SECTION 3. MEDICARE

CONTENTS

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 Program and Part B, Supplementary Medical Insurance Program. Total program outlays were $180.1 billion in fiscal year 1995. Net outlays after deduction of beneficiary premiums were $159.9 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 1996, part A will cover an estimated 37.5 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—$42.50 in 1996. In fiscal year 1996, part B will cover an estimated 36.0 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 ($736 in 1996) 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 the 21st–100th day ($92 in 1996). 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' services accounts for over 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 or 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 1996, the premium is $42.50. 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 $180.1 billion in fiscal year 1995. Net outlays (that is, net of premiums beneficiaries pay for enrollment, largely for part B) were $159.9 billion.

Tables 3–1, 3–2, and 3–3 provide historical spending and coverage data for Medicare. Table 3–4 provides State-by-State information for fiscal year 1995.

TABLE 3–1.—MEDICARE OUTLAYS, FISCAL YEARS 1967–2002

[In millions]

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

TABLE 3–1.—MEDICARE OUTLAYS, FISCAL YEARS 1967–2002—Continued

[In millions]

Fiscal year	Part A	Part B	Total Medicare outlays	Medicare premium offsets	Net Medicare outlays	Percent increase (over prior year)
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
HCFA PROJECTIONS						
1996	126,642	70,871	197,513	(19,842)	177,671	11.1
1997	138,372	78,184	216,556	(20,287)	196,269	10.5
1998	150,580	86,778	237,358	(22,048)	215,310	9.7
1999	163,291	95,001	258,292	(23,295)	234,997	9.1
2000	176,446	104,160	280,606	(24,304)	256,302	9.1
2001	190,243	114,630	304,873	(25,331)	279,542	9.1
2002	204,599	126,315	330,914	(26,422)	304,492	8.9
CBO PROJECTIONS (in billions)						
1996	127.1	71.9	199.0	(20.0)	179.1	12.0
1997	139.3	79.3	218.6	(20.6)	198.0	10.6
1998	151.8	87.8	239.7	(22.6)	217.1	9.6
1999	164.2	96.5	260.8	(24.0)	236.8	9.1
2000	177.0	106.0	283.0	(25.1)	257.9	8.9
2001	190.4	116.4	306.8	(26.2)	280.6	8.8
2002	204.5	127.9	332.3	(27.4)	305.0	8.7

Source: Office of the President, 1996; Congressional Budget Office projections are from CBO's April 1996 baseline.

TABLE 3–2.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES AND AVERAGE MEDICARE BENEFIT PAYMENTS PER ENROLLEE, 1975–98

[Beneficiaries in thousands]

Fiscal year	1975 (actual)	1980 (actual)	1985 (actual)	1990 (actual)	1991 (actual)	1992 (actual)	1993 (actual)	1994 (actual)	1995 (actual)	1996 (est.) [1]	1997 (est.) [1]	1998 (est.) [1]	Average annual growth 1975–85 (percent)	Average annual growth 1985–95 (percent)	Projected average annual growth 1995–98 (percent)
Part A															
Persons enrolled (monthly average):															
Aged	21,795	24,571	27,123	30,052	30,456	31,151	31,866	32,151	32,460	32,798	33,064	33,278	2.2	1.8	0.8
Disabled	2,047	2,968	2,944	3,313	3,380	3,617	3,833	4,158	4,474	4,730	5,009	5,300	3.7	4.3	5.8
Total	23,842	27,539	30,067	33,365	33,836	34,768	35,699	36,309	36,934	37,528	38,073	38,578	2.3	2.1	1.5
Beneficiaries receiving reimbursed services:															
Aged	4,906	5,943	6,168	6,314	6,110	6,690	6,870	6,890	7,150	7,270	7,370	7,470	2.3	1.5	1.5
Disabled	456	721	672	675	700	755	805	860	930	990	1,055	1,120	4.0	3.3	6.4
Total	5,362	6,664	6,840	6,989	6,810	7,445	7,675	7,750	8,080	8,260	8,425	8,590	2.5	1.7	2.1
Average annual benefit per person enrolled: [2] [3]															
Aged	$432	$853	$1,563	$1,942	$1,982	$2,294	$2,532	$2,788	$3,080	$3,346	$3,623	$3,902	13.7	7.0	8.2
Disabled	$460	$948	$1,809	$2,225	$2,250	$2,493	$2,664	$2,813	$3,001	$3,195	$3,396	$3,606	14.7	5.2	6.3
Total	$434	$863	$1,587	$1,970	$2,009	$2,315	$2,546	$2,791	$3,070	$3,327	$3,593	$3,861	13.8	6.8	7.9

