400.54	408.55	367.00	417.44	417.44	408.55
Arthur, NE	220.92	225.34	367.00	244.89	367.00	367.00
Presidio, TX	229.70	234.29	367.00	255.58	367.00	367.00

Note.—Before budget-neutrality adjustments are applied, county rates are determined by the highest of the three rates calculated under separate rules. In 1998, the budget-neutrality adjustment lowered all blended rates so that they were no higher than the minimum update or floor rates. As a result, rates for Hennepin and Fairfax Counties were set by the minimum update rule instead of the blend rule.

Source: Medicare Payment Advisory Commission analysis.

Across the counties, there is a substantial range above and below the average payment rate (chart 2-9). For 1997, the lowest rates in the country were \$221 in two rural Nebraska counties (Arthur and Banner). The highest rates in 1997 were \$767 and \$748, respectively, in Richmond County, New York (Staten Island), and Dade County, Florida (Miami). In 1998 the floor rate brings the national minimum rate (excluding territories) up to \$367, while the highest rate (Richmond County) rises to \$783. Despite these extreme values, about half of all beneficiaries live in counties with 1998 rates between about \$400 and \$540.

CHART 2-9. MEAN, MINIMUM, AND MAXIMUM COUNTY PAYMENT RATES, BY LOCATION, 1997-98



Note: The tick mark on each bar indicates the mean county payment rate (weighted by the number of beneficiaries in each county). The length of each bar represents the range of payment rates.

Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of payment rates under the Balanced Budget Act of 1997.

Regionally, payment varies considerably, with higher payments generally in more urbanized areas (chart 2-9). The 1998 floor mostly affects rural counties, but it raises rates for some urban counties as well. Since all counties not affected by the floor get the same increase for 1998 (that is, 2 percent), payment rates will continue to be higher in urban areas and lowest in the most rural areas. The

average payment in central urban counties is more than \$100 above that for other urban counties and nearly \$160 above that for rural counties. The range within each of the urban-rural categories remains substantial as well.

Payment rates range widely across markets as well as across counties. For example, plans serving southern Florida will be paid an average of \$675 per month in 1998, compared with \$409 in Minneapolis-St. Paul (table 2-33). Moreover, within some markets that encompass more than one county, the range of monthly payment rates across counties is \$200 or greater. Plans competing in the same market may receive substantially different payments for beneficiaries who live on opposite sides of a county boundary. These differing payment levels appear to affect plan participation and enrollment. The Balanced Budget Act will eventually reduce some of this variation, but generally not until increases are high enough to support blended rates. Among the largest markets, the only significant compression of variation for 1998 occurs in Minneapolis-St. Paul, where many suburban counties have rates raised to the \$367 floor.

TABLE 2-33.—MONTHLY PAYMENT RATES FOR AGED ENROLLEES IN SELECTED AREAS, 1998

County	Payment rate
Washington, DC-Maryland-Virginia:	
Prince George's County, MD	\$614
Washington, DC	596
Montgomery County, MD	501
Arlington County, VA	460
Falls Church City, VA	456
Alexandria City, VA	456
Fairfax City, VA	425
Loudoun, VA	422
Fairfax County, VA	409
Minneapolis-St. Paul, MN metro area:	
Ramsay (St. Paul)	431
Hennepin (Minneapolis)	414
Anoka	403
Dakota	387
Washington	373
Carver	367
Scott	367
Southern Florida:	
Dade (Miami)	763
Broward (Ft. Lauderdale)	663
Palm Beach	577
Southern California:	
Los Angeles	635
Orange	584
San Bernardino	544
Riverside	526

Source: Health Care Financing Administration.

Impact of reforms beyond 1998

This section uses the results of simulations conducted by MedPAC to assess the impact of the new payment rules established by the Balanced Budget Act. These simulations incorporate the published 1998 rates and simulated rates from 1999 to 2003, using CBO's assumptions about spending growth to set the annual national growth percentage. Dynamic assumptions about enrollment growth are incorporated into these simulations, that is, it is assumed that enrollment will respond to changes in payment rates leading to a different distribution of plan enrollment across the United States (regardless of how much the level of enrollment changes).

Source of payment rate determination.—Based on projections by MedPAC, it appears that there may be no counties with rates set by the blended rate rule in 1999, the same result as in 1998. This result assumes that the projected national growth percentage for 1999 will be too low to achieve budget neutrality and that at least some enrollment is shifting to counties affected by the floor rate or the minimum increase.

Starting in 2000, the national growth percentage is projected to be high enough to pay for increased enrollment in counties where rates have been raised to the floor or minimum increase and still support some higher blended rates. By 2003, when all transitions are complete, over 80 percent of all counties are projected to be at their blended rates, with 2 percent raised to the minimum increase and 16 percent raised to the floor rate (chart 2–8).

Once the various phased-in changes (blended percentages and phasing out of GME payments) are complete in 2003, the projection is that 16 percent of counties will remain at floor rates unless the Congress makes further changes in the payment methodology. This result occurs because floor rates and blended rates grow each year by the same amount.

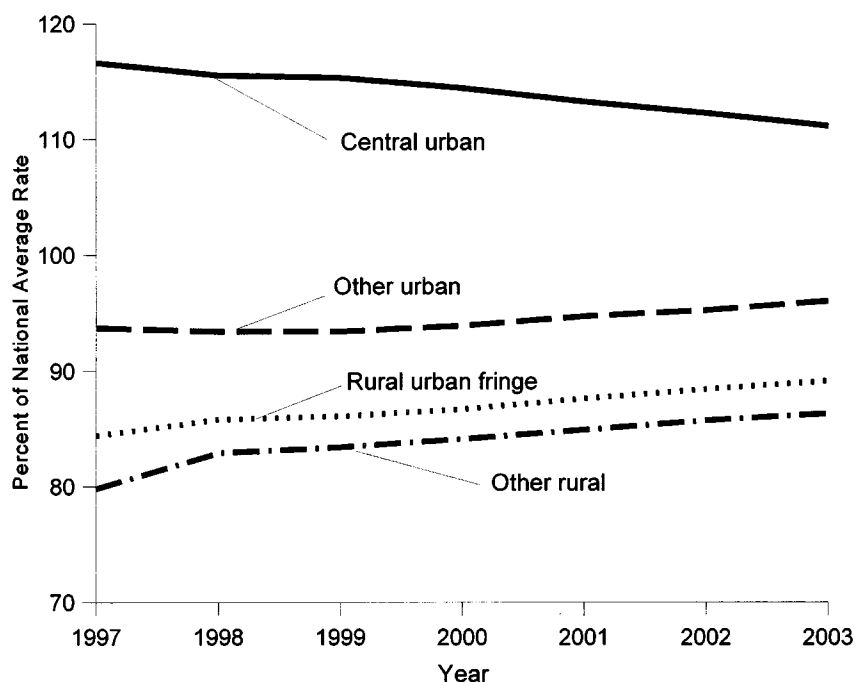
The small number of counties that are still affected by the minimum increase in 2003 (2 percent of all counties) should in the future receive blended rates, given no further shift in the blend proportions. As long as the national growth percentage is greater than 2 percent, blended rates for these counties will eventually rise above the minimum increase.

Reducing volatility in payments.—The Balanced Budget Act effectively eliminates the year-to-year volatility inherent in county payment rates under the old rules. In 1998, the \$367 floor rate caused volatility in the sense that rates for many counties rose dramatically to achieve that floor. But, from 1999 to 2003, as various changes are phased in, county rates generally will increase by a minimum of 2 percent each year and a maximum of about 2 percentage points above the national growth percentage that year. The differences among counties reflect the relative magnitudes of such factors as the amount of GME payments being excluded and the input-price adjustments (for example, hospital wages). After 2003, all county rates will increase uniformly by the national growth percentage (except for those few counties still affected by the minimum-increase rule).

Reducing variation in payments.—The rate system in the Balanced Budget Act will reduce the amount of variation occurring

under current law (chart 2-10). Although central urban counties remain on average substantially above the national average and all other types of counties remain below, the range is reduced over the first 5 years of new rates. In the first year, the only source for reducing variation is the use of the floor rate, since all other county rates are increased by a uniform 2 percent. Floor rates apply to about half of the most rural counties and to decreasing proportions of counties in the more urban categories.

CHART 2-10. EFFECT OF NEW RATES ON REGIONAL VARIATION, USING DYNAMIC ENROLLMENT GROWTH ASSUMPTIONS, 1997-2003



Note: Analysis based on actual rates for 1998 and simulated rates for 1999-2003.

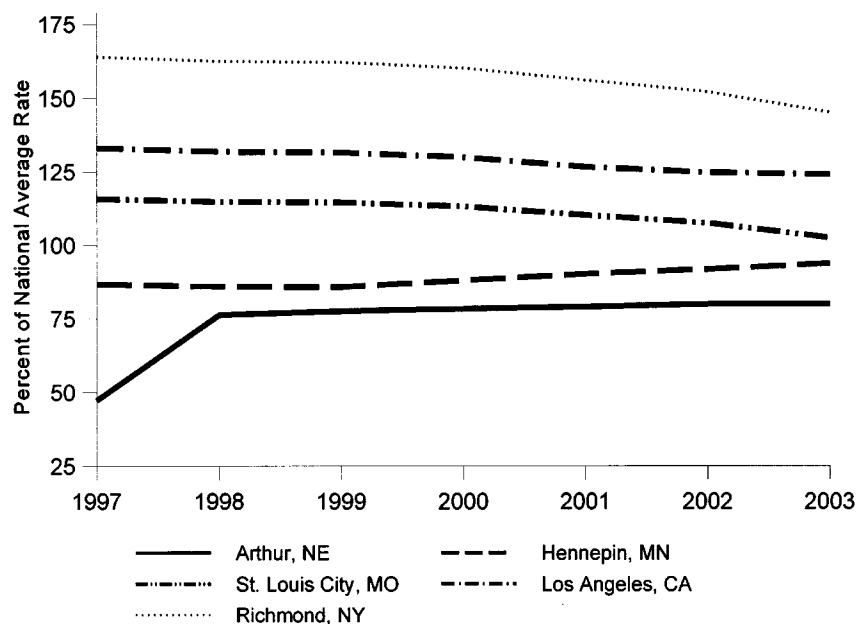
Source: Medicare Payment Advisory Commission simulations of payment rates under the Balanced Budget Act of 1997.

At the individual county level, changes can be more dramatic (chart 2-11). As a proportion of the national average rate, those rural counties paid at very low rates (for example, Arthur County, Nebraska) will get a big increase the first year, then stay at just under 80 percent of the national average. Counties with historically high rates (for example, Richmond County, New York) will get only a 2-percent increase each year and thus fall from nearly two-thirds above the national rate to only 50 percent above it. Other counties converge toward rates driven by local input-price variations.

The degree to which variation is reduced is influenced by at least two factors. First, the low national growth percentages projected

for Medicare+Choice combined with the guaranteed 2-percent increase limit the influence of the blended rates. Second, stopping the blended rates at a 50–50 blend, together with the appropriate application of input-price adjustments, limits the potential for convergence toward a national rate.

CHART 2–11. EFFECT OF NEW RATES ON COUNTY VARIATION, 1997–2003, USING DYNAMIC ENROLLMENT GROWTH ASSUMPTIONS



Note: Analysis based on actual rates for 1998 and simulated rates for 1999–2003.

Source: Medicare Payment Advisory Commission simulations of payment rates under the Balanced Budget Act of 1997.

ADJUSTED COMMUNITY RATE (ACR)

The adjusted community rate mechanism is a process through which health plans determine the minimum amount of Medicare noncovered benefits they are required to provide to Medicare enrollees and the premiums they are permitted to charge for those benefits. This system, which has been in place for the Risk Contract Program, will continue with only a few changes under Medicare+Choice. HCFA, however, is considering administrative changes to this system.

No later than May 1 of each year, each Medicare+Choice organization is required to submit to the Secretary for each of its Medicare+Choice plans specific information about premiums, cost sharing, and additional benefits (if any). Under Medicare's rules, a

plan may not earn a higher return from its Medicare business than it does in the commercial market. The Secretary will be required to review this information and approve or disapprove the premiums, cost-sharing amounts, and benefits. The Secretary will not have the authority to review the premiums for either MSA plans or private fee-for-service plans.

Beneficiaries are expected to share in any projected cost savings between Medicare's capitation payment to a plan and what it would cost the plan to provide Medicare benefits to its commercial enrollees. To accomplish this, a plan must provide additional benefits and reduced cost sharing to its enrollees. A plan is also permitted to offer extra benefits, known as supplemental benefits, beyond those required by the ACR mechanism.

The ACR process requires a plan to use its costs and revenues from its commercial business to estimate the cost of providing services to Medicare enrollees. These costs are adjusted to reflect differences between Medicare and commercial enrollees with regard to both utilization of services and the range of covered benefits. The plan's commercial revenues are used to calculate an allowance for administrative costs and profits.

As with medical costs, the allowance for administrative costs and profits for Medicare-covered services provided to Medicare enrollees is calculated by applying the ratio of administrative to direct patient care expenses for commercial enrollees. This provides plans with expected profits on Medicare enrollees that probably are comparable in percentage terms to profits on commercial members, but substantially larger in terms of dollars per member.

In the first year of Medicare participation, plans may use utilization factors provided by HCFA or obtained from other sources. In subsequent years, plans are supposed to use factors based on their own utilization data. Because the Balanced Budget Act drops the existing requirement that at least half of a plan's enrollment be commercial (the 50-50 rule), procedures will be created to calculate the ACR for plans without such enrollment.

REQUIRED NONCOVERED SERVICES

Plans must provide additional benefits or reduced premiums to Medicare enrollees valued at the difference between the projected cost of providing Medicare services and expected revenue for Medicare enrollees. HCFA calls this difference between expected Medicare costs and revenues "savings." These savings are distributed to Medicare enrollees in the form of additional benefits either as services or as reduced cost sharing (table 2-34).

Plans calculate the cost of providing Medicare noncovered services to make up this difference between their expected revenues and costs in the same way they determine their costs of providing Medicare covered services. They choose which additional benefits to offer. The total cost of these additional benefits must at least equal the "savings" on Medicare-covered services (table 2-34).

Allowable cost sharing

Plans are permitted to charge Medicare enrollees the expected cost of additional benefits (that is, Medicare noncovered services beyond the amount required to spend the savings) plus the na-

tional average amount of beneficiary cost sharing for Medicare-covered services. Plans can collect these payments through a combination of copayments and premiums. Premiums cannot exceed the difference between total allowable beneficiary cost sharing and expected copayments. Plans may choose to waive part or all of this allowable premium for all enrollees. Thus, plans report on the ACR proposal the maximum premium that will be charged to any Medicare enrollee (table 2–34).

TABLE 2–34.—CALCULATION OF ADJUSTED COMMUNITY RATE AND MAXIMUM MONTHLY PREMIUM USING NATIONAL AVERAGE AMOUNTS, 1995

Component	Weighted average
Cost of covered benefits and administrative overhead	\$433.14
Less average fee-for-service cost sharing	– 65.08
Adjusted community rate (ACR)	368.06
Average Medicare payment rate	409.97
Less ACR	– 368.06
“Savings”	41.91
Additional benefits	35.02
Net waived cost sharing	+51.59
Less “savings”	– 41.91
Maximum monthly premium	44.70
Monthly premium to be charged	17.65
Waived monthly premium	27.05

Note.—Weighted averages are based on the number of enrollees in each risk plan.

Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of adjusted community rate proposal data from the Health Care Financing Administration.

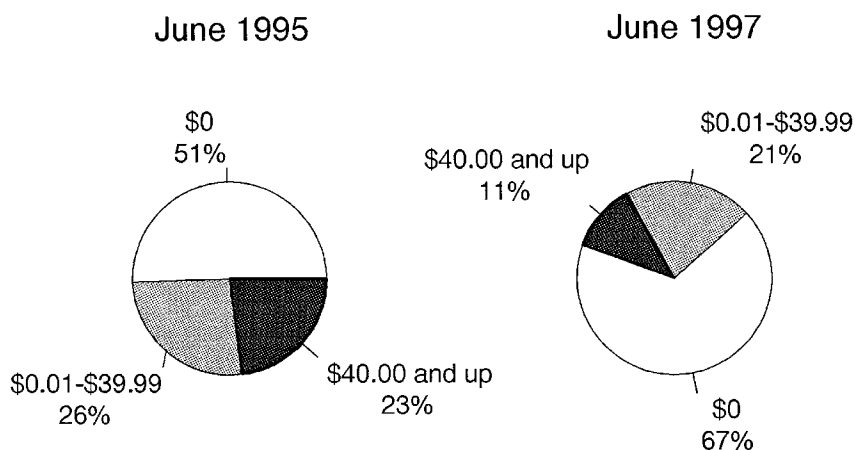
Differences for private fee-for-service and MSA plans

For private fee-for-service plans, most of the same rules apply as for other Medicare+Choice plans. For example, they must provide additional benefits to beneficiaries in the amount of the savings calculated through the ACR. Allowable cost sharing (not including premiums) cannot exceed the comparable cost sharing in traditional Medicare. But there is no limit on the additional premium charged by these plans. For MSA plans, there are no restrictions provided through the ACR process. These plans must submit information on premiums charged, but no review or approval by the Secretary is required.

ADDITIONAL BENEFITS AND PREMIUMS IN THE MEDICARE RISK PROGRAM

Although plans may charge premiums to enrollees, about two-thirds of plans do not do so for their basic package (chart 2-12). These are commonly referred to as zero-premium plans. The proportion of zero-premium plans increased by about one-third in the past 2 years. One in nine plans charges a monthly premium of over \$40 for their basic package. (Plans may charge higher premiums for high-option packages that include more extensive benefits.)

CHART 2-12. DISTRIBUTION OF MEDICARE RISK PLANS BY PREMIUMS CHARGED, 1995 AND 1997



Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Medicare Managed Care Contract Reports.

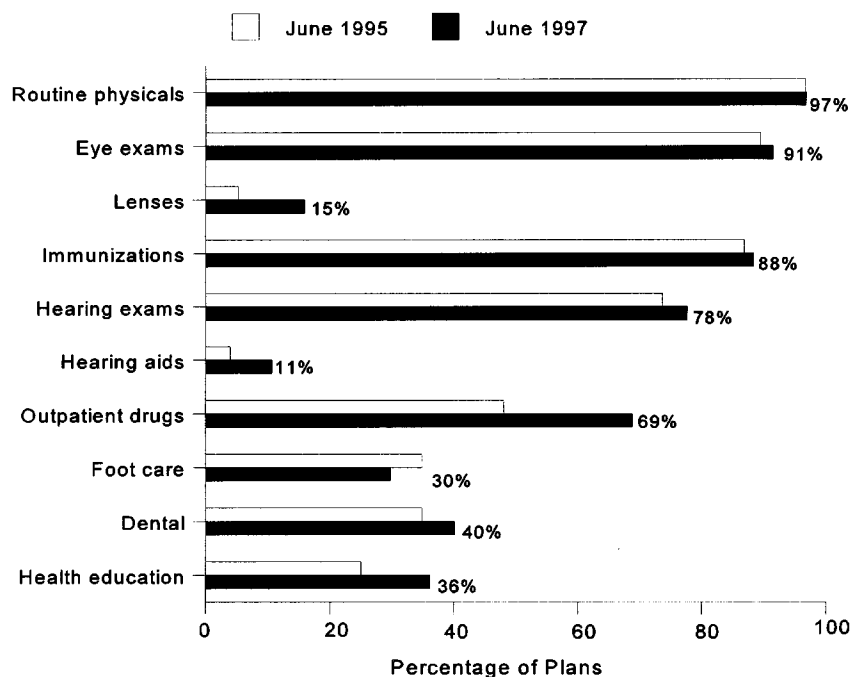
At least two reasons explain why a risk plan may offer a zero-premium plan. The first is that Medicare's capitation payment to a plan exceeds its costs (a "savings" in the terms of the ACR) and the plan chooses to add only enough benefits to match the savings. In this case, no premium would be allowable under the ACR rules. The second is that a plan is allowed to charge a premium to cover the cost of the total benefits offered, but the plan waives its premium to stay competitive in its local market. In the latter case, the plan may not be at risk of taking a loss on its Medicare business because profits and overhead based on commercial rates are included in its allowed costs under the ACR calculation.