TABLE 3–2.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES AND AVERAGE MEDICARE BENEFIT PAYMENTS PER ENROLLEE, 1975–98—Continued

[Beneficiaries in thousands]

Fiscal year	1975 (actual)	1980 (actual)	1985 (actual)	1990 (actual)	1991 (actual)	1992 (actual)	1993 (actual)	1994 (actual)	1995 (actual)	1996 (est.) [1]	1997 (est.) [1]	1998 (est.) [1]	Average annual growth		Projected average annual growth 1995–98 (percent)
													1975–85 (percent)	1985–95 (percent)	
Part B															
Persons enrolled (average):															
Aged	21,504	24,422	27,049	29,426	29,910	30,471	31,004	31,335	31,625	31,926	32,180	32,362	2.3	1.6	0.8
Disabled	1,835	2,698	2,672	2,907	3,023	3,163	3,374	3,638	3,873	4,080	4,310	4,561	3.8	3.8	5.6
Total	23,339	27,120	29,721	32,333	32,933	33,634	34,378	34,973	35,498	36,006	36,490	36,923	2.4	1.8	1.3
Beneficiaries receiving reimbursed services:															
Aged	11,311	16,034	20,199	23,820	24,115	25,603	26,012	26,118	26,684	27,265	27,731	28,114	6.0	2.8	1.8
Disabled	797	1,669	1,933	2,184	2,276	2,522	2,766	2,867	3,094	3,305	3,528	3,768	9.3	4.8	6.8
Total	12,108	17,703	22,132	26,004	26,391	28,125	28,778	28,985	29,778	30,570	31,259	31,882	6.2	3.0	2.3
Average annual benefit per person enrolled: [2]															
Aged	$153	$348	$705	$1,250	$1,342	$1,403	$1,472	$1,601	$1,728	$1,864	$2,035	$2,241	16.5	9.4	9.1
Disabled	$259	$610	$1,022	$1,603	$1,759	$1,847	$1,999	$2,154	$2,282	$2,339	$2,508	$2,697	14.7	8.4	5.7
Total	$161	$374	$734	$1,282	$1,381	$1,445	$1,524	$1,658	$1,788	$1,918	$2,091	$2,297	16.4	9.3	8.7

[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 3–3.—BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PART A AND PART B, SELECTED FISCAL YEARS 1975–97

[Dollars in millions]

	1975		1980		1985		1990		1995		1996 (est.)		1997 (est.) [1]		Average annual growth (percent)		
	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	1975–85	1985–95	1995–97
Part A																	
For inpatient hospital services	70.5	9.947	67.4	22,860	65.0	45,218	55.3	59,285	49.5	87,512	48.7	94,397	47.9	101,946	16.3	6.8	7.9
For skilled nursing facility services	1.9	273	1.2	392	0.8	550	2.6	2,821	5.2	9,142	5.6	10,823	5.7	12,251	7.3	32.5	15.8
For home health services	0.9	133	1.5	524	2.7	1,908	3.1	3,297	8.4	14,895	8.9	17,174	9.2	19,567	30.5	22.8	14.6
For hospice services	0	0	0	0	0	34	0.3	318	1.0	1,854	1.3	2,447	1.4	3,035	NA	49.2	27.9
Total benefit payments	73.3	10,353	70.1	23,776	68.6	47,710	61.3	65,721	64.1	113,403	64.4	124,841	64.2	136,799	16.5	9.0	9.8
Part B																	
For physician services [2]	21.7	3,067	23.0	7,813	24.1	16,788	27.0	28,922	22.8	40,376	21.7	42,166	21.1	45,063	18.5	9.2	5.6
For outpatient services	3.7	529	5.3	1,803	5.6	3,917	7.8	8,365	8.2	14,576	8.6	16,581	8.9	18,979	22.2	14.0	14.1
For other medical and health services	1.2	169	1.6	528	1.6	1,103	3.9	4,165	4.8	8,530	5.3	10,308	5.7	12,245	20.6	22.7	19.8
Total benefit payments	26.7	3,765	29.9	10,144	31.4	21,808	38.7	41,452	35.9	63,482	35.6	69,055	35.8	76.287	19.2	11.3	9.6
Total	100.0	14,118	100.0	33,920	100.0	69,518	100.0	107,173	100.0	176,885	100.0	193,896	100.0	213,086	17.3	9.8	9.8

[1] Represents current law. Does not include legislative proposals.
[2] Includes other services.