Nearly all plans offer some additional benefits to enrollees beyond those in traditional Medicare (chart 2-13). These include both required benefits offered to meet ACR rules and optional benefits the plan chooses to offer. Benefits widely available include routine physicals, eye exams, and immunizations. Two-thirds of plans offer some outpatient drug coverage as an additional benefit in their

basic package. In addition, about half of plans offer a high-option package that may include more extensive benefits.

The ACR data allow analysis of patterns in the availability of additional benefits. Risk plans with the most generous packages in 1996 served areas having above-average payment rates. They also expected to incur below-average costs in providing Medicare benefits (table 2-35). For example, plans that offered the richest packages served counties where payment rates were 17 percent above average, and they projected costs 7 percent below average. By contrast, plans offering the fewest extra benefits anticipated below-average payment rates and projected costs 3 percent above average.

CHART 2-13. PERCENTAGE OF MEDICARE RISK PLANS OFFERING ADDITIONAL BENEFITS IN THEIR BASIC OPTION PACKAGE, JUNE 1995 AND JUNE 1997



Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of Medicare Managed Care Contract Reports, June 1995 and June 1997.

At the market level, similar patterns appear. In Miami, which has one of the highest payment rates in the country, plans had an average Medicare savings of over \$100 per month for 1995, meaning that they were required to provide this amount to beneficiaries in benefits (table 2-36). Including optional benefits, they provided a total of over \$125 in benefits for no premium. Where Medicare payment rates were lower, plans typically provided fewer benefits.

TABLE 2-35.—CHARACTERISTICS OF MEDICARE RISK PLANS RANKED BY VALUE OF EXTRA BENEFITS, 1996

Decile	Average		
	Standardized extra benefits	Plan payment index	Cost index
All	\$ 77	1.00	1.00
10 (highest)	148	1.17	0.93
9	111	1.06	0.96
8	99	1.03	0.99
7	90	1.03	0.96
6	82	1.02	1.01
5	73	1.06	1.09
4	60	0.92	1.04
3	51	0.92	1.02
2	39	0.91	0.97
1 (lowest)	15	0.87	1.03

Note.—Extra benefits are the sum of any savings and the amount of waived premium, standardized by the Medicare hospital wage index for the risk plan's service area. They are expressed as per member per month values. The decile averages are for 10 equal-sized groups of plans, ranked by the value of extra benefits.

Source: Prospective Payment Assessment Commission (now Medicare Payment Advisory Commission) analysis of adjusted community rate proposal data from the Health Care Financing Administration.

TABLE 2-36.—RISK-PLAN BENEFITS AND MONTHLY PREMIUMS BASED ON ADJUSTED COMMUNITY RATE PROPOSALS BY MARKET, 1995

[Dollars per month]

Primary metropolitan statistical area	Number of plans	Medicare payment	Required benefit value	Optional benefit value	Premium charged
United States	174	\$382.27	\$25.17	\$56.67	\$22.04
Boston	8	360.06	4.09	71.56	47.84
Chicago	3	418.79	24.45	38.31	0.00
Los Angeles	13	462.88	68.83	37.18	6.08
Miami	8	488.65	106.27	20.75	0.00
Minneapolis	3	333.93	0.00	75.89	60.97
New York	5	465.95	53.37	46.77	8.80
Philadelphia	6	434.12	19.30	66.85	10.00
Portland, OR	7	315.07	9.38	64.52	46.00
San Francisco	8	390.51	21.50	56.96	20.25
Nonmetropolitan California	6	369.00	14.43	60.19	31.08
Nonmetropolitan Florida	5	353.36	12.46	73.61	9.80
Nonmetropolitan Pennsylvania ..	3	402.32	6.70	62.18	18.14

Note.—Required benefit value is equal to Medicare savings in the adjusted community rate proposal; optional benefit value is equal to the maximum monthly premium. Values are unweighted averages of all Medicare risk plans.

Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of 1995 adjusted community rate proposal data from the Health Care Financing Administration.

In Minneapolis, for example, plans' revenues matched their adjusted costs, so that beneficiaries received no required additional benefits in 1995. Plans offered \$76 in optional benefits, but charged a \$61 premium.

BENEFICIARY PROTECTIONS

Risk contract plans currently operating under section 1876 of the Social Security Act must comply with requirements designed to limit beneficiaries' financial liability and to assure beneficiaries of certain rights and remedies. Most of these requirements have been included and expanded in the new Medicare+Choice Program. A few of the areas in which there are significant differences between the risk plan requirements and those for Medicare+Choice relate to beneficiary liability, access to emergency medical services, and quality assurance. In addition, the Medicare+Choice requirements largely incorporate procedures for expedited review of coverage denials that were issued by HCFA in final regulations on April 30, 1997.

Beneficiary financial liability

Enrollees currently in risk plans pay the part B premium and have the same balance billing protections as beneficiaries under traditional Medicare, so long as they do not obtain unauthorized services from a provider that is not part of the plan's network. Under traditional (fee-for-service) Medicare, for example, hospitals must accept Medicare's payment as payment in full for inpatient services except for required beneficiary cost sharing. Similarly, participating physicians agree to accept Medicare's payment amount as payment in full. They can only bill patients for the coinsurance and any unmet deductible. Physicians who are not "participating" physicians in the Medicare Program, and who do not accept Medicare's payment as payment in full, can bill beneficiaries only 15 percent above Medicare's recognized payment amount. (Medicare's recognized payment for these physicians is actually 95 percent of the fee schedule amount for the service.) The amount in excess of Medicare's recognized payment amount is known as "balance billing." Balance billing limits do not apply to certain services (for example, durable medical equipment).

In the new program, all Medicare+Choice enrollees will continue to pay the part B premium. Additional beneficiary out-of-pocket liabilities will differ depending on the type of Medicare+Choice plan the individual elects (table 2-37). The rules for beneficiary financial liability apply to the basic benefit package and required additional benefits. The basic benefit package includes benefits required under traditional Medicare. Medicare+Choice plans might also have to cover additional benefits as part of the basic package if their capitation payment exceeds the estimate of the amount it would cost them to cover Medicare's benefits for a commercial population (as described in the section on the adjusted community rate).

TABLE 2–37.—BENEFICIARY COST SHARING AND PROVIDER REIMBURSEMENT UNDER MEDICARE+CHOICE PLANS FOR BASIC BENEFIT PACKAGE

Item	Coordinated care plan	Private fee-for-service plan	MSA plan
Beneficiary out-of-pocket costs (premium plus any deductibles, co-insurance, and copayments).	Premium and actuarial value of other cost sharing (for example, coinsurance) on average cannot exceed the actuarial value of the cost sharing applicable on average under traditional Medicare.	The actuarial value of the cost sharing (not including the premium) on average cannot exceed the actuarial value of cost sharing on average under traditional Medicare.	A deductible of no more than \$6,000 (indexed for inflation). Amounts above traditional Medicare payments (including coinsurance) do not have to be counted toward satisfying the deductible. Once deductible is met, MSA plan would have to pay for all Medicare-covered expenses including cost sharing. Plans are allowed to charge beneficiary for services not covered by Medicare (for example, very long hospital stays or experimental treatments).
Beneficiary liability for balance billing.	Beneficiaries are not liable for any balance billing amounts.	Contract providers can bill 15 percent above the private fee schedule (or other provider reimbursement amount). Noncontract providers cannot balance bill beneficiaries.	Balance billing is allowed and would not be subject to any limits, regardless of whether the deductible has been met.

Medicare+Choice plan payment obligation to physicians, hospitals, and other providers.	Contract providers are paid fees or rates that are privately negotiated by the plan with them. Noncontract providers must accept as payment in full Medicare's fee schedule (or other Medicare reimbursement rate) including the allowed balance billing amounts (if any) allowed under Medicare.	Contract providers are paid private fees (or rates) minus beneficiary cost sharing amounts. Fee schedule or rates must be as generous as Medicare unless plan has a sufficient number and range of provider contracts. Noncontract providers same as for noncontract providers in coordinated care plans.	Above the deductible, plan reimburses provider for traditional Medicare amounts including coinsurance.
Medicare+Choice payments received by physicians, hospitals, and other providers.	Contract providers receive payments based on a privately negotiated fee schedule. Noncontract providers receive payments based on traditional Medicare payment systems, including allowable balance billing (paid by the plan).	Contract providers receive payments based on a private fee schedule and can collect up to 15 percent additional from the beneficiary. Noncontract providers same as for noncontract providers in coordinated care plans.	Providers receive payments based on their charges. After the beneficiary's deductible is met, the plan's payment is based on traditional Medicare payment systems, but unlimited balance billing is allowed.

Source: Congressional Research Service and Medicare Payment Advisory Commission analysis of provisions in the Balanced Budget Act of 1997.

Enrollees in Medicare+Choice coordinated care plans are likely to experience the least amount of out-of-pocket costs (compared to other Medicare+Choice options). For them, the amount of cost sharing per enrollee (including premium) for covered services can be no more than the actuarial value of the deductibles, coinsurance, and copayments under traditional Medicare. Neither a contracting nor a noncontracting physician, hospital, or other provider can impose balance billing charges on coordinated care enrollees. Coordinated care plans will have to pay noncontracting providers at least the same amount they would have received if the enrollee was in traditional Medicare, including allowed balance billing amounts.

The rules for private fee-for-service plans and MSA plans are different (table 2–37). Generally, contract providers will be allowed to bill enrollees in private fee-for-service plans up to 15 percent above the fee schedule the plan uses. In contrast to traditional Medicare, this privilege extends to all categories of providers, including hospitals. The term “contract provider” refers to providers who have entered into an explicit agreement with a plan establishing payment amounts for services rendered to the plan’s enrollees. A provider can be deemed to have a contract with a Medicare+Choice private fee-for-service plan if, before furnishing services to the enrollee of such a plan, the provider: (1) received a notice of the individual’s enrollment in a private fee-for-service plan and had been informed of the terms and conditions of the plan’s payment or (2) if the provider was given reasonable opportunity to obtain such information. For MSA plans, unlimited balance billing is allowed, regardless of whether the deductible has been met. Plans could determine whether they count these amounts toward the deductible.

Access to emergency services

Each Medicare+Choice plan must ensure access to emergency services for emergency medical conditions. The so-called prudent layperson definition will apply. This definition states that an emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy (and in case of a pregnant women, her health or that of her unborn child); (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Quality standards

In the current risk program, a risk plan is required to have arrangements for an ongoing quality assurance program that stresses health outcomes and provides review by physicians and other health care professionals of the process followed in providing health services. External review is conducted by a peer review organization (PRO) or similar organization that contracts with the Secretary to do review of specified Medicare services. Such reviews cover both inpatient and outpatient care. The Secretary also has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided and the facilities of the or-

ganization when there is reasonable evidence of some need for inspection.

In the new program, Medicare+Choice organizations and plans must have a quality assurance program that: (1) stresses health outcomes and provides data permitting measurement of outcomes and other indices of quality; (2) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; (3) evaluates the continuity and coordination of care that enrollees receive; (4) is evaluated on an ongoing basis as to its effectiveness; (5) includes measures of consumer satisfaction, and (6) provides the Secretary with certain information to monitor and evaluate the plan's quality. Only coordinated care plans (and not private fee-for-service and nonnetwork MSA plans) will have to comply with other quality assurance requirements, such as providing for internal peer review, establishing written protocols for utilization review, and establishing mechanisms to detect under and over utilization.

Most Medicare+Choice organizations must obtain external review of the quality of their inpatient and outpatient services and of their response to written complaints about poor quality of care from an independent quality review and improvement organization (such as a PRO). In addition, the external review requirement does not apply to private fee-for-service plans and nonnetwork MSA plans that do not have utilization review programs. However, the Secretary is required to ensure that the external review activities do not duplicate the review activities conducted as part of the accreditation process. Also, the Secretary may waive the external review requirement if she determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other Medicare+Choice requirements. Plans may be deemed to have met all these requirements if they are accredited by an organization whose accreditations are no less stringent than Medicare's.

Grievances and appeals

A Medicare+Choice organization must have meaningful procedures for hearing and resolving grievances between the organization and enrollees. It also must maintain a process for determining whether an individual enrolled within the plan is entitled to receive a health service and the amount (if any) that the individual must pay for the service. These determinations must be made on a timely basis, appropriate to the urgency of the situation. The explanation of the determination must be in understandable language and state the reasons for the denial. A description of the reconsideration and appeals processes must be provided.

Upon request by the enrollee, the organization generally will have to provide for reconsideration of a determination. The reconsideration must occur within a time period specified by the Secretary, but (except where an expedited process is appropriate) no longer than 60 days after receipt of the request. A reconsideration of a denial of coverage based on lack of medical necessity must be made by a physician with appropriate expertise who was not involved in the initial determination.

An enrollee in a Medicare+Choice plan or a physician will be able to request an expedited determination or reconsideration. If the request is made by a physician, a Medicare+Choice organization is required to expedite the determination or reconsideration if the request indicates that the normal time frame for making the determination or reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The time limits for the organization to respond to the request will be established by the Secretary but must be within 72 hours of receipt of the request.

PLAN STANDARDS

Current program standards and contractor requirements

Under the existing program, managed care organizations seeking to enroll Medicare beneficiaries must meet standards that are specified under section 1876 of the Social Security Act. These include minimum enrollment requirements (they generally must have at least 5,000 members; those serving primarily rural areas may have 1,500 members). In addition, the entity seeking the Medicare contract must be organized under State law and be a federally qualified HMO or a CMP. The entity must provide physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups. The entity also has to assume full financial risk on a prospective basis for Medicare services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs. Finally, it has to make provision for protection against the risk of insolvency. Provider-sponsored organizations (PSOs) that are not organized under the laws of a State and are neither a federally qualified HMO or CMP are not eligible to contract with Medicare under the Risk Contract Program.

Current contracts with risk plans are for 1 year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) if the organization fails substantially to carry out the contract, carries out the contract in a manner inconsistent with the efficient and effective administration of Medicare HMO law, or no longer meets the requirements specified for Medicare HMOs. The Secretary also has authority to impose lesser sanctions.

Medicare+Choice standards

The Medicare+Choice standards and requirements draw extensively from those under current law. Contracts with Medicare+Choice organizations will be made for at least 1 year and will be automatically renewable in the absence of notice by either party of intention to terminate. Organizations must have at least 5,000 individuals (or 1,500 in the case of a PSO) who are receiving health benefits through the organization or at least 1,500 individuals (or 500 in the case of a PSO) who are receiving health benefits if the organization primarily serves individuals residing outside of urbanized areas.

The Secretary is required to establish by regulation standards for Medicare+Choice organizations and plans. By June 1, 1998, the Secretary must issue interim standards based on currently applicable standards for Medicare risk plans (except for Federal solvency standards that apply to PSOs, as described below). In certain areas, these Federal standards will preempt any State law or regulation with respect to Medicare+Choice plans to the extent such law or regulation is inconsistent with the Federal standards. State standards that are preempted are: (1) benefit requirements, (2) requirements relating to inclusion or treatment by providers, and (3) coverage determinations (including related appeals and grievance processes).

Organizational and financial requirements.—In general, a Medicare+Choice organization must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan. A Medicare+Choice organization must assume full risk for Medicare benefits on a prospective basis. However, an organization may obtain insurance or make other arrangements to cover: (1) aggregate costs in excess of a level specified by the Secretary; (2) medically necessary services provided by nonnetwork providers; and (3) no more than 90 percent of the amount by which its costs exceed 155 percent of its income. The organization also may make arrangements with physicians or other health care professionals and health care institutions to assume all or part of the financial risk on a prospective basis for the provision of Medicare benefits by these individuals and entities.

Provider-sponsored organizations.—Special rules apply to PSOs. A PSO is defined as a public or private entity that is established or organized and operated by a health care provider or group of affiliated providers. A PSO must provide a substantial proportion of health care under a Medicare+Choice contract directly through the provider or affiliated group of providers. The affiliated providers must share, directly or indirectly, substantial financial risk with respect to Medicare benefits and have at least a majority financial interest in the entity.

A PSO may seek a waiver of State law by filing an application with the Secretary by no later than November 1, 2002. The waiver will be effective for 3 years and is not renewable. The Secretary will have to approve the waiver application if the State denied the PSO's licensing application based on its failure to meet solvency requirements that are the same as the Federal ones or that the State imposed as a condition of approval procedures or standards regarding solvency that were different from those applied under Federal law. Waivers are also available if the State fails to act on a substantially complete license application within 90 days.

A waiver granted to a PSO will depend on the organization's compliance with all State consumer protection and quality standards insofar as such standards: (1) would apply to the organization if it were licensed under State law; (2) are generally applicable to other Medicare+Choice organizations and plans in the State; and (3) are consistent with the Federal standards established under the act. Certain State standards will be preempted as they apply to PSOs and Medicare+Choice plans more generally (as described

above). The Secretary is required to report by December 31, 2001 on whether the waiver process should be continued after December 31, 2002. The report must consider the impact of the waiver process on beneficiaries and the long-term solvency of Medicare.

The Secretary is required to establish, on an expedited basis and using a negotiated rulemaking process, final standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. The target date for publication of the resulting rule is April 1, 1998. The negotiated rulemaking committee was appointed by the Secretary in October 1997. In establishing the standards for PSO solvency, the Secretary is required to take into consideration any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

Provider protections and requirements.—Each Medicare+Choice organization is required to establish reasonable procedures relating to the participation of physicians in any Medicare+Choice plan it offers. The procedures include: (1) providing notice of the rules regarding participation; (2) providing written notice of adverse participation decisions; and (3) providing a process for appealing adverse decisions. The organization must consult with contracting physicians regarding the organization's medical policy, quality, and medical management procedures. The use of gag clauses (restricting communications between providers and their patients) is prohibited. The use of physician financial incentive plans is also limited. (A financial incentive plan is any compensation arrangement between the organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to enrollees.)

Protections against fraud.—Like the current program, Medicare+Choice requires contractors to comply with various disclosure and notification requirements. Medicare+Choice organizations are required to report financial information to the Secretary, including information demonstrating that the organization is fiscally sound, a copy of the financial report filed with HCFA containing information on ownership, and a description of transactions between the organization and parties in interest.

The Secretary is also required to audit annually the financial records of at least one-third of the Medicare+Choice organizations (including data relating to utilization, costs, and computation of the adjusted community rate). In addition, the Secretary has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services, as well as the organization's facilities, if there is reasonable evidence of need for such inspection. Also, the Secretary has the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or pertain to services performed or determinations of amounts payable under the contract. Medicare+Choice contracts must require the organization to provide and pay for advance written notice to each enrollee of a plan termination, along with a description of alternatives for obtaining benefits. They must also require that organizations notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

Sanctions and termination of contracts.—The Secretary is authorized to carry out specific remedies in the event that a Medicare+Choice organization: (1) fails substantially to provide medically necessary items and services required to be provided, if the failure adversely affects the individual; (2) imposes premiums on individuals that are in excess of those allowed; (3) acts to expel or refuses to reenroll an individual in violation of Federal requirements; (4) engages in any practice that would have the effect of denying or discouraging enrollment (except as permitted by law) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (5) misrepresents or falsifies information to the Secretary or others; (6) fails to comply with rules regarding physician participation; or (7) employs or contracts with any individual or entity that has been excluded from participation in Medicare. The remedies include civil money penalties, and suspension of enrollment until the Secretary is satisfied the deficiency has been corrected and is not likely to recur. A non-complying plan can also be terminated from participation in Medicare+Choice if the Secretary determines that the organization: (1) fails substantially to carry out the contract; (2) is carrying it out in a manner substantially inconsistent with the efficient and effective administration of Medicare+Choice; or (3) no longer substantially meets Medicare+Choice conditions.

DEMONSTRATIONS AUTHORIZED BY THE BALANCED BUDGET ACT

The Balanced Budget Act authorizes several demonstrations in conjunction with the Medicare+Choice Program. The most important of these are a medical savings account option for Medicare beneficiaries, a test of whether savings can be achieved by setting payments to plans through competitive pricing of plan premiums, and a test of the feasibility of using enrollment brokers for Medicare+Choice.

Medical savings account (MSA) demonstration

The Balanced Budget Act authorizes a demonstration to test the feasibility of medical savings accounts for the Medicare Program. Although this is the first use of this system in Medicare, the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–1) authorized an MSA demonstration for employed individuals who are not yet eligible for Medicare.

The Medicare+Choice option is a combination of an MSA plan providing health insurance with an annual deductible initially limited to \$6,000 and a Medicare+Choice MSA. Initial enrollment for MSA plans will take place in November 1998 for the 1999 plan year. Under the terms of the demonstration, new enrollments will not be allowed after 2002 or after the number of enrollees reaches 390,000.

MSA plans will not be available to certain low-income or disabled individuals, among others. When enrolled in an MSA plan, individuals will not be able to have other health insurance (including Medigap policies), with some exceptions, and they must reside in the United States for at least half the year. Individuals will be able to disenroll from an MSA plan only during an annual election period or under special circumstances.

An MSA plan will provide reimbursement for items and services covered under parts A and B of Medicare, though only after the enrollee incurs countable expenses equal to the annual deductible (limited to \$6,000, indexed for inflation). Countable expenses include at least those payable by Medicare under parts A and B as well as the deductibles, coinsurance, and copayments the enrollee would have paid under those parts. At a plan's option, other expenses (such as prescription drugs or charges that exceed what Medicare would have paid) may also be counted.

After the deductible is met, the plan will have to reimburse at least 100 percent of parts A and B expenses (the provider charges) or 100 percent of what Medicare would have paid for these expenses without regard to deductibles or coinsurance, whichever is less. Providers delivering services to those with MSA plans will not be subject to balance billing limitations, and the plans will not be required to pay any balance billing charges, though some might do so (see table 2-37).

Contributions to a Medicare+Choice MSA will be made annually from the enrollee's capitation rate after the MSA plan insurance premium has been paid. Contributions to accounts will be exempt from taxes, as will account earnings. Withdrawals will likewise not be taxed nor be subject to penalties if they are used to pay unreimbursed enrollee medical expenses that are deductible under the Internal Revenue Code. However, qualified withdrawals cannot be made to pay insurance premiums other than for long-term care insurance, continuation coverage (such as COBRA), or coverage while an individual is receiving unemployment compensation.

Nonqualified withdrawals will be included in the individual's gross income for tax purposes. Withdrawals would also be subject to an additional 50-percent penalty to the extent they exceed the amount by which the account balance on December 31 of the prior year is greater than 60 percent of the MSA plan deductible for the year of withdrawal. For example, if the account balance on December 31 were \$3,500 and the plan deductible the next year were \$5,000, the amount that could be withdrawn for nonqualified purposes without the penalty is \$500 (that is, \$3,500 minus 60 percent of \$5,000). The 50-percent penalty will not apply in cases of death or disability. Account balances at death will be subject to various tax treatments depending on their disposition.

If MSA plan enrollees switch to another Medicare+Choice option or traditional Medicare, they will be able to maintain their account and use it to pay qualified medical expenses. No additional contributions will be allowable unless enrollees elect an MSA plan again.

Medicare competitive pricing demonstration

Under its demonstration authority, HCFA attempted to initiate a project in 1996 and 1997 to determine whether changes in methods for paying health plans, specifically a shift to some form of negotiated rates, would have the effect of increasing the efficiency and economy of providing Medicare services. HCFA's plan called for the application of competitive bidding as a method for establishing payments for risk contract HMOs in either the Baltimore or the

Denver area. Through a combination of court and legislative decisions, these demonstrations have been terminated.

The Balanced Budget Act of 1997 requires the Secretary of DHHS to establish a demonstration project under which payments to Medicare+Choice organizations in certain areas are determined in accordance with a competitive pricing methodology.

The Secretary is required to designate, in accordance with recommendations of the newly created Competitive Pricing Advisory Committee (CPAC), up to seven Medicare payment areas in which the project would be conducted. The Balanced Budget Act spells out the composition and responsibilities of the CPAC. The CPAC is required to recommend to the Secretary four specific areas to be included. Demonstrations in two areas should begin January 1, 1999, and in two other areas on January 1, 2000. Of the four areas recommended, three must be in urban areas and one in a rural area. By December 31, 2001, the committee could recommend to the Secretary the designation of up to three additional payment areas to be included in the project. The CPAC will terminate on December 31, 2004.

For each Medicare payment area in the project, the Secretary will (in accordance with recommendations of the CPAC), establish the benefit design among plans, structure the method for selecting plans, establish methods for setting the price to be paid to plans, and provide for the collection and dissemination of plan information. In doing this, the Secretary will have to consult an area advisory committee created for that payment area. The Secretary is required to monitor the project and report to Congress on its impact by the end of 2002.

Medicare+Choice enrollment demonstration

Under both the risk program and the Medicare+Choice Program, plans with Medicare contracts may directly market to and enroll Medicare beneficiaries. The Balanced Budget Act authorizes the Secretary to conduct a 3-year demonstration using a third-party contractor (sometimes called a broker) to conduct Medicare+Choice plan enrollment and disenrollment functions in an area. The demonstration must be conducted separately from the Medicare competitive pricing demonstrations. Before implementing the project, the Secretary must consult with affected parties on the design of the project, the selection criteria, and the establishment of performance standards. The Secretary is required to establish performance standards for accuracy and timeliness of enrollment and disenrollment. In the event that the third-party contractor fails to comply substantially with the performance standards, the enrollment and disenrollment functions will be performed by Medicare+Choice organizations until a new contractor is appointed by the Secretary.

SELECTED ISSUES

UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS

The Medicare Utilization and Quality Control Peer Review Organization Program was established by Congress under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Public Law 97–

35). Building on the former professional standards review organizations, the new peer review organizations (PROs) were charged by the 1982 law with reviewing services furnished to Medicare beneficiaries to determine if the services met professionally recognized standards of care and were medically necessary and delivered in the most appropriate setting. Major changes were made to the PRO Program by the Social Security Act Amendments of 1983 (Public Law 98-21) and subsequent budget reconciliation acts. Most PRO review is focused on inpatient hospital care. However, there is limited PRO review of ambulatory surgery, postacute care, and services received from Medicare HMOs.

There are currently 53 PRO areas, incorporating the 50 States and the territories. Organizations eligible to become PROs include physician-sponsored and physician-access organizations. In limited circumstances, Medicare fiscal intermediaries may also be eligible. Physician-sponsored organizations are composed of a substantial number of licensed physicians practicing in the PRO review area (for example, a medical society); physician access organizations are those which have available to them sufficient numbers of licensed physicians so that adequate review of medical services can be assured. Such organizations obtain PRO contracts from the Secretary of DHHS through a competitive proposal process. Each organization's proposal is evaluated by HCFA for technical merit using specific criteria that are quantitatively valued. Priority is given to physician-sponsored organizations in the evaluation process. Effective October 1, 1996, all 53 PROs are operating under the fifth round of contracts (also referred to as the "fifth scope of work").

In general, each PRO has a medical director and a staff of nurse reviewers (usually registered nurses), data technicians, and other support staff. In addition, each PRO has a board of directors, comprised of physicians and, generally, representatives from the State medical society, hospital association, and State medical specialty societies. The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) requires each board to have a consumer representative. Because the board is usually consulted before a case is referred by the PRO to the DHHS inspector general for sanction, it assumes a major role in the PRO review process. Each PRO also has physician advisors who are consulted on cases in which there is a question regarding the nurse reviewer's referral. Only physician advisors can make initial determinations about services furnished or proposed to be furnished by another physician.

PROs are paid by Medicare on a cost basis for their review work. Spending for the PROs in fiscal year 1996 totaled \$191 million; in fiscal years 1997 and 1998, spending was expected to be \$269 million and \$279 million, respectively. Spending varies considerably from year to year depending on where the PROs are in their contract cycles. HCFA has indicated that actual spending for 1997 and 1998 may be considerably lower than these figures. Funds for the PRO Program are apportioned each year from the Medicare HI and SMI Trust Funds in an amount that is supposed to be sufficient to finance PRO Program requirements. This is the same procedure as that followed for payment of Medicare services provided directly to beneficiaries. HCFA is bound by law to follow the apportionments in the running of the PRO Program; as such, the apportion-

ments determine contract specifications and serve as a device to control spending.

The PRO review process combines both utilization and quality review. In conducting utilization review, the PRO determines whether the services provided to a Medicare patient were necessary, reasonable, and appropriate to the setting in which they were provided. Although some utilization review is done on a prospective basis, the bulk of the reviews are done retrospectively. When a PRO determines that the services provided were unnecessary or inappropriate (or both), it issues a payment denial notice. The providers, the physicians, and the patient are given an opportunity to request reconsideration of the determination.

The PRO checks for indications of poor quality of care as it is conducting utilization review. If a PRO reviewer detects a possible problem, further inquiry is made into the case. If it is determined that the care was of poor quality, the PRO must take steps to correct the problem. Specific sanctions are required if the PRO determines that the care was grossly substandard or if the PRO has found that the provider or the physician has a pattern of substandard care. In addition, under section 9403 of COBRA (Public Law 99-272), as amended by Public Law 101-239, authority exists for the PROs to deny payments for substandard quality care. This provision, however, has never been used.

Each of the contracts between DHHS and the PROs must contain certain similar elements outlined in a document known as the Scope of Work. Under the third and previous scopes of work, PRO review was centered on case-by-case examinations of individual medical records, selected primarily on a sample basis. This approach to medical review was criticized by the Institute of Medicine and others as being costly, confrontational, and ineffective. The fourth scope of work incorporated a new review strategy called the Health Care Quality Improvement Initiative. PROs were required to use explicit, more nationally uniform criteria to examine patterns of care and outcomes using detailed clinical information on providers and patients. Instead of focusing on unusual deficiencies in care, the PROs were instructed to focus on persistent differences between actual indications of care and outcomes from those patterns of care and outcomes considered achievable. HCFA believed that this approach would encourage a continual improvement of medical practice in a way that would be viewed by physicians and providers as educational and not adversarial.

The fifth scope of work similarly emphasizes continuous quality improvement. Sample case reviews, other than those mandated by law (such as those relating to hospital notices of noncoverage and to beneficiary complaints) are no longer required. Instead, each PRO is required to conduct 4-18 quality improvement projects each year, depending on the size of their beneficiary populations.

SECONDARY PAYER

Generally, Medicare is the "primary payer," that is, it pays health claims first, with an individual's private or other public health insurance filling in some or all of Medicare's coverage gaps. However, in certain cases, the individual's other coverage pays

first, while Medicare is the secondary payer. This phenomenon is referred to as the Medicare Secondary Payer (MSP) Program.

An employer (with 20 or more employees) is required to offer workers age 65 and over (and workers' spouses age 65 and over) the same group health insurance coverage as is made available to other employees. Workers have the option of accepting or rejecting the employer's coverage. If the worker accepts the coverage, the employer's plan is primary for the worker and/or spouse who is over age 65; Medicare becomes the secondary payer. Employers may not offer a plan that circumvents this provision.

Similarly, a group health plan, offered by a large employer with 100 or more employees, is the primary payer for employees or their dependents who are on the Medicare Disability Program. The provision applies only to persons covered under the group health plan because the employee (generally the spouse of the disabled person) is in "current employment status" (that is, is an employee or is treated as an employee by the employer).

Secondary payer provisions also apply to ESRD individuals with employer group health plans (regardless of employer size). Prior to enactment of the Balanced Budget Act of 1997, the group health plan was the primary payer for 18 months for persons who became eligible for Medicare ESRD benefits. The employer's role as primary payer was limited to a maximum of 21 months (18 months plus the usual 3-month waiting period for Medicare ESRD coverage). The Balanced Budget Act extends the application of the secondary payer provisions for the ESRD population from 18 to 30 months. This applies to items and services furnished on or after August 5, 1997 for periods beginning on or after February 5, 1997.

Medicare is also the secondary payer when payment has been made, or can reasonably be expected to be made, under workers' compensation, automobile medical liability, all forms of no-fault insurance, and all forms of liability insurance.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in Social Security Administration and Internal Revenue Service files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of previous incorrect Medicare payments are identified and recoveries are attempted. The Balanced Budget Act clarifies that recoveries can be initiated up to 3 years after the date the service was furnished. Further, recoveries may be made from third-party administrators except where such administrators cannot recover amounts from the employer or group health plan.

Table 2-38 shows savings attributable to these Medicare secondary payer provisions. In fiscal year 1996, combined Medicare part A and B savings are estimated at \$2.9 billion.

TABLE 2-38.—MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS
BY TYPE OF PROVISION, FISCAL YEARS 1988-96

[In millions of dollars]

Year and Medicare part	Workers' compensa- tion	Working aged	End-stage renal dis- ease	Automobile	Disability	Total
1988:						
Part A	\$110.1	\$786.7	\$88.4	\$149.6	\$275.5	\$1,410.3
Part B	18.1	313.8	20.2	22.3	93.5	467.9
Total	128.2	1,100.5	108.6	171.9	369.0	1,878.2
1989:						
Part A	99.4	867.7	75.0	179.6	399.3	1,621.0
Part B	27.5	337.1	25.1	28.2	137.0	554.9
Total	126.9	1,204.8	100.1	207.8	536.3	2,175.9
1990:						
Part A	120.9	981.6	144.1	220.1	498.4	1,965.1
Part B	21.6	325.8	21.5	26.4	123.2	518.5
Total	142.5	1,307.4	165.6	246.5	621.6	2,483.6
1991:						
Part A	107.4	932.7	144.9	235.6	526.6	1,947.2
Part B	21.2	417.5	40.2	26.6	186.2	691.7
Total	128.6	1,350.2	185.1	262.2	712.8	2,638.9
1992:						
Part A	118.9	1,044.9	140.8	233.9	600.9	2,139.4
Part B	17.3	398.3	37.4	34.5	182.9	670.4
Total	136.2	1,443.2	178.2	268.4	783.8	2,809.8
1993:						
Part A	100.4	1,073.1	133.6	239.6	657.8	2,204.5
Part B	11.3	392.2	32.8	28.9	192.3	657.5
Total	111.7	1,465.3	166.4	268.5	850.1	2,862.0
1994:						
Part A	96.5	1,101.1	130.2	265.9	682.3	2,276.0
Part B	13.0	398.1	31.8	32.7	211.8	687.4
Total	109.5	1,499.2	162.0	298.6	894.1	2,963.4
1995:						
Part A	107.0	1,068.0	142.0	295.5	728.9	2,341.4
Part B	10.5	360.3	39.0	40.2	215.5	665.5
Total	117.5	1,428.3	181.0	335.7	944.4	3,006.9

TABLE 2-38.—MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS
BY TYPE OF PROVISION, FISCAL YEARS 1988-96—Continued

[In millions of dollars]

Year and Medicare part	Workers' compensation	Working aged	End-stage renal disease	Automobile	Disability	Total
1996:						
Part A	93.6	1,062.5	133.4	335.0	728.5	2,353.0
Part B	11.1	295.1	34.3	50.1	196.4	586.9
Total	104.7	1,357.6	167.6	385.0	924.9	2,939.9

Source: Health Care Financing Administration, Bureau of Program Operations.

SUPPLEMENTING MEDICARE COVERAGE

In 1995, 7.7 percent of the total Medicare population were enrolled in Medicare managed care plans. Approximately 87 percent of persons not enrolled in Medicare managed care plans had some form of supplementary coverage. Of these, 33 percent had individually purchased coverage, known as Medigap; 31 percent had employer-provided coverage; 6 percent had both Medigap and employer-provided coverage; 15 percent had Medicaid; and 2 percent had other supplemental coverage such as the military or veterans benefits. Approximately 13 percent of the fee-for-service population had Medicare coverage only (see table 2-39).

TABLE 2-39.—SUPPLEMENTAL INSURANCE STATUS OF BENEFICIARIES IN MEDICARE
FEE-FOR-SERVICE, 1995

Type of coverage	Persons (in percent)
Medigap	33
Employer provided	31
Medigap and employer provided	6
Medicaid	15
Other supplemental	2
Medicare only	13
Total	100

Source: Physician Payment Review Commission, 1997.

Medigap

Medigap policies offer coverage for Medicare's deductibles and co-insurance and for some services not covered by Medicare. The typical premium for a community-rated plan is estimated to be \$1,300 in 1997 (Physician Payment Review Commission, 1997). The Omnibus Budget Reconciliation Act of 1990 provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices and to prevent marketing abuses. Implementing regulations generally limit the number of different

types of Medigap plans that can be sold in a State to no more than 10 standard benefit plans, known as “plan A” to “plan J.” The standardized plan A covers a core benefits package. Each of the other nine includes the core package plus a different combination of additional benefits. Four plans make up an estimated three-quarters of plan sales: plan A, 7 percent; plan B, 16 percent; plan C, 22 percent; and plan F (the most frequently sold policy), 33 percent. Only plan H, plan I, and plan J offer some drug coverage; together they account for 14 percent of plan sales. Beneficiaries who purchased policies prior to the standardization requirement may renew these policies; however, policies issued after July 1992 must be one of the 10 standard plans. Approximately half of the beneficiaries with Medigap policies have nonstandardized plans.