NA—Not available.

Note.—Totals may not add due to rounding.

Source: Health Care Financing Administration, Division of Budget.

TABLE 3–4.—MEDICARE ESTIMATED BENEFIT PAYMENTS AND NUMBER OF PERSONS BY STATE, FISCAL YEAR 1995

State	Benefit payments in thousands	Persons [1]
Alabama	3,042,184	637,466
Alaska	132,635	33,232
Arizona	2,717,415	593,046
Arkansas	1,638,020	420,208
California	20,406,000	3,609,722
Colorado	1,834,837	417,748
Connecticut	2,583,742	499,683
Delaware	444,964	99,618
District of Columbia	1,164,389	77,973
Florida	14,826,459	2,596,865
Georgia	4,089,815	825,657
Hawaii	580,455	148,444
Idaho	463,308	148,597
Illinois	7,276,339	1,610,013
Indiana	3,491,081	818,903
Iowa	1,526,969	472,510
Kansas	1,545,162	381,445
Kentucky	2,401,250	582,370
Louisiana	3,447,745	576,581
Maine	706,519	200,525
Maryland	2,667,555	597,475
Massachusetts	5,496,129	927,936
Michigan	6,237,472	1,340,016
Minnesota	2,378,016	627,592
Mississippi	1,722,814	394,259
Missouri	3,821,093	827,877
Montana	488,525	129,257
Nebraska	840,202	247,921
Nevada	894,027	190,107
New Hampshire	597,488	154,889
New Jersey	5,603,125	1,162,395
New Mexico	710,444	209,155
New York	13,903,736	2,623,291
North Carolina	4,276,049	1,017,769
North Dakota	411,918	102,740
Ohio	7,282,212	1,658,932
Oklahoma	2,178,428	484,398
Oregon	1,885,253	465,330
Pennsylvania	10,796,231	2,059,821
Rhode Island	772,209	167,217
South Carolina	1,928,044	503,726
South Dakota [2]	563,046	116,160
Tennessee	4,083,406	764,938
Texas	11,504,091	2,061,794
Utah	708,036	185,699
Vermont	283,894	82,308
Virginia	2,979,371	811,257
Washington	2,602,675	682,443
West Virginia	1,207,737	327,588

TABLE 3–4.—MEDICARE ESTIMATED BENEFIT PAYMENTS AND NUMBER OF PERSONS BY STATE, FISCAL YEAR 1995—Continued

State	Benefit payments in thousands	Persons [1]
Wisconsin	2,673,209	757,404
Wyoming	180,261	59,654
Puerto Rico	875,417	473,408
All other areas	32,857	314,691
All Areas	$176,884,237	37,278,050

[1] Data as of July 1, 1995.

[2] Data overstated due to reporting problems.

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 health maintenance organizations 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 1995 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 1996 monthly premium is $289 ($188 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 Supplementary Medical Insurance Program by paying the monthly premium. The 1996 premium is $42.50 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 1995, 32.5 million aged and 4.5 million disabled had protection under part A. Of those, 7.2 million aged and 0.9 million disabled actually received reimbursed services. In fiscal year 1995, 31.6 million aged and 3.9 million disabled were enrolled in part B. About 26.7 million of the aged and 3.1 million of the disabled actually received reimbursed services, see table 3–2.

BENEFITS AND BENEFICIARY COST-SHARING

PART A

Part A coverage includes:

1. *Inpatient hospital care.*—The first 60 days of inpatient hospital services in a benefit period subject to a deductible ($736 in calendar year 1996). 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 ($184 in calendar year 1996) 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 ($368 in calendar year 1996) is imposed for each reserve day.
2. *Skilled nursing facility care.*—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 ($92 in calendar year 1996).
3. *Home health care.*—Home health visits provided to persons who need skilled nursing care on an intermittent basis, or physical therapy, or speech therapy.
4. *Hospice care.*—Hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less up to a 210-day lifetime limit. A subsequent period of hospice coverage is allowed beyond the 210-day limit if the beneficiary is recertified as 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:

1. *Doctor's services*.—Including 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.
2. *Other medical and health services*.—Laboratory and other diagnostic tests, x ray and other radiation therapy, outpatient hospital services, rural health clinic services, durable medical equipment, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.
3. *Specified preventive services*.—A screening mammography once every 2 years for persons over age 65 and at specified intervals for the disabled. A screening pap smear is authorized once every 3 years, except for women who are at a high risk of developing cervical cancer.
4. *Drugs and vaccines*.—Generally Medicare does not pay for outpatient prescription drugs or biologicals. However there are a few exceptions. Part B pays for immunosuppressive drugs for 24 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.
5. *Home health services*.—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.