The Balanced Budget Act of 1997 significantly changed certain Medigap enrollment requirements, effective July 1, 1998. Prior to that date, the following rules apply. All insurers offering Medigap policies are required to offer a 6-month open enrollment period for persons turning age 65. This is known as guaranteed open enrollment. There is no guaranteed open enrollment for the under-65 disabled population. At the time insurers sell a Medigap policy, whether or not during an open enrollment period, they are permitted to limit or exclude coverage for services related to a pre-existing health condition; such exclusions cannot be imposed for more than 6 months. An individual who has met the preexisting condition limitation in one Medigap policy does not have to meet the requirement under a new policy for previously covered benefits. However, an insurer could impose exclusions for newly covered benefits.

The Balanced Budget Act also expands the guaranteed issue requirements, effective July 1, 1998. Specifically, the law guarantees issuance of specified Medigap policies without a preexisting condition exclusion for certain continuously enrolled individuals. The insurer is prohibited from discriminating in the pricing of such policy on the basis of the individual’s health status, claims experience, receipt of health care, or medical condition.

The guaranteed issuance is extended to the following persons provided they enroll within 63 days of termination of other enrollment:

1. An individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.
2. A person enrolled with a Medicare+Choice organization who discontinues enrollment under circumstances permitting disenrollment other than during an annual election period. (These include: (1) the termination of the entity’s certification, (2) the individual moves outside of the entity’s service area; or (3) the individual elects termination due to cause.)
3. An individual enrolled with an HMO and enrollment ceases for the reasons noted above.
4. An individual enrolled under a Medigap policy and enrollment ceases because: (1) of the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage and there is no provision under applicable State law for the continuation of such coverage, (2) the issuer substantially vio-

- lates a material provision; or (3) the issuer misrepresented the policy's provisions.
5. An individual who: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a Medicare+Choice organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare Select policy; and (3) terminates such enrollment during any period within the first 12 months during which the individual is permitted to terminate enrollment, but only if the individual was never previously enrolled with such an entity.
 6. An individual who upon first becoming eligible for Medicare at age 65, enrolls in a Medicare+Choice plan, and disenrolls from such plan within 12 months.

The guaranteed issue is generally for plan A, B, C or F. However: (1) for persons described in (5) it refers to the same policy in which the person was previously enrolled; and (2) for persons described in (6) it is for any Medigap policy. At the time of the event which resulted in the cessation of enrollment or loss of coverage, the organization, insurer, or plan administrator (whichever was appropriate) would have to notify the individual of his or her rights and the obligations of issuers of Medigap policies.

The Balanced Budget Act prohibits the imposition of a preexisting exclusion period for persons who on the date of application, have at least 6 months of creditable coverage. Specifically, such an exclusion can not be imposed on an individual who, on the date of application, has a continuous period of at least 6 months of health insurance coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA). If the individual has less than 6 months coverage, the policy would have to reduce the period of any preexisting exclusion by the aggregate of periods of "creditable coverage" applicable to the individual as of the enrollment date. The rules used to determine the reduction would be based on rules used under HIPAA.

The Balanced Budget Act provides for high deductible Medigap plans. Specifically, it adds 2 plan types to the current list of 10 standard Medigap plans. These will offer the benefit package of either plan F or plan J, except for the high deductible feature. The high deductible is \$1,500 in 1998 and 1999, increased by the CPI in subsequent years. The beneficiary would be responsible for expenses up to this amount.

Medicare Select

OBRA 1990 established a demonstration project under which insurers could market a product known as Medicare Select. Select policies are the same as other Medigap policies except that they will only pay in full for supplemental benefits if covered services are provided through designated health professionals and facilities known as preferred providers. OBRA 1990 limited the demonstration project to 3 years (1992–94) and to 15 States. The Social Security Amendments of 1994 (Public Law 103–432) extended Select for 6 months. Public Law 104–18 extended the program for 3 years (to June 30, 1998) and to all States. A permanent extension beyond the 3 year period is authorized unless the Secretary determines

that the Select Program significantly increased Medicare expenditures, significantly diminished access to and quality of care, or did not result in lower Medigap premiums for beneficiaries. This determination must be made by December 31, 1997, based on a study completed by June 30, 1997.

Public Law 104-18 also required the General Accounting Office (GAO) to determine the extent to which individuals who are continuously covered under a Medigap policy are subject to medical underwriting if they change the policy under which they are covered. Further, GAO was required to identify options, if necessary, for modifying the Medigap market to make sure that continuously insured beneficiaries are able to switch plans without medical underwriting. Many of the issues identified in the GAO report were addressed in the Balanced Budget Act of 1997.

Employer-based policies

In 1995, employer-based policies covered 37 percent of Medicare beneficiaries. Employer-based plans are typically more comprehensive than Medigap plans. Generally they are defined benefit plans which may overlap significantly with Medicare benefits. As a result, employers use a variety of approaches to coordinate their plans with Medicare (which is the primary payer for retirees). The costs of coverage are generally shared by the employer and retiree. In 1996, large firms (over 500 employees) shared the costs for 43 percent of individual retiree plans, and paid in full for an additional 29 percent of plans. In 1996, retirees on average spent \$948 for their employer-sponsored coverage (Foster Higgins, 1996).

In recent years, the percentage of employers offering retiree health coverage for their Medicare retirees has dropped. Between 1994 and 1996, the number of large firms offering such coverage dropped from 40 percent to 33 percent (Foster Higgins, 1996).

In addition, many other employers are pursuing strategies to lower their liabilities for retiree health costs. Some employers are moving toward a defined contribution model for retiree health benefits. Others are using Medicare risk plans and other managed care organizations to deliver services to their retirees. A number of large employers (accounting for over 2 million Medicare-eligible retirees) have joined the National Medicare HMO initiative to negotiate contracts with Medicare risk plans for the provision of benefits in excess of those otherwise offered by the plans (Physician Payment Review Commission, 1997).

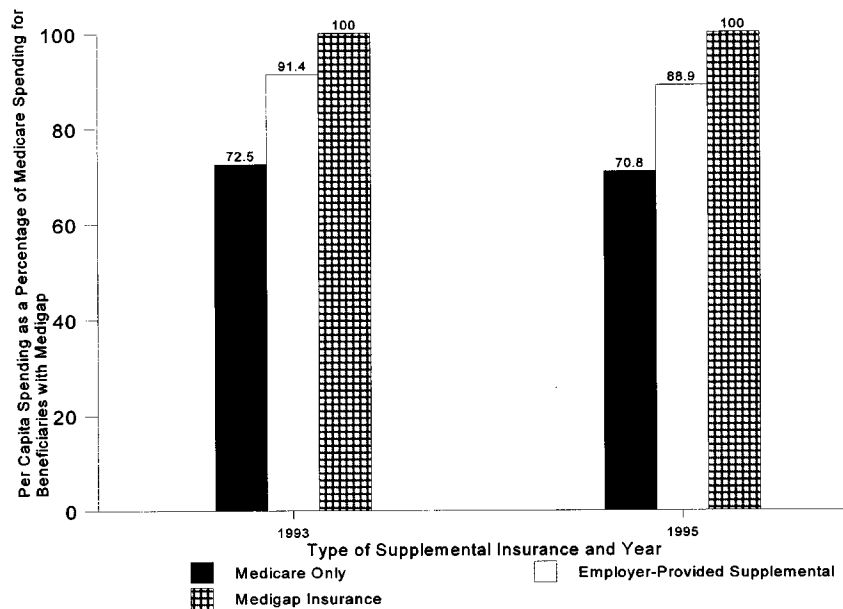
Impact of supplemental insurance on Medicare spending

Medicare cost-sharing requirements are intended, in part, to encourage cost-conscious utilization. Insurance that supplements Medicare by covering deductibles and coinsurance removes these incentives. Many analyses have addressed how supplemental insurance affects beneficiaries' use of Medicare-covered services and the cost of those services to Medicare. Typically, these studies have estimated that Medicare spending for beneficiaries with supplemental coverage are one-quarter to one-third higher, on average, than expenditures for beneficiaries without such coverage.

A Physician Payment Review Commission analysis (Physician Payment Review Commission, 1997) of the Medicare Current Bene-

fiary Survey (MCBS) found a similar effect: Medicare expenditures for beneficiaries covered by supplemental insurance were about 30 percent higher than they were for those without such coverage. Subsequent analysis showed that the effect of secondary coverage on Medicare expenditures differs, depending on the source of coverage. Expenditures for beneficiaries having Medicare only are less than 75 percent of those for beneficiaries with Medigap. Spending for beneficiaries with employer-provided benefits average only about 10 percent less (chart 2-14).

CHART 2-14. COMPARISON OF PROJECTED PER CAPITA SPENDING FOR AVERAGE BENEFICIARIES, BY TYPE OF SUPPLEMENTAL INSURANCE AND YEAR



Note.—These spending levels represent the expected differences in outlays after other factors have been taken into account.

Source: Physician Payment Review Commission analysis of data from the 1993 and 1995 Medicare Current Beneficiary Survey. The sample size for 1993 was 11,285 and the sample size for 1995 was 13,261.

Higher utilization among beneficiaries with supplemental insurance translates into increased Medicare costs because Medicare is the primary payer for those services. The MCBS analysis found that per capita expenditures for Medicare beneficiaries with Medigap insurance were from \$1,000 to \$1,400 higher than those for beneficiaries with Medicare only. Per capita spending for beneficiaries with employer-provided supplements were from \$700 to \$900 higher than those for beneficiaries with no supplemental coverage.

These results reflect the difference in spending by source of insurance, once other factors have been considered. High service use among beneficiaries with secondary insurance appears to be a consequence of having such insurance, presumably reflecting the reduced financial burden associated with using additional services.

QUALIFIED MEDICARE BENEFICIARIES (QMBs)

Medicare beneficiaries are liable for specified cost-sharing charges; namely, premiums, deductibles, and coinsurance. Such charges could pose a potential hardship for some persons, especially those who do not have supplementary protection, either through an individually-purchased “Medigap” policy or employer-based coverage. Certain low-income persons are entitled to have their Medicare cost-sharing charges paid by the Federal-State Medicaid Program. More limited coverage is available for two other population groups: (1) persons who meet the QMB criteria (see below) except that their income is slightly in excess of the poverty line; and (2) qualified disabled and working individuals. Persons meeting the qualifications for coverage under one of these categories, but not otherwise eligible for Medicaid, are not entitled to the regular Medicaid benefits package. Instead, they are entitled to have Medicaid make specified payments in their behalf.

QMB eligibility

State Medicaid Programs are required to make Medicare cost-sharing assistance available to QMBs. A QMB is an aged or disabled Medicare beneficiary who has: (1) income at or below the Federal poverty line (\$7,890 for a single, \$10,610 for a couple in 1997); and (2) resources below 200 percent of the resources limit set for the Supplemental Security Income (SSI) Program (the QMB resource limits are \$4,000 for an individual and \$6,000 for a couple). Certain items, such as an individual’s home and household goods, are excluded from the calculation.

Persons meeting the QMB definition are entitled to Medicare part A. Included is the relatively small group of aged persons who are not automatically entitled to part A coverage, but who have bought part A protection by paying a monthly premium. Not included are working disabled persons who have exhausted Medicare part A entitlement but who have extended their coverage by payment of a monthly premium.

QMB benefits

Medicaid is required to pay Medicare premiums and cost-sharing charges for the QMB population as follows: (1) part B monthly premiums; (2) part A monthly premiums paid by the limited number of persons not automatically entitled to part A protection; (3) coinsurance and deductibles under part A and part B including the Medicare hospital deductible, the part B deductible, and the part B coinsurance; and (4) coinsurance and deductibles that health maintenance organizations (HMOs) and competitive medical plans charge their enrollees.

Medicaid coverage is limited to payment of these charges unless the individual is otherwise eligible for Medicaid. A person eligible for regular Medicaid benefits as well as QMB assistance is entitled

to Medicaid payment for Medicare premiums and cost-sharing charges as well as to the full range of Medicaid services otherwise available to them.

Payment of QMB benefits

States are required to pay part A and part B premiums in full for the QMB population. They are also required to pay the requisite deductibles and coinsurance, though the actual amount of the payment may vary. State Medicaid Programs frequently have lower payment rates for services than those applicable under Medicare. Federal program guidelines permit States to either: (1) pay the full Medicare deductible and coinsurance amounts; or (2) only pay those amounts to the extent that the Medicare provider or supplier has not received the full Medicaid rate for the service. If the Medicare service is not covered under the State Medicaid Program, the State may either pay the full Medicare deductibles and coinsurance amounts or alternatively provide for reasonable payments (subject to approval by DHHS).

Twenty-nine States instituted policies which used payment rates below those applicable under Medicare. However, the U.S. Court of Appeals for four judicial circuits issued decisions which required States in their jurisdictions to pay the full Medicare cost-sharing expenses for QMBs. As a result, 8 of the 29 States were required to change their policies. However, in May 1997, another judicial circuit found that California could cap payments to Medicare providers at Medicaid payment rates. This issue was subsequently addressed by the Balanced Budget Act of 1997 which permits States to limit total payments to the amount which would otherwise be paid by Medicaid. The provision is effective on enactment, except that it also applies to services furnished before that date if payment for such services is subject of a pending lawsuit.

Buy-in

All States have buy-in agreements with the Secretary that allow them to enroll their QMB population in part B. Some States have also elected to include payment of part A premiums under their buy-in agreements. Payment of premiums under a buy-in agreement is advantageous to the State because premiums paid through this method are not subject to delayed enrollment penalties which might otherwise be applicable in the case of delayed enrollment or reenrollment.

The buy-in agreements for the QMB population are in addition to the traditional buy-in agreements that States have for other population groups. Under these traditional buy-in agreements, States enroll in Medicare part B persons who are eligible for both Medicare and Medicaid. As a minimum, States may limit buy-in coverage to persons receiving cash assistance; alternatively, they may add some or all categories of other persons who are eligible for both programs.

Specified low-income Medicare beneficiaries (SLMBs)

States are also required to pay Medicare part B premiums for SLMBs. These are persons meeting the QMB criteria except that their income is slightly over the QMB limit. In 1997, the SLMB in-

come limit is 120 percent of the Federal poverty line. Medicaid protection is limited to payment of the Medicare part B premiums, unless the beneficiary is otherwise eligible for Medicaid.

The Balanced Budget Act of 1997 requires State Medicaid Programs, effective January 1, 1998 through December 31, 2002, to pay part B premiums for beneficiaries with incomes up to 135 percent of poverty. For Medicare beneficiaries with incomes between 135 and 175 percent of poverty, State Medicaid Programs are required to cover that portion of the Medicare part B premium attributable to the transfer of home health visits from part A to part B.

The Federal Government will pay 100 percent of the costs associated with expanding Medicare part B premium assistance from 120 percent to 135 percent, as well as the extra premium cost attributable to the home health transfer for persons between 135 and 175 percent. To cover these costs, the Secretary will be required to provide for allocations to States based on the sum of: (1) a State's number of Medicare beneficiaries with incomes between 135 and 175 percent of poverty, and (2) twice the number of Medicare beneficiaries with incomes between 120 and 135 percent of poverty, relative to the sum for all eligible States. Total amounts available for allocations are \$200 million for fiscal year 1998, \$250 million for fiscal year 1999, \$300 million for fiscal year 2000, \$350 million for fiscal year 2001, and \$400 million for fiscal year 2002. The Federal matching rate for each participating State will be 100 percent up to the State's allocation. If a State exceeds its allocation, the matching rate on the excess is zero. Payments are to be made from Medicare part B for the costs of this program.

Qualified disabled and working individuals (QDWIs)

Medicaid is authorized to provide partial protection against Medicare part A premiums for QDWIs. QDWIs are persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have the disabling condition. Medicaid is required to pay the Medicare part A premium for such persons if their incomes are below 200 percent of the Federal poverty line, their resources are below 200 percent of the SSI limit, and they are not otherwise eligible for Medicaid. States are permitted to impose a premium, based on a sliding scale, for individuals between 150 and 200 percent of poverty.

Data

As of May 1997, Medicare reported that there were 317,753 Medicare part A beneficiaries for whom QMB payments for part A premiums were being made. As of the same date, States reported a total of 4,987,918 part B buy-ins of which 2,429,792 were separately identified as QMBs and 242,749 were separately identified as SLMBs (see table 2-40). However, these numbers are low due to reporting problems. The QMB and SLMB numbers include persons who were eligible for the full Medicaid benefit package. No QMB-only or SLMB-only number is available. Nationwide there were 18 QDWIs in May 1997; this information is not broken down by State.

TABLE 2-40.—NUMBER OF QUALIFIED MEDICARE BENEFICIARIES AND PART B BUY-INS
BY STATE, MAY 1997

State	Part A QMBs	Part B buy-ins	Part B buy-ins identified as QMBs by State
Alabama	3,444	122,455	30,441
Alaska	630	6,821	15
Arizona	433	48,777	31,519
Arkansas	4,027	79,371	21,534
California	78,784	767,174	403,732
Colorado	512	50,574	12,589
Connecticut	2,453	50,639	41,009
Delaware	468	8,293	1,900
District of Columbia	1,264	14,374	269
Florida	40,583	303,138	214,388
Georgia	7,017	167,895	46,156
Hawaii	4,855	18,597	3,779
Idaho	264	14,099	8,121
Illinois	3,686	144,828	112,728
Indiana	1,841	76,479	49,777
Iowa	1,326	49,865	35,551
Kansas	602	37,243	13,216
Kentucky	3,230	104,766	30,041
Louisiana	5,570	115,045	26,254
Maine	10	31,861	13,748
Maryland	6,256	59,858	46,670
Massachusetts	14,814	131,730	104,371
Michigan	5,748	130,454	38,093
Minnesota	3,118	56,216	17,444
Mississippi	7,269	106,647	74,407
Missouri	662	79,264	58,821
Montana	455	11,798	9,602
Nebraska	1	17,356	652
Nevada	983	16,374	12,057
New Hampshire	28	6,041	1,425
New Jersey	7,188	134,114	87,141
New Mexico	535	33,599	7,441
New York	190	349,797	168,195
North Carolina	11,522	203,477	32,471
North Dakota	8	5,683	1,363
Ohio	6,643	176,472	79,081
Oklahoma	4,722	62,727	56,416
Oregon	37	49,120	26,801
Pennsylvania	15,609	172,703	114,830
Puerto Rico	0	0	0
Rhode Island	840	17,213	1,812
South Carolina	1,904	100,941	84,818
South Dakota	779	12,766	4,560
Tennessee	8,316	161,479	66,794
Texas	43,166	334,970	94,082
Utah	158	14,523	9,804
Vermont	241	12,996	3,228
Virgin Islands	0	210	0

TABLE 2-40.—NUMBER OF QUALIFIED MEDICARE BENEFICIARIES AND PART B BUY-INS BY STATE, MAY 1997—Continued

State	Part A QMBs	Part B buy-ins	Part B buy-ins identified as QMBs by State
Virginia	2,961	109,046	42,105
Washington	4,548	81,054	29,654
West Virginia	3,714	43,386	39,095
Wisconsin	4,114	76,831	17,871
Wyoming	225	5,778	1,936
Northern Marianas	0	311	0
Guam	0	690	0
Total	317,753	4,987,918	2,429,792

Note.—See text for data limitations; QMB = qualified Medicare beneficiary.

Source: Health Care Financing Administration.

LEGISLATIVE HISTORY, 1980-97

This section summarizes major Medicare legislation enacted into law, beginning with the Social Security Disability Amendments of 1980 and continuing chronologically through the Balanced Budget Act of 1997. Previous editions of the *Green Book* review legislation enacted before 1980. Since only technical changes were included in the Social Security Amendments of 1994, this act is not discussed here.

The summary highlights major provisions; it is not a comprehensive list of all Medicare amendments. Included are provisions which had a significant budget impact, changed program benefits, modified beneficiary cost sharing, or involved major program reforms. Provisions involving policy changes are mentioned the first time they are incorporated in legislation, but not necessarily every time a modification is made. For example, the enactment of the initial secondary payer provisions are noted in 1980, 1981, and 1982. Subsequent clarifying amendments to these provisions are not mentioned. The descriptions include either the initial effective date of the provision or, in the case of budget savings provisions, the fiscal years for which cuts were specified.

SOCIAL SECURITY DISABILITY AMENDMENTS OF 1980, PUBLIC LAW 96-265

Established a voluntary certification program for Medicare supplemental policies in States that failed to establish equivalent or more stringent standards. (Federal program put in place July 1, 1982.)

OMNIBUS RECONCILIATION ACT OF 1980, PUBLIC LAW 96-499

Home health services

Liberalized home health benefits by eliminating the number of visits limits, the prior hospitalization requirement, and the deductible for any benefits provided under part B. (Effective July 1, 1981.)

Ambulatory surgical services

Required the Secretary to develop a list of surgical procedures that could appropriately be performed on an outpatient basis in an ambulatory surgical center and provided that payments would be made for facility services on the basis of prospectively determined rates. (Effective on enactment.)

Secondary payer

Provided that Medicare would be the secondary payer where payment could be made under liability or no-fault insurance. (Effective on enactment.)

PUBLIC LAW 96-611 (AN AMENDMENT TO THE SOCIAL SECURITY
ACT)

Authorized coverage for pneumococcal vaccines. (Effective July 1, 1981.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (OBRA 1981),
PUBLIC LAW 97-35

Part A deductible

Increased the multiplier for computing the inpatient hospital deductible by 12.5 percent. (Effective January 1, 1982.)

Part B deductible

Eliminated the use of medical expenses incurred during the last 3 months of the preceding calendar year for determining whether an individual had met the part B deductible for the current calendar year. The part B deductible was also increased from \$60 to \$75. (Effective January 1, 1982.)

Medicare secondary payer

Modified the existing Medicare benefit payment coordination rules for persons with end-stage renal disease (ESRD), making the individual's private employer group health plan the primary payer and Medicare the secondary payer for the first 12 months after an individual was determined to be eligible for Medicare under the ESRD provisions. (Effective October 1, 1981.)

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA),
PUBLIC LAW 97-248

Part A provider payments

Expanded prospective limits on hospital costs reimbursed under Medicare originally enacted in the Social Security Amendments of 1972 (Public Law 92-603), to include, in addition to routine costs, all other inpatient hospital operating costs, such as ancillary costs (for example, laboratory, operating room, pharmacy, and so forth) and costs of special care units (for example, intensive care units). Established a 3-year Medicare ceiling (or target rate) on the allowable annual rate of increase in operating costs per case for inpatient hospital services. Required the Secretary to develop proposals for the prospective payment of hospitals under Medicare by the end

of 1982. (Effective for hospital cost-reporting periods beginning on or after October 1, 1982.)

Part B premium

Increased the part B premium to cover 25 percent of program costs for the aged for 1-year periods beginning July 1, 1983 and July 1, 1984. This provision was subsequently extended through 1990. (Effective July 1, 1983.)

Reimbursement for inpatient radiology and pathology services

Eliminated the special 100-percent reimbursement rate for radiologist and pathologist services furnished directly to hospital inpatients, and the exemption of such services from being subject to the part B deductible and coinsurance. (Effective for items or services furnished on or after October 1, 1982.)

Medicare secondary payer for older workers

Amended the existing benefit payment coordination rules making Medicare secondary payer for older workers with private employer group health insurance coverage. Required private employers with 20 or more full-time workers to provide older workers with the same coverage provided for workers under age 65. Subsequently extended to spouses. (Effective January 1, 1983.)

Hospice care

Authorized 210 days of hospice care for terminally ill Medicare beneficiaries with a life expectancy of 6 months or less. (Effective for the period from November 1, 1983 to October 1, 1986, with benefit becoming permanent and day limit repealed at a later date.)

Health maintenance organizations (HMOs) and competitive medical plans (CMPs)

Provided for contracts with HMOs or CMPs on a risk sharing (prospective) basis. Individuals eligible to receive benefits under Medicare would be eligible to enroll with any HMO or CMP that had a Medicare contract and served the geographic area in which the individual resided. Medicare's payment to the entity with a risk-sharing contract would be made on a per capita basis for each class of beneficiary enrolled in the plan, adjusted for factors such as age, disability status, and other factors. (Effective when the Secretary certified to Congress that the payment methodology was adequate.)

Peer review organizations (PROs)

Established the PROs to review the medical necessity and reasonableness of care, quality of care, and the appropriateness of the setting in which the care was delivered for Medicare services furnished primarily in hospitals. Repealed authorization for the Professional Standards Review Organizations (PSROs), which had been charged since 1972 with reviewing both Medicare and Medicaid services. (Effective on enactment.)

Hospital insurance (HI) tax for Federal employees

Required Federal employees to begin paying the Medicare HI tax and to earn eligibility for HI coverage under Medicare. (Effective January 1, 1983.)

SOCIAL SECURITY AMENDMENTS OF 1983, PUBLIC LAW 98-21

Part A hospital reimbursement

Established a new method of Medicare reimbursement for hospital inpatient care, called the prospective payment system (PPS). Under this system, payment for each patient would be made at predetermined, specific rates based on the average cost of treating similar patients. Categories of patients would be defined by the diagnosis-related groups (DRGs) patient classification system which assigned each inpatient to a DRG based on the diagnosis and other factors. (Effective for hospital cost-reporting periods beginning on or after October 1, 1983.)

PROs

Authorized PROs to deny payment to a hospital for unnecessary or inappropriate services. (Effective on enactment.)

DEFICIT REDUCTION ACT OF 1984 (DEFRA), PUBLIC LAW 98-369

Physicians' services

Froze physicians fees for 15 months, established the Participating Physicians' Program, and froze billed charges of nonparticipating physicians. (Freeze effective July 1, 1984 through September 30, 1985.)

Laboratory services

Established two fee schedules for clinical laboratory services, one for independent laboratories and physicians and one for services provided by hospital outpatient labs. Required independent laboratories to accept assignment on claims and waived patient cost-sharing charges on such claims, and permitted physicians to bill for lab services only when they personally performed or supervised the performance of the test. (Fee schedules effective July 1, 1984, with schedule for outpatient hospital services initially limited to 3 years and made permanent in subsequent legislation.)

Hepatitis B vaccine

Authorized coverage for hepatitis B vaccine and its administration when furnished to a high risk individual. (Effective September 1, 1984.)

EMERGENCY EXTENSION ACT OF 1985, PUBLIC LAW 99-107

Froze PPS payment rates for inpatient hospital services at fiscal year 1985 levels and continued physician payment freeze through November 14, 1985. Subsequent acts (Public Law 99-155, Public Law 99-181, Public Law 99-189, and Public Law 99-201) extended the freezes through March 14, 1986. (See below for further extension through April 30, 1986.)

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985
(COBRA), PUBLIC LAW 99-272

Hospital patient protection

Established requirements for hospitals participating in Medicare to examine and treat patients in active labor or with emergency medical conditions (also known as “antidumping” provisions). (Effective on first day of first month beginning at least 90 days after enactment.)

Hospital payment freeze

Extended freeze on payments through April 30, 1986 and reduced PPS updates for the remainder of fiscal year 1986. (Effective on enactment.)

Indirect medical education

Began phased reduction of payments for indirect costs of medical education. (Applied to cost-reporting periods beginning on or after May 1, 1986.)

Direct graduate medical education

Replaced cost-based hospital reimbursement for direct costs of medical education with a hospital-specific cost amount per approved full-time equivalent resident. Limited the period of residency training for which payments would be made. (Applied to cost-reporting periods beginning on or after July 1, 1985.)

Disproportionate-share hospitals

Codified payment adjustments for hospitals serving a disproportionate share of low-income patients. (Effective May 1, 1986.)

Physician fee freeze

Extended fee freeze from March 14, 1986 through April 30, 1986 for participating physicians and through December 1, 1986 for non-participating physicians. Required the Secretary in consultation with the newly established Physician Payment Review Commission to develop a relative value scale for payments for physician services. (Fee freeze extension was effective on enactment; other changes became effective later in 1986.)

Return on equity

Began phase-out of return on equity capital for for-profit hospital services and reduced return on equity for other services. (Effective for hospitals for cost-reporting periods beginning on or after October 1, 1986; for other providers, on or after October 1, 1985.)

Coverage of new State and local employees

Extended Medicare HI tax to State and local government employees hired on or after April 1, 1986 and established Medicare part A entitlement for these employees. (Effective beginning after March 31, 1986 for both tax and entitlement to coverage.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (OBRA 1986),
PUBLIC LAW 99-509

Part A deductible

Changed the annual indexing of the part A (hospital) deductible from an amount based on the average cost of 1 day of inpatient hospital care to an amount based on the applicable percentage increase used for prospective payment rates, adjusted to reflect changes in real case mix. (Effective for services provided on or after January 1, 1987.)

Payments for physicians' services

Provided for higher recognized payment screens for participating physicians beginning January 1, 1987. Imposed limits on balance billing for nonparticipating physicians known as the maximum allowable actual charge (MAACs). (Effective January 1, 1987 with MAAC limits effective for 4 years.)

Secondary payer for the disabled

Made Medicare the second payer for disabled Medicare beneficiaries who elected to be covered under employer plans as a current employee (or family member of such employee) of an employer with at least 100 employees. (Effective January 1, 1987 through December 31, 1992. Subsequently modified and extended.)

Payment for cataract surgical procedures

Reduced the prevailing charges of participating and nonparticipating physicians for certain cataract surgical procedures. (Effective for services furnished on or after January 1, 1987 until the earlier of December 31, 1990 or 1 year after the Secretary reported to Congress on the relative value scale.)

Ambulatory surgery

Revised payment methodology for ambulatory surgery provided in hospital outpatient departments to be the lesser of costs or charges or a blend of hospital costs and ASC rates (reaching 50/50 in fiscal year 1988). Required the Secretary to develop a prospective payment system for ambulatory surgery performed in outpatient departments. (Applied to payment rates for cost-reporting periods beginning on or after October 1, 1987.)

Vision care

Provided for payment for vision care services furnished by optometrists if the services were among those covered by Medicare and the optometrist was legally authorized to perform that service. (Prior to this change, Medicare only covered optometrist services related to the treatment of aphakia.) (Effective April 1, 1987.)

Physician assistants

Provided for coverage of and separate payment for services performed by a physician assistant if the service would be covered when performed by a physician. (Effective January 1, 1987.)

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT
OF 1987, PUBLIC LAW 100-93

Fraud and abuse

Amended titles XI, XVIII, and XIX of the Social Security Act to improve antifraud provisions. Established civil penalties and sanction authority, including mandatory exclusion from Medicare, Medicaid, and other programs under the Social Security Act for specific acts of fraud or abuse. (Effective on the 15th day after enactment.)

Beneficiary protections and information clearinghouse

Improved program protections for beneficiaries and created an information-reporting system concerning sanctions taken by State entities to prevent sanctioned providers in one State from setting up practices anew in another. (Generally effective on the 15th day after enactment.)

BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL
REAFFIRMATION ACT OF 1987, PUBLIC LAW 100-119

Froze payment rates at fiscal year 1987 levels through November 20, 1987, and mandated a sequester order that resulted in Medicare payment reductions of 2.324 percent effective November 21, 1987. (Effective as specified.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA 1987),
PUBLIC LAW 100-203

Part A and B reductions under sequester order

Extended payment reductions under the sequester order for all inpatient hospital services (including capital and direct medical education) until March 31, 1988, and for other part A services until December 31, 1987. Froze part B prevailing charges and the customary charges for physicians' services for the period January 1 through March 31, 1988 at 1987 levels, and extended the sequester order for part B services through March 31, 1988. (Effective on enactment.)

Hospital inpatient payment rates

Reduced the update factors for PPS hospitals for fiscal year 1988 and fiscal year 1989. Established separate updates for large urban, "other urban," and rural areas. (Effective for discharges occurring on or after April 1, 1988, for fiscal year 1988 update factors.)

Hospital capital payments

Reduced hospital capital-related payments by 7 percent between October 1 and December 31, 1987; by 12 percent for the remainder of fiscal year 1988, beginning January 1, 1988; and by 15 percent for fiscal year 1989. Required Secretary to establish a prospective payment system for capital to begin with cost-reporting periods beginning on or after October 1, 1991. (Effective as specified.)

Physician payments

Reduced payment update for 1988 and 1989 for participating physicians for nonprimary care services, beginning on April 1, 1988. Reduced nonparticipating physician payments to 95.5 percent of prevailing charges for participating physicians for services furnished from April 1 to December 31, 1988; for fiscal year 1989, further reduced payments to 95 percent of the prevailing charges of participating physicians. Added a 5-percent bonus payment for services provided in underserved areas, effective January 1, 1989 in rural areas and January 1, 1991 in urban areas. (Effective as specified.)

Reductions in overpriced procedures

Expanded list of overpriced procedures (previously limited to cataract surgery) and reduced prevailing charges for them. Reduced prevailing charges by 2 percent from the 1987 level, and further reduced prevailing charges by specified amounts if the prevailing charge was above 85 percent of the national average level. (Effective for items and services provided on or after April 1, 1988.)

Durable medical equipment (DME) fee schedule

Froze payment screens for DME for 1 year from January 1 through December 31, 1988. Required the Secretary to establish a fee schedule for the fee screen year beginning January 1, 1989, for each of 6 categories of DME services. (Effective date of fee schedule for items furnished on or after January 1, 1989.)

Ambulatory surgery copayment

Required that the deductible and coinsurance requirements be imposed for assigned physicians' services provided in ASCs and hospital outpatient departments. (Effective for services furnished on or after April 1, 1988.)

Flu vaccine

Provided coverage of influenza vaccine and its administration if a demonstration conducted by the Secretary found it to be cost effective. (Effective date of 24-month demonstration October 1, 1988; Secretary authorized coverage effective May 1, 1993.)

Therapeutic shoes for diabetics

Provided coverage for therapeutic shoes for diabetics contingent on the demonstration of their cost effectiveness by the Secretary. (Effective date of 24-month demonstration October 1, 1988; Secretary authorized coverage effective May 1, 1993.)

Coverage of mental health services

Increased the limit on recognized charges for the outpatient treatment of mental disorders beginning in calendar year 1988. Beginning calendar year 1989, the payment limit would not include brief office visits to prescribe or monitor prescription drugs used as treatment. (Effective January 1, 1988.)

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (MCCA), PUBLIC
LAW 100-360

Part A benefits

Modified hospital coverage by specifying a maximum of one hospital deductible per year and eliminating the day limits, coinsurance charges, and spell of illness provisions. Modified skilled nursing facility (SNF) benefit by requiring coinsurance for the first 8 days of care; eliminating coinsurance for days 21-100; covering up to 150 days per year; and eliminating the prior hospitalization requirement. Modified home health benefit by expanding definition of intermittent care and permitting extension of hospice benefit beyond 210 days. (Hospital and SNF benefits effective January 1, 1989; home health and hospice benefits effective January 1, 1990.)

Part B benefits

Established a maximum out-of-pocket limit ("catastrophic cap") on beneficiary liability for part B cost-sharing charges, and set cap at level to cover 7 percent of beneficiaries. Added coverage for routine mammography screening and home intravenous drug therapy services. Provided respite coverage for up to 80 hours per year for chronically dependent individuals who had met the catastrophic or prescription drug cap. (Effective January 1, 1990.)

Catastrophic drug benefits

Established, effective January 1, 1990, a limited prescription drug benefit for two categories of drugs (home intravenous (IV) drugs and immunosuppressive drugs) once the beneficiary met a \$550 deductible. Extended, beginning January 1, 1991, catastrophic coverage for all outpatient prescription drugs once the beneficiary met a \$600 deductible (indexed to cover 16.8 percent of beneficiaries in future years). Set the coinsurance at 50 percent, dropping to 20 percent by 1993. (Limited coverage effective beginning in 1990; coverage for all drugs beginning in 1991, with full implementation in 1993.)

Financing

Added an additional amount to the monthly part B premium. Added a supplemental premium (a surtax collected in conjunction with the Federal income tax) for persons with income tax liability above \$150. (Effective for part B premiums beginning January 1, 1989; supplemental premiums effective for tax years beginning after 1988.)

Qualified Medicare beneficiaries (QMBs)

Required Medicaid to pay Medicare premiums and cost-sharing charges for Medicare beneficiaries below poverty. (Coverage phased in beginning January 1, 1989)

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989, PUBLIC
LAW 101-234

Repealed the Medicare and financing provisions included in the 1988 law. Generally the repeal restored prior law provisions as if the catastrophic act had not been passed. For hospital and SNF

benefits which had gone into effect in 1989, prior law provisions were restored, effective January 1, 1990 with transition provisions included for persons in a hospital or SNF on that date. The additional part B premium was repealed, effective January 1, 1990. The QMB provision was not repealed.

OMNIBUS BUDGET RECONCILIATION ACT OF 1989 (OBRA 1989),
PUBLIC LAW 101-239

Sequester

Extended sequester affecting part A and HMO payments (a reduction of 2.1 percent) through December 31, 1989, and extended sequester for part B payments (a 2.1-percent reduction) through March 31, 1990. (Effective on enactment.)

Hospital capital payments

Extended the 15-percent reduction in hospital capital payments for discharges occurring during the period January 1 through September 30, 1990. (Effective on enactment.)

DRG weighting factors

Reduced the weighting factors for each diagnosis-related group (DRG) by 1.22 percent for hospital discharges occurring in fiscal year 1990 and revised the update factors for fiscal year 1990. (Effective on enactment.)

Disproportionate-share adjustment for hospitals

Increased the adjustment for certain hospitals that served a disproportionate share of low-income patients. (Effective for discharges occurring on or after April 1, 1990.)

Additional payments for rural hospitals

Extended rural referral centers designations for 3 years; expanded the Sole Community Hospital Program; established new criteria for Medicare-dependent small rural hospitals; and established the Essential Access Community Hospital Program. (Effective for varying periods after enactment.)