Table 3–5 illustrates the deductible, coinsurance and premium amounts for both part A and part B services from the inception of Medicare.

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.

TABLE 3–5.—HISTORICAL AND PROJECTED AMOUNTS OF PART A AND PART B DEDUCTIBLE, COINSURANCE AND PREMIUMS,[1] 1966–2001

For benefit periods beginning in calendar year	Inpatient hospital[2]			Skilled nursing facility 21st thru 100th day coinsurance per day[5]	HI monthly premium[6]			SMI deductible	SMI premium	
	First 60 days deductible	61st thru 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	$10	([7])	([7])	.....	.....	NA	$50	7/66	$3.00
1967	40	10	([7])	$5.00	.....	.....	NA	50	.....	3.00
1968	40	10	$20	5.00	.....	.....	NA	50	4/68	4.00
1969	44	11	22	5.50	.....	.....	NA	50	.....	4.00
1970	52	13	26	6.50	.....	.....	NA	50	7/70	5.30
1971	60	15	30	7.50	.....	.....	NA	50	7/71	5.60
1972	68	17	34	8.50	.....	.....	NA	50	7/72	5.80
1973	72	18	36	9.00	7/73	$33	NA	60	[8] 9/73	6.30
1974	84	21	42	10.50	7/74	36	NA	60	7/74	6.70
1975	92	23	46	11.50	7/75	40	NA	60	.....	6.70
1976	104	26	52	13.00	7/76	45	NA	60	7/76	7.20
1977	124	31	62	15.50	7/77	54	NA	60	7/77	7.70
1978	144	36	72	18.00	7/78	63	NA	60	7/78	8.20
1979	160	40	80	20.00	7/79	69	NA	60	7/79	8.70
1980	180	45	90	22.50	7/80	78	NA	60	7/80	9.60
1981	204	51	102	25.50	7/81	89	NA	60	7/81	11.00
1982	260	65	130	32.50	7/82	113	NA	75	7/82	12.20
1983	304	76	152	38.00	.....	113	NA	75	.....	12.20
1984	356	89	178	44.50	1/84	155	NA	75	1/84	14.60
1985	400	100	200	50.00	1/85	174	NA	75	1/85	15.50
1986	492	123	246	61.50	1/86	214	NA	75	1/86	15.50
1987	520	130	260	65.00	1/87	226	NA	75	1/87	17.90
1988	540	135	270	67.50	1/88	234	NA	75	1/88	24.80

1989	[9] 560	NA	NA	[10] 25.50	1/89	156	NA	75	1/89	31.90
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 [11]	772	193	386	96.50	1/97	314	188	100	1/97	43.90
1998 [11]	808	202	404	101.00	1/98	337	185	100	1/98	47.70
1999 [11]	844	211	422	105.50	1/99	362	199	100	1/99	49.10
2000 [11]	884	221	442	110.50	1/00	386	212	100	1/00	50.50
2001 [11]	924	231	462	115.50	1/01	411	226	100	1/01	51.90

[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—190 day lifetime limit.

[3] Always equal to ¼ of inpatient hospital deductible through 1988, and for 1990 and later, eliminated for 1989.

[4] Always equal to ½ of inpatient hospital deductible through 1988, and for 1990 and later, eliminated for 1989.

[5] Always equal to ⅓ 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 a 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.

[11] Administration projections under current law using fiscal year 1996 budget assumptions.

NA—Not available; HI = hospital insurance; SMI = supplementary medical insurance.

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; and January 1, 1983 through December 31, 1989, $500 per year; January 1, 1990, and thereafter $750 per year.

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

HOSPITAL INSURANCE TRUST FUND—INCOME

The primary source of income to the HI fund is HI payroll taxes. This source accounted for $104.4 billion (88.2 percent) of the total $118.4 billion in income in fiscal year 1995. 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 $62,700 in 1996 continues to apply under Social Security. Table 3–6 shows the history of the contribution rates and maximum taxable earnings base for both the HI and OASDI Programs.