Physician payment reform

Established a fee schedule for payment of physician services based on a resource-based relative scale, to be phased in over a 5-year period beginning January 1, 1992.

Physician payments

Delayed the inflation update from January 1 until April 1, 1990 and reduced the 1990 update for certain physician services; reduced payments for certain overvalued procedures; and reduced payments under the radiology fee schedule. (Effective for the 9-month period beginning on April 1, 1990.)

Clinical lab fee schedule

Established a ceiling on lab fee schedule payments at 93 percent of the national median for the particular test. (Effective for lab tests performed on or after January 1, 1990.)

Durable medical equipment update

Eliminated the inflation update in the fee schedules for durable medical equipment. (Effective for equipment provided during calendar year 1990.)

Mental health services

Eliminated the dollar limit on payments for mental health services, and expanded settings in which services of clinical psychologists and clinical social workers could be covered. (Dollar limit elimination effective January 1, 1990; expanded settings provision effective July 1, 1990.)

Pap smear coverage

Authorized coverage of pap smears, once every 3 years, more often for women at high risk of developing cervical cancer. (Effective July 1, 1990.)

Agency for Health Care Policy and Research (AHCPR)

Created the AHCPR and authorized the agency to undertake research on the effectiveness, efficiency, quality, and outcomes of health care services, assuring that the needs and priorities of Medicare were reflected in such research. (Effective on enactment.)

Self-referral

Prohibited physician referral to clinical laboratories with which the referring physician has a financial relationship. (Effective January 1, 1992.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (OBRA 1990),
PUBLIC LAW 101-508

General payment freeze

Froze payments for part A services at fiscal year 1990 levels for the period October 21 through December 31, 1990. Reduced part B payments by 2 percent for November 1990 and December 1990. (Effective as specified.)

Hospital inpatient payment rates

Reduced update factors for PPS hospitals for fiscal years 1991-93. Set update factors for rural hospitals such that rural payment rates would equal those for "other urban" hospitals by fiscal year 1995. Increased and made permanent payment adjustments to disproportionate-share hospitals. (Effective for fiscal years 1991-95.)

Hospital capital payments

Reduced capital payments by 15 percent for fiscal year 1991; for fiscal years 1992-95, required reductions in hospital payments equal to 10 percent of what would have been paid for capital costs on a reasonable cost basis. (Effective for fiscal years 1991-95.)

Physician payments

Reduced the 1991 inflation update for primary care services and froze rates for other services; reduced 1992 increases for nonpri-

mary care services. Continued payment reductions for overpriced procedures and added to the list of such procedures. Established new limits on balance billing charges to be phased in over the 1991–93 period. (Payment limits effective for calendar years 1991 and 1992; balance billing limits effective beginning in 1991.)

Hospital outpatient payments

Reduced by 5.8 percent payments for services paid on a reasonable cost basis. (Effective for fiscal years 1991–95.)

Durable medical equipment (DME)

Replaced regional limits on DME fees with phased-in national upper and lower limits and reduced DME update. (Update reductions effective for calendar years 1991 and 1992; national limits effective for 1991 and later years.)

Clinical laboratory services

Limited the update for clinical laboratory services to 2 percent per year for 1991–93 and reduced the national limits on laboratory fee schedules. (Update reductions effective for calendar years 1991–93; national limit reductions effective January 1, 1991.)

Injectable drugs for osteoporosis

Added coverage of injectable drugs for treatment of bone fractures of homebound individuals with osteoporosis who were unable to self-administer the drug. (Effective January 1, 1991 through December 31, 1995.)

Mammography

Added coverage of mammography screenings at specified intervals. (Effective January 1, 1991.)

Part B deductible

Increased the part B deductible from \$75 to \$100. (Effective January 1, 1991.)

Part B premium

Set part B premiums at fixed dollar amounts projected to equal 25 percent of program costs. (Effective for fiscal years 1991–95.)

Medigap

Established mandatory standards for Medigap policies, including uniform benefit packages, to replace the previous voluntary certification system. (Generally effective no later than 1 year after promulgation of model regulation by National Association of Insurance Commissioners.)

Federally qualified health centers (FQHCs)

Established cost-based reimbursement for services furnished by FQHCs, including federally funded community and migrant health centers and similar facilities. (Effective October 1, 1991.)

HI tax

Raised the income level subject to the HI tax. (Effective January 1, 1991.)

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993),
PUBLIC LAW 103-66

Payment for part A services

Reduced update factors for inpatient hospital and hospice services for fiscal years 1994-97; reduced hospital capital payment rates for fiscal years 1996-98; froze cost limits for SNFs for fiscal years 1994-95; eliminated return on equity payments for SNFs. (Payment reductions effective as specified; elimination of return on equity effective October 1, 1993.)

Payment for physician services

Reduced updates for services other than primary care. Reduced Medicare volume performance standards (MVPS) for 1994 and subsequent years and increased the potential reductions in fee updates for failure to meet the MVPS for 1995 and subsequent years. (Update reductions effective for calendar years 1994 and 1995.)

Payment for other part B services

Froze payment rates for certain DME services, clinical laboratory services, ASC services, and home health agencies. Extended existing reductions in payments for hospital outpatient services for fiscal years 1996-98. (Payment freezes generally effective for 1994 and 1995.)

Graduate medical education

Froze per resident payment amounts for nonprimary care residents. (Effective for fiscal years 1994 and 1995.)

Part B premium

Extended policy of setting part B premium at 25 percent of program costs. (Effective for calendar years 1996-98.)

Oral cancer drugs

Added coverage of certain self-administered anticancer drugs. (Effective January 1, 1994.)

Physician ownership and referral

Extended self-referral prohibition to additional services, including DME, physical therapy, home health, prescription drugs, and hospital services. (Effective for referrals made after December 31, 1994.)

Part A revenue provisions

Eliminated upper limit on earnings subject to HI payroll tax. Also transferred into part A trust fund new revenues from increased taxation of Social Security benefits. (Effective January 1, 1994.)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF
1996, PUBLIC LAW 104-1

Added new criminal health care fraud provisions, strengthened existing civil and criminal fraud and abuse provisions and provided funding for new antifraud programs (generally effective on enactment or January 1, 1997).

BALANCED BUDGET ACT OF 1997, PUBLIC LAW 105-33

Hospitals

Froze PPS hospital and PPS-exempt hospitals and units and limited updates for fiscal years 1999–2002. Established a prospective payment system for inpatient rehabilitation hospitals, effective beginning in fiscal year 2001. Rebased capital payment rates and provided for additional reductions over the fiscal year 1997–2002 period. Reduced the IME payment from the current 7.7 percent to 5.5 percent by fiscal year 2001 and reformed direct GME payments (generally effective on enactment or October 1, 1997).

Skilled nursing facilities

Provided for a phase in of a prospective payment system that will pay a Federal per diem rate for covered SNF services (generally effective July 1, 1998).

Home health

Provided for the establishment of a prospective payment system for home health services. Provided for a reduction in per visit cost limits prior to the implementation of the prospective payment system, clarified the definitions of part-time and intermittent care, and provided for a study of the definition of homebound. Provided for the transfer of some home health costs from part A to part B (prospective payment effective October 1, 1999, reduction in cost-limits effective on enactment, definition clarification effective October 1, 1997, and transfer of costs effective January 1, 1998).

Hospice

Reduced the hospice payment update for each of fiscal year 1998 through fiscal year 2002, and clarified the definition of hospice care (generally effective on enactment).

Physicians

Provided for use of a single conversion factor; replaced the volume performance standard with the sustainable growth rate; provided for phased-in implementation of resource-based practice expenses; and permitted use of private contracts under specified conditions (generally effective January 1, 1998).

Hospital outpatient departments

Extended reductions in payments for outpatient hospital services paid on the basis of costs through December 1999 and established a prospective payment system for hospital outpatient departments for covered services beginning in 1999 (generally effective on enactment).

Other providers

Froze payments for laboratory services for fiscal years 1998–2002; provided for establishment of a fee schedule in 2000 for payment for ambulance services (generally effective on enactment).

Beneficiary payments

Permanently set the part B premium at 25 percent of program costs and expanded the premium assistance beginning in 1998 available under the Specified Low-Income Medicare Beneficiary (SLMB) Program (effective on enactment).

Prevention initiatives

Authorized coverage for annual mammograms for all women over 40. Added coverage for screening pelvic exams, prostate cancer screening tests, colorectal cancer screening tests, diabetes self-management training services, and bone mass measurements for certain high-risk persons (generally effective in 1998, except prostate cancer screening effective 2000).

Supplementary coverage

Provided for guaranteed issuance of specified Medigap policies without a preexisting condition exclusion for certain continuously enrolled aged individuals (effective July 1, 1998).

Competitive bidding

Provided for competitive bidding demonstrations for furnishing part B services (not including physicians services) (effective on enactment).

Commissions

Established a 17-member National Advisory Commission on the Future of Medicare (with appointments to be made by December 1, 1997). Established the Medicare Payment Advisory Commission replacing the Prospective Payment Assessment Commission and the Physician Payment Review Commission (with appointments to be made by September 30, 1997).

Medicare+Choice

Established a new part C of Medicare called Medicare+Choice. This program is built on the existing Medicare Risk Contract Program which enabled beneficiaries to enroll, where available, in health maintenance organizations (HMOs) that contracted with the Medicare Program. The Medicare+Choice Program expands, beginning in 1999, the private plan options that could contract with Medicare to other types of managed care organizations (for example, preferred provider organizations and provider-sponsored organizations), private fee-for-service plans, and, on a limited demonstration basis, high deductible plans (called medical savings account plans) offered in conjunction with medical savings accounts (effective on enactment).

**CBO SAVINGS AND REVENUE ESTIMATES FOR BUDGET
RECONCILIATION ACTS, 1981–93**

Table 2–41 shows estimates of savings and revenue increases for budget reconciliation legislation enacted from 1981 to 1993. These estimates were made at the time of enactment by the Congressional Budget Office (CBO). It should be noted that the estimates are compared with the CBO budget baseline in effect at the time. The savings from the various reconciliation bills cannot be added together.

TABLE 2–41.—MEDICARE SAVINGS ESTIMATES, 1981–93

[In billions of dollars]

Legislative act	Savings
Omnibus Budget Reconciliation Act of 1981:	
Spending reductions for fiscal years 1982–84	\$4.3
Tax Equity and Fiscal Responsibility Act of 1982:	
Spending reductions for fiscal years 1983–87	23.1
Social Security Amendments of 1983:	
Spending reductions for fiscal years 1983–88	0.2
Revenue increases for fiscal years 1983–88	11.5
Deficit Reduction Act of 1984:	
Spending reductions for fiscal years 1984–87	6.1
Consolidated Omnibus Budget Reconciliation Act of 1985:	
Spending reductions for fiscal years 1986–81	12.6
Omnibus Budget Reconciliation Act of 1986:	
Spending reductions for fiscal years 1987–89	1.0
Omnibus Budget Reconciliation Act of 1987:	
Spending reductions for fiscal years 1988–90	9.8
Omnibus Budget Reconciliation Act of 1989:	
Spending reductions for fiscal years 1990–94	10.9
Omnibus Budget Reconciliation Act of 1990:	
Spending reductions for fiscal years 1991–95	43.1
Revenue increases for fiscal years 1991–95	26.9
Omnibus Budget Reconciliation Act of 1993:	
Spending reductions for fiscal years 1994–98	55.8
Revenue increases for fiscal years 1994–98	53.8
Health Insurance Portability and Accountability Act of 1996:	
Spending reductions for fiscal years 1996–2002	3.0
Balanced Budget Act of 1997:	
Spending reductions for fiscal years 1998–2002	116.4
Spending reductions for fiscal years 1998–2007	393.8

Note.—Savings relative to baseline at time of enactment. Figures cannot be summed.

Source: Committee on Ways and Means, (1988, 1989, 1991); Congressional Budget Office.

MEDICARE HISTORICAL DATA

Tables 2-42 through 2-52 present detailed historical data on the Medicare Program. Tables 2-42, 2-43, and 2-44 present detailed enrollment data. Table 2-45 describes the percentage of enrollees participating in a State buy-in agreement. Tables 2-46 and 2-47 show the distribution of Medicare payments by type of coverage and by type of service. Tables 2-48 and 2-49 show the number of persons served and the average reimbursement per person served and per enrollee. Table 2-50 shows the utilization of hospital services. Table 2-51 presents Medicare utilization and reimbursement by State. Table 2-52 shows the number of participating institutions and organizations.

TABLE 2-42.—NUMBER OF MEDICARE ENROLLEES BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, SELECTED YEARS 1968–95

[In thousands]

Type of entitlement and coverage	Year														Average annual rate of growth (percent)		
	1968	1975	1980	1982	1984	1986	1988	1989	1990	1991	1992	1993	1994	1995	1968– 75	1975– 83	1984– 95
Total:																	
HI ¹ and/or SMI ² ...	19,821	24,959	28,478	29,494	30,456	31,750	32,980	33,579	34,203	34,870	35,579	36,306	36,935	37,535	3.3	2.3	2.1
Total HI:	19,770	24,640	28,067	29,069	29,996	31,216	32,413	33,040	33,719	34,429	35,153	35,904	36,543	37,135	3.2	2.3	2.2
HI only	1,016	1,054	1,079	1,082	1,040	1,160	1,363	1,481	1,574	1,633	1,645	1,694	1,768	1,850	0.5	0.0	5.9
Total SMI	18,805	23,905	27,400	28,412	29,416	30,590	31,617	32,099	32,629	33,237	33,933	34,612	35,167	35,685	3.5	2.4	2.0
SMI only	51	318	411	425	460	534	567	539	484	441	425	425	392	400	29.9	4.1	-1.4
Aged:																	
HI and/or SMI	19,821	22,790	25,515	26,540	27,571	28,791	29,879	30,409	30,948	31,485	32,010	32,462	32,801	33,142	2.0	2.2	1.9
Total HI	19,770	22,472	25,104	26,115	27,112	28,257	29,312	29,869	30,464	31,043	31,584	32,060	32,409	32,742	1.8	2.2	1.9
HI only	1,016	845	835	833	807	928	1,098	1,192	1,263	1,300	1,297	1,315	1,353	1,000	-2.6	-0.4	2.2
Total SMI	18,805	21,945	24,680	25,707	26,765	27,863	28,780	29,216	29,686	30,185	30,712	31,147	31,447	31,742	2.2	2.3	1.7
SMI only	51	318	411	425	459	534	567	539	484	441	425	401	392	400	29.9	4.1	-1.4
All disabled:																	
HI and/or SMI	(4)	2,168	2,963	2,954	2,884	2,959	3,102	3,171	3,255	3,385	3,568	3,844	4,135	4,393	NA	3.8	4.3
Total HI	(4)	2,168	2,963	2,954	2,884	2,959	3,101	3,171	3,255	3,385	3,568	3,844	4,135	4,393	NA	3.8	4.3
HI only	(4)	209	244	249	233	232	265	288	311	333	348	378	807	451	NA	1.5	6.8
Total SMI	(4)	1,959	2,719	2,759	2,682	2,727	2,837	2,883	2,943	3,052	3,220	3,466	3,720	3,942	NA	4.0	4.0
SMI only ³	(4)																
ESRD ⁵ only:																	
HI and/or SMI	(4)	13	28	27	30	39	53	58	65	69	72	226	235	71	NA	10.1	9.0
Total HI	(4)	13	28	27	30	39	53	58	65	69	72	224	233	71	NA	10.1	9.0
HI only	(4)	1	1	2	2	3	4	5	6	6	7	11	10	8	NA	9.1	14.9
Total SMI	(4)	12	27	26	28	36	49	54	59	62	65	215	225	63	NA	10.1	8.4
SMI only ³	(4)																

¹ Hospital insurance, entitlement began in 1973.

² Supplementary medical insurance, disabled and end-stage renal disease only must have HI to be eligible for SMI coverage.

³ End-stage renal disease.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-43.—GROWTH IN NUMBER OF AGED MEDICARE ENROLLEES BY SEX AND AGE, SELECTED YEARS 1968–95

Sex and age	Year										Average annual growth rate (percent)		Total aged population 1995 ¹	Enrollees as percent of total aged population 1995
	1968	1975	1980	1984	1986	1990	1991	1992	1993	1995	1968–75	1975–84	1986–95	
All persons	19,496	22,548	25,515	27,571	28,791	30,948	31,485	32,011	32,462	33,142	2.1	2.3	1.6	33,530 97.8
65–69	6,551	7,642	8,459	8,784	9,163	9,695	9,690	9,692	9,683	9,517	2.2	1.6	0.4	9,928 96.6
70–74	5,458	5,950	6,756	7,300	7,564	7,951	8,163	8,373	8,509	8,756	1.2	2.3	1.6	8,830 98.6
75–79	3,935	4,313	4,809	5,327	5,573	6,058	6,175	6,261	6,369	6,563	1.3	2.4	1.8	6,681 95.8
80–84	2,249	2,793	3,081	3,382	3,559	3,957	4,065	4,166	4,257	4,470	3.1	2.2	2.6	4,463 97.8
85 and over	1,303	1,850	2,410	2,778	2,932	3,286	3,393	3,519	3,643	3,837	5.1	4.6	3.0	3,628 102.9
Males	8,177	9,201	10,268	11,044	11,525	12,416	12,650	12,886	13,095	13,434	1.7	2.0	1.7	13,688 96.9
65–69	2,944	3,420	3,788	3,942	4,109	4,352	4,358	4,374	4,386	4,348	2.2	1.6	0.6	4,506 96.8
70–74	2,322	2,504	2,841	3,088	3,214	3,406	3,505	3,604	3,670	3,791	1.1	2.4	1.9	3,836 98.1
75–79	1,596	1,669	1,854	2,061	2,160	2,382	2,441	2,485	2,542	2,642	0.6	2.4	2.3	2,720 94.3
80–84	864	1,005	1,062	1,161	1,221	1,369	1,411	1,454	1,495	1,593	2.2	1.6	3.0	1,609 96.0
85 and over	450	604	722	793	822	906	934	968	1,003	1,060	4.3	3.1	2.9	1,017 101.2
Females	11,319	13,347	15,247	16,526	17,266	18,532	18,835	19,125	19,367	19,708	2.4	2.4	1.5	19,842 98.5
65–69	3,606	4,222	4,671	4,842	5,054	5,343	5,332	5,317	5,298	5,169	2.3	1.5	0.3	5,422 96.5
70–74	3,136	3,446	3,914	4,212	4,350	4,545	4,657	4,769	4,839	4,964	1.4	2.3	1.5	4,994 99.0
75–79	2,338	2,644	2,954	3,266	3,414	3,676	3,734	3,776	3,827	3,921	1.8	2.4	1.6	3,961 96.8
80–84	1,386	1,788	2,019	2,222	2,339	2,588	2,653	2,713	2,762	2,877	3.7	2.4	2.3	2,854 98.9
85 and over	853	1,246	1,689	1,985	2,110	2,380	2,459	2,551	2,640	2,777	5.6	5.3	3.1	2,611 103.6

¹ U.S. residents only.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy; and U.S. Department of Commerce, Bureau of the Census.