TABLE 3–6.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES AND TAXABLE EARNINGS BASES

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

[1] Prior to 1991, the upper limit on tax earnings was the same as for Social Security. The Omnibus Budget Reconciliation Act of 1990 (OBRA 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.

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

Source: Health Care Financing Administration.

Other income

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

1. *Railroad retirement account transfers.*—In fiscal year 1995, $396 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 1995, $462 million was transferred to HI on this basis.
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 ($289 in 1996; $188 for persons who have at least 30 quarters of covered employment). This accounted for an estimated $998 million of financing in fiscal year 1995.
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-1957 deemed wage credits; and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on noncontributory wage credits. In fiscal year 1995, this accounted for $61 million of income to the HI Trust Fund.
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 $3.9 billion in fiscal year 1995.

6. *Interest.*—The remaining income to the trust fund consists almost entirely of interest on the investments of the trust fund. This amounted to an estimated $11.0 billion in fiscal year 1995.

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 upon the projected costs of the program for the coming year. The monthly premium amount in calendar year 1996 is $42.50.

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 figure was used. As a result, the 1996 premium is $42.50, a full $3.60 less than the 1995 premium. Under current law, the provision limiting the annual percentage increase to the percentage increase in the Social Security COLA would again apply, beginning in 1999.

FINANCIAL STATUS OF HOSPITAL INSURANCE TRUST FUND

Current operations and short-term projections

The Hospital Insurance Trust Fund balance is dependent on total income to the HI Trust Fund exceeding total outlays from the fund. Tables 3–7 and 3–8 show historical information from the 1996 trustees report on the operation of the trust fund and intermediate projections for the 1996–2005 period. The information is presented on both a calendar year and fiscal year basis.

TABLE 3–7.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED FISCAL YEARS 1970–2005

[In millions of dollars]

Fiscal year [1]	Income							Disbursements			Trust fund	
	Payroll taxes	Income from taxation of benefits	Railroad retirement account transfers	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other income [2]	Total income	Benefits payments [3]	Administrative expenses [4]	Total disbursements	Net increase in fund	Fund at end of year
Historical data:													
1970	4,785	.....	64	617	.....	11	137	5,614	4,804	149	4,953	661	2,677
1975	11,291	.....	132	481	6	48	609	12,568	10,353	259	10,612	1,956	9,870
1980	23,244	.....	244	697	17	141	1,072	25,415	23,790	497	24,288	1,127	14,490
1985	46,490	.....	371	766	38	86	3,182	50,933	47,841	813	48,654	[5] 4,103	21,277
1986	53,020	.....	364	566	40	[6] −714	3,167	56,442	49,018	667	49,685	[7] 17,370	38,648
1987	57,820	.....	368	447	40	94	3,982	62,751	49,967	836	50,803	11,949	50,596
1988	61,901	.....	364	475	42	80	5,148	68,010	52,022	707	52,730	15,281	65,877
1989	67,527	.....	379	515	42	86	6,567	75,116	57,433	805	58,238	16,878	82,755
1990	70,655	.....	367	413	113	107	7,908	79,563	65,912	774	66,687	12,876	95,631
1991	74,655	.....	352	605	367	[8] −1,011	8,969	83,938	68,705	934	69,638	14,299	109,930
1992	80,978	.....	374	621	484	86	10,133	92,677	80,784	1,191	81,974	10,703	120,633
1993	83,147	.....	400	367	622	81	[9] 12,484	97,101	90,738	866	91,604	5,497	126,131
1994	92,028	1,639	413	506	852	80	10,676	106,195	101,535	1,235	102,770	3,425	129,555
1995	98,053	3,913	396	462	998	61	10,963	114,847	113,583	1,300	114,883	−36	129,520
Intermediate estimates:													
1996	104,433	3,976	412	419	1,100	[10] −2,298	10,375	118,417	125,250	1,327	126,577	−8,160	121,360
1997	109,620	4,331	412	481	1,224	66	9,519	125,653	137,199	1,407	138,606	−12,953	108,407
1998	114,416	4,623	406	265	1,348	64	8,151	129,273	149,720	1,488	151,208	−21,935	86,472
1999	120,498	4,927	403	206	1,475	64	6,166	133,739	162,994	1,572	164,566	−30,827	55,645
2000	126,897	5,260	406	170	1,612	63	3,447	137,855	176,889	1,663	178,552	−40,697	14,948
2001	133,033	5,627	416	160	1,759	63	45	141,103	191,664	1,759	193,423	−52,320	−37,372

2002	140,213	6,022	429	151	1,918	63	−3,735	145,061	207,204	1,862	209,066	−64,005	−101,377
2003	147,916	6,459	443	143	2,088	63	−8,224	148,888	223,885	1,976	225,861	−76,973	−178,350
2004	155,968	6,936	459	148	2,275	63	−13,439	152,410	241,878	2,098	243,976	−91,566	−269,916
2005	166,620	7,447	476	151	2,466	63	−19,030	158,193	261,050	2,228	263,278	−105,085	−375,001

[1] Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.