TABLE 2-44.—GROWTH IN NUMBER OF DISABLED MEDICARE ENROLLEES WITH HOSPITAL INSURANCE COVERAGE BY TYPE OF ENTITLEMENT AND AGE,
SELECTED YEARS 1975–95

Type of entitlement and age	Year										Average annual per- cent growth rate		
	1975	1980	1984	1988	1990	1992	1993	1994	1995	1975– 82	1982– 88	1982– 95	
All disabled persons	2,058,424	2,425,231	2,884,410	3,101,482	3,254,983	3,568,625	3,844,178	4,134,604	4,393,287	2.3	4.3	4.7	
Under age 35	238,070	193,392	388,240	471,129	483,262	512,495	545,644	574,003	587,709	-2.7	15.7	8.8	
35–44	251,142	258,374	422,207	572,408	654,953	762,759	834,426	908,076	973,328	1.0	13.4	10.4	
45–54	508,345	572,823	584,214	670,131	741,193	874,797	974,589	1,083,945	1,187,993	0.7	3.9	6.4	
55–64	1,060,967	1,400,642	1,489,749	1,397,814	1,375,575	1,418,574	1,489,519	1,568,580	1,644,257	4.2	-0.2	1.1	
All disabled workers	1,638,662	2,396,897	2,309,866	2,456,135	2,579,097	2,856,517	3,100,532	3,367,187	3,602,559	5.5	0.5	3.2	
Under age 35	100,439	184,619	193,094	249,291	257,760	286,486	317,876	345,322	357,794	9.3	4.9	5.1	
35–44	164,439	253,186	290,395	414,749	482,071	576,549	642,386	710,431	769,071	7.0	7.8	8.6	
45–54	426,451	565,846	485,378	552,442	612,692	731,713	823,552	926,390	1,023,616	3.0	0.8	5.3	
55–64	947,333	1,393,246	1,340,999	1,239,653	1,226,574	1,261,769	1,316,718	1,385,044	1,452,078	5.9	-2.1	-0.2	
Adults disabled as children	324,864	409,072	459,620	519,009	542,416	566,336	580,439	595,750	609,081	4.4	2.8	2.5	
Under age 35	151,708	173,684	186,003	207,311	208,901	208,710	210,760	212,944	213,973	2.4	2.2	1.3	
35–44	84,508	105,092	126,252	146,460	158,725	170,363	176,182	182,861	189,108	4.8	3.8	3.8	
45–54	71,484	80,381	87,380	99,444	107,092	117,333	122,435	127,622	132,484	2.4	2.8	3.5	
55–64	45,164	49,910	59,985	65,774	67,698	69,930	71,062	72,323	73,516	3.2	2.7	2.1	
Widows and widowers	83,771	110,785	85,227	73,101	68,793	74,157	91,643	101,247	111,121	2.5	-5.0	0.9	
Under 55	7,446	7,577	4,608	5,685	5,615	7,399	9,811	11,458	12,420	-3.5	-0.4	6.0	
55–64	76,325	103,208	80,618	67,416	63,178	66,758	81,832	91,789	98,701	2.9	-5.3	-0.4	
End-stage renal disease only ..	11,127	28,334	29,697	53,237	64,677	71,615	71,564	68,420	70,526	13.7	11.7	7.6	
Under age 35	3,729	8,773	9,143	14,507	16,601	17,299	17,008	15,737	15,942	12.3	9.5	5.0	
35–44	2,187	5,188	5,559	11,199	14,157	15,847	15,858	14,784	15,149	12.3	14.7	9.0	
45–54	2,966	6,977	6,848	12,560	15,794	18,352	18,791	18,475	19,473	12.2	11.2	8.6	
55–64	2,245	7,396	8,147	14,971	18,125	20,117	19,907	19,424	19,962	18.6	12.5	7.9	

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-45.—NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OR 1995 AREA OF RESIDENCE, SELECTED YEARS 1968–95

Year or area of residence ¹	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
Year:						
1968	1,648	8.8	1,648	8.8	NA	NA
1975	2,846	12.0	2,483	11.4	363	18.7
1980	2,954	10.9	2,449	10.0	504	18.9
1981	3,257	11.7	2,659	10.6	598	21.7
1982	2,791	9.8	2,288	8.9	503	18.6
1983	2,654	9.3	2,177	8.4	477	18.1
1984	2,601	8.9	2,127	8.0	474	18.2
1985	2,670	9.0	2,164	8.0	505	19.2
1986	2,776	9.2	2,222	8.0	554	20.9
1987	2,985	9.6	2,337	8.2	648	23.2
1988	3,033	9.6	2,341	8.1	691	24.4
1989	3,351	10.4	2,549	8.7	802	27.8
1990	3,604	11.0	2,714	9.1	890	30.2
1991	3,768	10.4	2,817	8.7	949	27.8
1992	4,066	12.0	2,972	9.7	1,083	33.6
1993	4,353	12.6	3,122	10.0	1,231	35.5
1994	4,625	13.2	3,243	10.3	1,382	37.2
1995	4,895	13.7	3,369	10.6	1,526	38.7
Area of residence: ¹						
Alabama	124	20.1	86	16.4	34	41.5
Alaska	6	19.4	4	14.8	2	50.0
Arizona	46	8.0	31	6.0	15	30.0
Arkansas	83	20.3	58	16.7	22	41.5
California	783	22.4	561	17.9	204	63.6
Colorado	49	12.2	32	9.0	17	42.5
Connecticut	45	9.4	31	7.1	19	51.4
Delaware	6	6.2	4	4.6	3	33.3
District of Columbia ...	15	21.4	11	17.5	4	57.1
Florida	284	11.1	211	9.0	77	42.3
Georgia	170	21.1	119	17.5	48	45.3
Hawaii	18	12.9	14	10.8	4	44.4
Idaho	14	9.7	8	6.2	5	41.7
Illinois	144	9.3	89	6.4	54	37.8
Indiana	84	10.6	53	7.5	29	34.9
Iowa	53	11.5	33	7.8	18	48.6
Kansas	36	9.7	24	7.1	12	41.4
Kentucky	101	17.8	67	14.3	35	42.2
Louisiana	114	20.5	80	17.1	35	44.9
Maine	29	14.9	18	10.6	12	57.1
Maryland	64	11.2	44	8.5	19	38.8
Massachusetts	122	13.9	83	10.6	49	59.0
Michigan	145	11.2	75	6.5	53	37.6
Minnesota	57	9.4	35	6.3	26	53.1

TABLE 2-45.—NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OR 1995 AREA OF RESIDENCE, SELECTED YEARS 1968–95—Continued

Year or area of residence ¹	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
Mississippi	111	28.9	77	24.4	30	51.7
Missouri	77	9.6	48	6.7	28	34.1
Montana	11	8.7	7	6.3	5	38.5
Nebraska	17	7.1	9	4.1	8	44.4
Nevada	15	8.2	10	6.1	5	33.3
New Hampshire	6	4.1	3	2.2	3	23.1
New Jersey	127	11.3	92	9.0	39	42.4
New Mexico	31	16.1	22	12.6	9	40.9
New York	313	12.6	232	10.5	105	42.7
North Carolina	177	17.8	138	16.1	56	47.9
North Dakota	6	6.0	4	4.3	2	25.0
Ohio	173	10.8	119	8.3	54	32.5
Oklahoma	65	13.8	45	10.8	17	38.6
Oregon	45	10.0	29	7.1	16	42.1
Pennsylvania	166	8.3	105	5.8	64	38.8
Rhode Island	15	9.6	10	7.0	6	40.0
South Carolina	103	20.9	69	16.6	31	48.4
South Dakota	13	11.6	9	8.8	4	44.4
Tennessee	150	20.2	104	16.4	52	55.3
Texas	322	16.1	252	14.1	75	41.4
Utah	15	8.4	8	5.0	6	40.0
Vermont	12	15.2	8	11.4	5	62.5
Virginia	110	14.0	74	10.8	34	40.5
Washington	76	11.5	46	7.8	29	49.2
West Virginia	40	12.5	26	9.7	16	34.0
Wisconsin	86	11.7	45	6.8	31	45.6
Wyoming	5	8.6	3	5.8	2	40.0
Puerto Rico	0	0.0	0	0.0	0	0.0
Guam and Virgin Islands ²	1	8.9	1	9.1	0	6.3
United States	4,892	13.9	3,367	10.7	1,525	41.7
All areas	4,895	13.7	3,369	10.6	1,526	41.0

¹ State of residence is not necessarily State that bought coverage.

² Data for these areas combined to prevent disclosure of confidential information.

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-46.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE AND TYPE OF SERVICE, SELECTED YEARS 1975-95

Type of coverage and type of service	1975 amount	Per-cent	1980 amount	Per-cent	1985 amount	Per-cent	1990 amount	Per-cent	1992 amount	Per-cent	1993 amount	Per-cent	1994 amount	Per-cent	1995 amount	Per-cent
Hospital insurance	\$11,315	72.6	\$25,051	70.2	\$47,444	67.4	\$66,050	60.9	\$83,691	62.9	\$93,290	63.3	\$103,093	63.8	116,176	64.1
Inpatient	10,877	69.8	24,116	67.6	44,940	63.8	59,383	54.7	71,000	53.4	76,182	51.7	81,517	50.4	89,127	49.2
Skilled nursing facility	254	1.6	395	1.1	548	0.8	2,620	2.4	4,051	3.0	5,797	3.9	7,596	4.7	9,595	5.3
Home health agency	104	0.7	540	1.5	1,913	2.7	3,689	3.4	7,760	5.8	10,252	7.0	12,559	7.8	15,571	8.6
Hospice .....	.....	.....	.....	.....	43	0.1	358	0.3	880	0.7	1,059	0.7	1,421	0.9	1,883	1.0
Supplementary medical insurance	4,273	27.4	10,635	29.8	22,947	32.6	42,468	39.1	49,260	37.1	53,979	36.7	58,618	36.2	64,973	35.9
Physicians ¹ ..	3,416	21.9	8,187	22.9	17,312	24.6	29,609	27.3	32,394	24.4	35,282	24.0	37,435	23.1	40,435	22.3
Outpatient hospital	643	4.1	1,897	5.3	4,319	6.1	8,482	7.8	10,990	8.3	11,539	7.8	13,497	8.3	15,394	8.5
Home health agency	95	0.6	234	0.7	38	0.1	74	0.1	71	0.1	112	0.1	144	0.1	194	0.1
Group practice plan ..	80	0.5	203	0.6	720	1.0	2,827	2.6	3,933	3.0	5,002	3.4	5,465	3.4	6,883	3.8
Independent laboratory	39	0.3	114	0.3	558	0.8	1,476	1.4	1,872	1.4	2,044	1.4	2,077	1.3	2,067	1.1
Total payment	15,588	100.0	35,686	100.0	70,391	100.0	108,518	100.0	132,951	100.0	147,269	100.0	161,711	100.0	181,149	100.0

¹ Includes other services.

Note.—Amounts in millions.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-47.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE, TYPE OF SERVICE, AND TYPE OF ENROLLEE, 1995

Type of coverage and service	Type of enrollee					
	All enrollees		Aged		Disabled	
	Amount (in millions)	Percentage distribu- tion	Amount (in millions)	Percentage distribu- tion	Amount (in millions)	Percentage distribu- tion
Hospital insurance	\$116,176	78.9	\$102,889	64.8	\$13,287	59.3
Inpatient	89,127	60.5	77,607	48.9	11,520	51.4
Skilled nursing facil- ity	9,595	6.5	9,176	5.8	419	1.9
Home health agency	15,571	10.6	14,317	9.0	1,254	5.6
Hospice	1,883	1.3	1,789	1.1	94	0.4
Supplementary medical insurance	64,973	44.1	55,844	35.2	9,129	40.7
Physicians ¹	40,435	27.5	35,813	22.6	4,622	20.6
Outpatient hospital ...	15,394	10.5	11,955	7.5	3,439	15.3
Home health agency	194	0.1	194	0.1	0	0.0
Group practice plan ..	6,883	4.7	6,096	3.8	787	3.5
Independent labora- tory	2,067	1.4	1,786	1.1	281	1.3
Total payments	181,149	100.0	158,733	100.0	22,416	100.0

¹ Includes other services.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-48.—PERSONS SERVED AND REIMBURSEMENTS FOR AGED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND BY 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1968-95

Year, period, and 1994 characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Year:									
1968	397.8	\$670.08	\$266.56	204.0	\$934.42	\$190.67	394.8	\$203.94	\$80.51
1975	527.9	1,054.63	556.78	220.9	1,855.38	409.78	536.0	295.91	158.60
1980	637.7	1,790.51	1,141.84	240.0	3,378.53	810.77	652.3	545.42	355.77
1981	655.0	2,024.49	1,325.97	243.4	3,877.39	943.84	669.5	613.13	410.47
1982	641.4	2,439.38	1,564.65	250.7	4,461.53	1,118.69	653.8	732.53	478.92
1983	660.2	2,610.80	1,723.69	250.9	4,803.71	1,205.13	672.2	825.26	554.77
1984	685.7	NA	NA	239.6	NA	NA	698.9	NA	NA
1985	722.1	2,762.06	1,994.59	218.8	6,167.28	1,349.60	739.1	933.25	689.79
1986	731.7	2,870.05	2,099.93	213.0	6,528.36	1,390.28	750.8	1,012.17	759.95
1987	754.1	3,025.22	2,281.19	209.8	6,902.60	1,448.33	775.9	1,147.95	890.64
1988	767.8	3,177.60	2,439.87	207.5	7,514.76	1,559.23	792.5	1,192.41	944.96
1989	784.9	3,444.86	2,703.90	206.1	8,196.19	1,688.96	812.8	1,338.10	1,087.56
1990	801.6	3,578.43	2,868.57	209.0	8,519.97	1,780.60	831.6	1,398.86	1,163.29
1991	800.1	3,905.65	3,124.82	211.8	9,348.53	1,980.26	830.0	1,473.27	1,222.80
1992	794.4	4,193.90	3,331.60	213.0	10,126.30	2,157.20	823.4	1,522.90	1,254.00
1993	825.4	4,263.99	3,519.44	215.6	10,555.75	2,275.67	855.9	1,548.86	1,325.63
1994	830.0	4,739.79	3,933.86	217.3	11,794.20	2,563.28	861.0	1,699.26	1,461.54
1995	826.1	5,074.92	4,192.53	218.3	12,541.50	2,737.52	858.0	1,392.49	1,553.67

TABLE 2-48.—PERSONS SERVED AND REIMBURSEMENTS FOR AGED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND BY 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1968–95—Continued

Year, period, and 1994 characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Annual percentage change in period:									
1968–75	4.1	6.7	11.1	1.1	10.3	11.5	4.5	5.5	10.2
1975–85	3.2	10.1	13.6	−0.1	12.8	12.7	3.3	12.2	15.8
1985–95	1.4	6.3	7.7	0.0	7.4	7.3	1.5	4.1	8.5
Age:									
65 and 66 years	809.3	\$3,014.06	\$2,467.31	130.4	\$11,146.10	\$1,493.82	888.4	\$1,216.70	\$1,087.20
67 and 68 years	746.2	3,735.35	2,798.73	140.8	11,820.17	1,674.16	790.3	1,532.80	1,214.86
69 and 70 years	772.6	3,929.28	3,038.79	156.7	11,784.69	1,852.45	808.1	1,568.08	1,269.35
71 and 72 years	790.2	4,280.82	3,429.51	171.2	12,135.43	2,135.10	818.8	1,655.06	1,370.48
73 and 74 years	816.6	4,628.87	3,746.84	194.8	12,232.54	2,348.54	838.0	1,770.49	1,467.95
75–79 years	844.8	5,173.87	4,434.61	232.3	12,242.76	2,875.92	858.2	1,868.11	1,624.22
80–84 years	889.6	5,823.22	5,183.68	304.5	11,795.31	3,546.93	900.3	1,904.48	1,716.14
85 years and over	910.6	6,416.43	5,840.81	383.1	11,196.61	4,214.11	947.5	1,860.01	1,762.06
Sex:									
Male	784.4	5,125.14	4,046.50	212.7	12,354.05	2,640.54	824.6	1,823.24	1,510.64
Female	854.6	4,498.92	3,857.40	222.1	11,422.80	2,510.57	880.2	1,619.11	1,428.92
Race:									
White	835.8	4,611.30	3,862.70	217.2	11,558.04	2,496.00	865.0	1,659.52	1,437.14
All other	754.9	6,094.26	4,628.90	233.0	13,829.43	3,204.08	803.1	2,040.84	1,645.54

TABLE 2-49.—PERSONS SERVED AND REIMBURSEMENTS FOR DISABLED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND BY 1995 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1968-95

Year, period, and 1994 characteristic	Hospital insurance and/or supplementary medi- cal insurance				Hospital insurance				Supplementary medical insurance				
	Persons served per 1,000 enrollees		Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
	Per person served	Per enrollee	Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee			
Year:													
1968	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1975	449.5	\$1,548.09	\$695.83		219.2	\$2,076.58	\$455.20	471.4	\$564.95		471.4	\$266.32	
1980	594.1	2,544.04	1,511.34		245.7	3,798.09	933.16	633.8	994.18		633.8	630.06	
1981	615.2	2,880.99	1,772.39		251.4	4,400.27	1,106.16	655.9	1,103.92		655.9	724.04	
1982	608.9	3,431.26	2,089.35		256.9	5,109.65	1,312.85	650.5	1,303.37		650.5	847.90	
1983	628.8	3,658.08	2,300.24		257.7	5,549.82	1,430.30	670.1	1,412.07		670.1	946.23	
1984	639.5	NA	NA		242.6	NA	NA	683.5	NA		683.5	NA	NA
1985	668.8	3,855.22	2,578.24		227.9	7,223.96	1,646.25	715.5	1,414.04		715.5	1,011.70	
1986	681.0	4,032.05	2,745.64		226.3	7,622.94	1,724.99	729.0	1,518.86		729.0	1,107.32	
1987	695.7	3,993.70	2,778.14		219.4	7,610.01	1,669.66	747.8	1,611.42		747.8	1,205.10	
1988	703.7	4,114.84	2,895.52		209.3	8,372.64	1,752.76	760.0	1,643.77		760.0	1,249.35	
1989	721.3	4,530.89	3,268.36		208.0	9,481.76	1,971.89	785.0	1,816.65		785.0	1,426.08	
1990	734.3	4,702.65	3,452.97		208.9	9,846.77	2,056.60	803.5	1,921.76		803.5	1,544.18	
1991	728.5	5,069.61	3,693.15		208.7	10,634.43	2,218.91	799.0	2,046.50		799.0	1,635.16	
1992	729.3	5,351.81	3,903.33		208.9	11,278.42	2,355.73	799.4	2,145.26		799.4	1,714.91	
1993	751.3	5,487.71	4,123.00		211.1	11,678.14	2,465.72	824.7	2,229.08		824.7	1,838.22	
1994	755.9	6,020.83	4,551.42		212.6	13,082.43	2,781.71	831.7	2,365.02		831.7	1,966.96	
1995	758.6	6,308.12	4,785.54		212.4	13,666.40	2,902.71	836.9	2,507.18		836.9	2,098.15	

Annual percentage change
in period:

	NA	NA	NA	NA	NA	NA	NA	NA	NA
1968–1975	4.05	9.55	13.99	0.39	13.28	13.72	4.26	9.61	14.28
1975–1985	1.27	5.05	6.38	–0.70	6.58	5.84	1.58	5.89	7.57
1985–1994									

Age:

Under 35 years	740.6	\$6,165.57	\$4,566.25	200.5	\$13,654.42	\$2,736.12	806.2	\$2,494.30	\$2,010.93
35–44 years	731.1	6,099.46	4,459.24	197.8	13,460.28	2,661.94	809.8	2,483.45	2,011.13
45–54 years	729.1	6,252.92	4,559.26	199.4	13,635.98	2,718.60	816.7	2,550.75	2,083.13
55–59 years	765.1	6,573.88	5,029.76	220.2	13,959.38	3,074.09	842.7	2,581.74	2,175.65
60–64 years	831.9	6,453.85	5,368.65	246.0	13,679.54	3,364.86	904.9	2,434.15	2,202.71

Sex:

Male	713.5	6,286.21	4,485.01	199.9	13,913.10	2,780.83	789.6	2,416.56	1,908.13
Female	825.9	6,336.28	5,232.85	231.0	13,348.74	3,084.11	906.4	2,623.31	2,377.66

Race:

White	760.4	5,684.71	4,322.77	204.5	12,978.13	2,654.26	840.2	2,215.36	1,861.44
All other	762.9	8,127.10	6,200.45	239.8	15,347.97	3,679.88	833.8	3,341.78	2,786.50

Census region:

Northeast	781.0	6,914.23	5,399.69	212.5	15,713.52	3,339.57	866.6	2,668.28	2,312.38
North central	778.3	5,709.39	4,443.64	211.2	12,903.54	2,725.33	859.6	2,229.50	1,916.47
South	792.3	6,269.54	4,967.55	235.7	12,806.23	3,017.91	849.4	2,482.44	2,108.58
West	686.6	6,868.41	4,715.68	179.2	15,615.82	2,798.55	752.6	2,818.33	2,121.17

NA—Not available.

Note.—Data for 1995 are preliminary.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-50.—USE OF SHORT-STAY HOSPITAL SERVICES BY MEDICARE EMPLOYEES BY YEAR AND 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1975-95

Calendar year, period, and 1994 characteristic	Hospital in- surance en- rollees in thousands		Discharges		Total days of care			Program payments			
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per 1,000 enrollees	Number in thousands	Per dis- charge	Per 1,000 en- rollees	Amount in millions	Per discharge	Per cov- ered day of care	Per en- rollee
Year:											
1975	24,640		8,001	325	89,275	11.2	3,623	\$9,748	\$1,218	\$109	\$396
1980	28,067		10,279	366	109,175	10.6	3,890	22,099	2,150	202	787
1982	29,069		11,109	382	113,047	10.0	3,889	30,601	2,755	271	1,053
1984	29,996		10,896	363	96,485	8.9	3,217	38,500	3,533	399	1,284
1985	30,589		10,027	328	86,339	8.6	2,823	40,200	4,009	466	1,314
1986	31,216		10,044	322	86,910	8.7	2,784	41,781	4,160	481	1,338
1987	31,853		10,110	317	89,651	8.9	2,815	44,068	4,359	492	1,383
1988	32,483		10,256	316	90,873	8.9	2,798	46,879	4,571	516	1,443
1989	33,040		10,148	307	89,902	8.9	2,721	49,091	4,838	546	1,486
1990	33,719		10,522	312	92,735	8.8	2,750	53,708	5,104	579	1,593
1991	34,428		10,896	316	93,936	8.6	2,728	58,901	5,406	627	1,711
1992	35,154		11,111	316	92,900	8.4	2,643	64,976	5,848	699	1,848
1993	35,904		11,158	311	88,871	8.0	2,475	67,439	6,044	759	1,878
1994	36,543		11,471	314	85,734	7.5	2,346	70,623	6,157	824	1,933
1995	37,135		11,681	315	81,282	7.0	2,189	74,836	6,407	921	2,015
Annual percentage change in period:											
1975-1984 ¹	2.2	4.8		2.4	1.0	-2.8	-1.5	18.7	14.2	17.6	15.8
1984-1994 ¹	2.0	-1.3		-3.1	-1.2	-1.7	-3.1	6.3	5.7	7.5	4.2
1975-1994 ¹	2.1	1.9		-0.2	-0.5	-2.3	-2.5	10.7	8.7	11.3	8.5

Age:	Less than 65 years	65-69 years	70-74 years	75-79 years	80-84 years	85 years or over
Sex:	Male	Female				
Race: ²	White	All other				
Census region:	Northeast	North central	South	West		

¹ Does not reflect discharges for beneficiaries who received covered services but for whom program payments were reported during the year; for example, beneficiaries who received inpatient services in health maintenance organizations were not included in the denominator used to calculate the average program payments per discharge.

²Excludes unknown race.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-51.—NUMBER OF AGED PERSONS SERVED UNDER HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE PER 1,000 ENROLLED AND REIMBURSEMENT PER PERSON SERVED BY CENSUS DIVISION AND STATE, SELECTED CALENDAR YEARS 1967-94

Census division and State	Year and persons served per 1,000 enrolled					Annual percent change					Year and reimbursement per person served					Annual percent change				
	1967	1985	1990	1994	1995	1967-85	1985-90	1990-93	1993-95		1967	1985	1990	1994	1995	1967-85	1985-90	1990-93	1993-95	
New England	380.4	767.4	829.0	871.7	871.1	4.0	1.6	1.4	0.4		680	2,708	3,573	5,018	5,546	8.0	5.7	8.2	10.7	
Maine	330.1	756.1	868.8	920.0	924.5	4.7	2.8	1.8	0.4		586	2,369	2,744	3,704	3,906	8.1	3.0	6.4	8.7	
New Hampshire	391.6	739.7	810.5	874.3	888.1	3.6	1.8	2.4	0.6		467	2,374	2,974	3,820	4,043	9.5	4.6	5.8	7.1	
Vermont	411.7	742.8	841.0	888.8	907.5	3.3	2.5	1.3	1.8		515	1,990	2,569	3,494	4,067	7.8	5.2	7.6	12.7	
Massachusetts	394.2	766.5	813.6	851.8	840.6	3.8	1.2	1.4	-0.4		708	2,971	4,029	5,891	6,504	8.3	6.3	8.8	12.0	
Rhode Island	375.4	829.6	853.6	849.2	841.6	4.5	0.6	-0.5	0.0		625	2,619	3,236	4,563	5,139	8.3	4.3	11.2	7.5	
Connecticut	390.9	764.1	838.1	893.1	906.8	3.8	1.9	1.6	1.6		711	2,570	3,511	4,759	5,380	7.4	6.4	7.7	10.7	
Middle Atlantic	388.1	768.2	834.7	864.3	862.2	3.9	1.7	0.9	0.3		578	2,771	3,933	5,384	5,488	9.1	7.3	6.5	7.5	
New York	406.9	765.7	830.4	841.3	839.7	3.6	1.6	0.2	0.2		610	2,533	4,119	5,347	5,751	8.2	10.2	5.2	9.5	
New Jersey	399.0	759.8	826.7	879.4	885.2	3.6	1.7	1.3	1.5		526	2,650	3,483	4,973	5,235	9.4	5.6	10.6	5.4	
Pennsylvania	365.0	776.4	844.7	884.2	877.1	4.3	1.7	1.5	-0.3		533	3,147	3,948	5,657	5,320	10.4	4.6	6.1	6.3	
East North Central	350.2	725.9	834.4	888.3	895.3	4.1	2.8	1.6	1.2		614	2,906	3,595	4,414	4,786	9.0	4.3	4.2	8.4	
Ohio	353.6	718.4	846.3	897.4	904.8	4.0	3.3	1.3	1.4		585	2,792	3,824	4,078	4,692	9.1	6.5	2.2	7.3	
Indiana	343.7	672.2	837.0	885.5	891.7	3.8	4.5	1.4	1.1		545	2,510	3,234	4,314	4,665	8.9	5.2	6.5	9.3	
Illinois	339.2	693.4	788.1	840.1	849.3	4.1	2.6	1.6	1.4		703	3,313	3,760	4,750	5,112	9.0	2.6	5.3	7.9	
Michigan	379.5	804.3	871.4	929.3	933.2	4.3	1.6	1.6	1.0		532	2,991	3,749	4,675	5,173	10.1	4.6	4.3	10.2	
Wisconsin	354.7	736.9	843.2	903.6	910.4	4.1	2.7	2.1	0.8		639	2,527	2,877	3,487	3,790	7.9	2.6	4.4	7.7	
West North Central	363.2	693.4	979.7	871.9	884.2	3.7	7.2	-4.3	1.5		558	2,627	3,108	3,876	4,041	9.0	3.4	3.7	8.0	
Minnesota	389.0	624.8	682.5	796.3	816.1	2.7	1.8	4.5	2.4		601	2,447	3,101	3,341	3,624	8.1	4.9	1.6	5.5	
Iowa	365.9	715.3	850.6	918.8	936.6	3.8	3.5	2.5	1.2		505	2,282	2,753	3,121	3,435	8.7	3.8	4.3	4.9	
Missouri	364.8	712.0	816.6	871.8	876.6	3.8	2.8	1.6	1.1		544	3,118	3,514	4,523	4,773	10.2	2.4	4.2	9.5	
North Dakota	441.2	730.7	853.4	917.7	921.5	2.8	3.2	2.1	0.8		492	2,466	2,949	3,514	3,725	9.4	3.6	1.7	9.6	
South Dakota	358.0	694.2	815.1	877.6	886.4	3.7	3.3	2.1	1.1		514	2,281	2,714	6,296	3,805	8.6	3.5	3.7	12.1	
Nebraska	352.5	634.2	808.8	886.3	901.7	3.3	5.0	2.3	2.0		540	2,449	2,719	3,181	3,543	8.8	2.1	2.6	9.8	
Kansas	365.3	765.4	850.0	914.0	924.6	4.2	2.1	2.0	1.3		540	2,553	3,144	3,987	4,420	9.0	4.3	5.7	9.2	

South Atlantic	350.5	740.4	827.7	862.3	863.2	4.2	2.3	1.2	0.4	554	2,531	3,438	4,705	5,031	8.8	6.3	7.3	8.8
Delaware	368.2	770.9	843.6	935.3	940.6	4.2	1.8	2.5	1.8	552	2,612	3,526	4,878	4,395	9.0	6.2	4.8	4.0
Maryland	349.4	757.6	838.3	875.6	880.8	4.4	2.0	1.2	0.7	564	2,975	4,190	5,498	5,771	9.7	7.1	6.6	6.6
District of Columbia	452.8	739.4	772.7	784.5	789.0	2.8	0.9	0.1	0.9	570	3,774	5,019	6,553	6,650	11.1	5.9	6.4	4.8
Virginia	317.3	729.7	848.5	891.0	899.0	4.7	3.1	1.3	1.0	516	1,976	3,127	4,054	4,322	7.7	9.6	5.2	9.0
West Virginia	342.2	692.0	828.6	890.7	904.7	4.0	3.7	1.9	1.6	489	2,575	3,197	4,064	4,477	9.7	4.4	4.6	10.6
North Carolina	324.0	727.9	852.3	908.1	924.1	4.6	3.2	1.8	1.4	515	1,982	2,799	3,691	4,201	7.8	7.1	7.5	9.9
South Carolina	296.2	680.6	832.2	896.8	914.3	4.7	4.1	2.3	1.3	523	2,340	2,689	4,137	4,276	8.7	2.8	9.6	9.9
Georgia	320.2	743.5	843.8	899.5	911.7	4.8	2.6	1.8	1.2	474	2,479	3,456	4,848	5,148	9.6	6.9	8.6	7.8
Florida	420.9	759.1	805.8	813.5	797.4	3.3	1.2	0.3	-1.0	588	2,773	3,709	5,223	5,606	9.0	6.0	7.9	9.6
East South Central	332.1	698.1	846.9	901.7	908.5	4.2	3.9	1.6	1.1	489	2,570	3,413	4,758	5,177	9.7	5.8	7.6	10.3
Kentucky	365.9	671.9	837.3	901.1	906.9	3.4	4.5	1.7	1.5	458	2,395	3,424	4,273	4,615	9.6	7.4	3.8	9.7
Tennessee	354.8	678.7	853.4	897.7	905.6	3.7	4.7	1.5	0.8	502	2,816	3,402	4,974	5,389	10.1	3.9	9.7	9.5
Alabama	322.7	743.8	848.9	906.6	912.6	4.7	2.7	1.6	1.2	490	2,502	3,596	4,959	5,359	9.5	7.5	6.8	10.6
Mississippi	283.2	699.9	845.1	902.6	909.6	5.2	3.8	1.6	1.3	471	2,480	3,122	4,711	5,278	9.7	4.7	10.3	12.3
West South Central	374.8	687.4	825.0	863.7	856.5	3.4	3.7	1.1	0.3	504	2,811	3,624	5,163	5,778	10.0	5.2	7.0	14.2
Arkansas	319.3	715.4	862.9	897.2	908.7	4.6	3.8	0.8	1.4	466	2,550	3,155	4,211	4,538	9.9	4.3	5.3	11.0
Louisiana	343.4	653.5	821.1	877.1	861.7	3.6	4.7	1.5	0.2	446	3,167	4,368	6,208	6,872	11.5	6.6	6.2	14.6
Oklahoma	416.1	677.8	878.3	877.5	885.0	2.7	5.3	-0.4	1.0	486	2,482	3,127	4,507	5,068	9.5	4.7	8.2	13.2
Texas	393.7	693.2	805.1	850.2	838.4	3.2	3.0	1.5	-0.1	522	2,860	2,652	5,232	5,916	9.9	5.0	7.1	14.8
Mountain	417.1	716.6	772.7	760.7	749.2	3.1	1.5	-0.1	-1.3	560	2,637	3,992	4,188	4,347	9.0	8.6	-2.4	8.2
Montana	416.5	679.7	823.5	895.1	905.6	2.8	3.9	2.1	1.7	505	2,348	3,000	4,122	3,990	8.9	5.0	3.7	9.2
Idaho	408.8	714.5	862.5	905.2	920.5	3.2	3.8	1.7	0.8	467	2,384	2,556	3,320	3,616	9.5	1.4	6.7	7.9
Wyoming	395.0	681.7	782.7	877.7	892.1	3.1	2.8	2.7	2.6	432	2,804	3,182	3,932	4,311	11.0	2.6	7.4	4.6
Colorado	475.4	704.0	740.8	778.0	760.1	2.2	1.0	1.5	-1.0	578	2,521	3,223	4,167	4,514	8.5	5.0	6.0	8.5
New Mexico	377.6	689.8	736.4	735.1	728.5	3.4	1.3	1.4	-2.5	513	2,462	3,154	3,552	4,056	9.1	5.1	-0.4	14.1
Arizona	431.7	758.1	774.3	670.5	644.2	3.2	0.4	-3.5	-3.8	612	2,896	3,692	4,781	4,541	9.0	5.0	2.8	6.5
Utah	346.0	713.1	808.2	865.8	875.1	4.1	2.5	1.6	1.7	580	2,225	2,799	3,556	4,150	7.8	4.7	8.2	8.1
Nevada	414.9	688.9	721.2	687.2	670.3	2.9	0.9	-0.7	-2.6	532	3,243	3,903	5,023	5,072	10.6	3.8	3.3	8.6
Pacific	468.9	739.7	713.8	665.4	629.9	2.6	-0.7	-1.2	-4.3	630	6,153	3,853	4,864	5,354	13.5	-8.9	5.6	8.6
Washington	433.0	731.1	760.8	875.4	770.1	3.0	0.8	1.4	-1.5	507	2,522	3,218	3,738	4,117	9.3	5.0	3.4	7.6
Oregon	392.6	716.2	707.8	701.7	694.9	3.4	-0.2	0.2	-1.3	583	2,459	2,833	3,288	3,587	8.3	2.9	3.7	6.5
California	490.7	745.7	710.3	640.0	594.8	2.4	-1.0	-2.1	-5.6	653	3,379	4,138	5,416	5,987	9.6	4.1	6.5	9.4
Alaska	307.2	678.4	759.0	818.2	828.3	4.5	2.3	2.1	1.3	376	3,554	4,007	4,463	6,021	13.3	2.4	0.9	21.0

TABLE 2-51.—NUMBER OF AGED PERSONS SERVED UNDER HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE PER 1,000 ENROLLED AND REIMBURSEMENT PER PERSON SERVED BY CENSUS DIVISION AND STATE, SELECTED CALENDAR YEARS 1967-94—Continued

Census division and State	Year and persons served per 1,000 enrolled					Annual percent change				Year and reimbursement per person served				Annual percent change				
						1967-85	1985-90	1990-93	1993-95					1967-85	1985-90	1990-93	1993-95	
	1967	1985	1990	1994	1995					1967	1985	1990	1994	1995				
Hawaii	407.4	709.3	589.9	585.7	590.0	3.1	-3.6	0.7	-1.1	572	2,334	3,095	3,321	3,718	8.1	5.8	3.5	4.1
Total, all areas ¹	366.5	722.1	801.6	830.0	826.1	3.8	2.1	1.0	0.0	592	2,762	3,578	4,740	5,075	8.9	5.3	6.0	9.1
United States ²	370.9	731.2	810.5	838.7	834.6	3.8	2.1	1.0	0.0	593	2,772	3,592	4,750	5,096	8.9	5.3	6.0	9.1

¹ Consists of United States, Puerto Rico, Virgin Islands, and other outlying areas.

² Consists of 50 States, District of Columbia, and residence unknown.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 2-52.—MEDICARE PARTICIPATING INSTITUTIONS AND ORGANIZATIONS, 1984 AND 1996

Institution or organization	Year	
	1984	1996
Hospitals	6,675	6,273
Short stay	6,038	5,185
Long stay	637	1,088
Skilled nursing facilities	5,952	14,177
Home health agencies	4,684	8,860
Independent laboratories	3,801	5,769
Laboratories registered under the Clinical Laboratory Improvement Act (CLIA)	NA	157,335
Outpatient physical therapy providers	791	2,432
Portable x-ray suppliers	269	609
Rural health clinics	420	2,217
Comprehensive outpatient rehabilitation facilities	48	403
Ambulatory surgical centers	155	2,265
Hospices	108	2,161
Facilities providing services to renal disease benefit	1,335	3,082
Hospital certified as both renal transplant and renal dialysis center	147	156
Hospital certified as renal transplant centers	16	81
Hospital dialysis facilities	117	256
Nonhospital renal dialysis facilities	645	2,212
Dialysis centers only	359	334
Inpatient care	51	43
Hospital and skilled nursing facility beds:		
Hospitals	1,144,142	1,038,105
Short stay	1,023,465	912,054
Long stay	120,677	126,051
Skilled nursing facilities	530,403	671,839

NA—Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

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