[2] Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous income.

[3] Includes costs of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983).

[4] Includes costs of experiments and demonstration projects.

[5] Includes repayment of loan principal from the OASI Trust Fund of $1,824 million.

[6] Includes the lump-sum general revenue adjustment of −$805 million, as provided for by section 151 of Public Law 98–21.

[7] Includes repayment of loan principal from the OASI Trust Fund of $10,613 million.

[8] Includes the lump-sum general revenue adjustment of −$1,100 million, as provided for by section 151 of Public Law 98–21.

[9] Includes $1,805 million transfer from the SMI catastrophic coverage reserve fund, as provided for by Public Law 102–394.

[10] Includes −$2,366 million preliminary estimate of the lump-sum general revenue adjustment provided for by section 151 of Public Law 98–21.

Note.—Totals may not add due to rounding. Estimates shown for 2001 and later are hypothetical, since the Hospital Insurance Trust Fund would be exhausted in those years.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (1996).

TABLE 3–8.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED CALENDAR YEARS 1970–2005

[In millions of dollars]

Calendar year	Income								Disbursements			Trust fund	
	Payroll taxes	Income from taxation of benefits	Railroad retirement account transfers	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other income [1]	Total income	Benefits payments [2]	Administrative expenses [3]	Total disbursements	Net increase in fund	Fund at end of year
Historical data:													
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
Intermediate estimates:													
1996	106,568	3,976	412	419	1,131	[9] −2,298	10,073	120,281	128,171	1,346	129,517	−9,236	121,031
1997	111,139	4,331	412	481	1,255	66	8,987	126,671	140,224	1,428	141,652	−14,981	106,050
1998	116,141	4,623	406	265	1,379	64	7,302	130,180	152,964	1,508	154,472	−24,292	81,758
1999	121,814	4,927	403	206	1,507	64	4,928	133,849	166,373	1,594	167,967	−34,118	47,640
2000	123,056	5,260	406	170	1,647	63	1,913	137,515	180,488	1,685	182,173	−44,658	2,982
2001	134,806	5,627	416	160	1,796	63	−1,652	141,216	195,464	1,783	197,247	−56,031	−53,049

2002	142,131	6,022	429	151	1,959	63	−5,304	145,451	211,201	1,888	213,089	−67,638	−120,687
2003	150,182	6,459	443	143	2,131	63	−9,885	149,536	228,223	2,005	230,228	−80,692	−201,379
2004	158,725	6,936	459	148	2,323	63	−15,299	153,355	246,526	2,129	248,655	−95,300	−296,679
2005	168,213	7,447	476	151	2,514	63	−21,661	157,203	266,023	2,261	268,284	−111,081	−407,760

[1] Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous income.
[2] Includes cost of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983).
[3] Includes costs of experiments and demonstration projects.
[4] Includes the lump-sum general revenue adjustment of −$805 million, as provided for by section 151 of Public Law 98–21.
[5] Includes repayment of loan principal from the OASI Trust Fund of $1,824 million.
[6] Includes repayments of loan principal from the OASI Trust Fund of $10,613 million.
[7] Includes the lump-sum general revenue adjustment of −$1,100 million, as provided for by section 151 of Public Law 98–21.
[8] Includes $1,805 million transfer from the SMI catastrophic coverage reserve fund, as provided for by Public Law 102–394.
[9] Includes −$2,366 million preliminary estimate of the lump-sum general revenue adjustment provided for by section 151 of Public Law 98–21.

Note.—Totals may not add due to rounding. Estimates shown for 2001 and later are hypothetical, since the Hospital Insurance Trust Fund would be exhausted in those years.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (1996).

The 1996 trustees report states that the program fails to meet both short-range and long-range tests of financial adequacy. Disbursements began to exceed income in 1995. Under the trustee's 1996 intermediate assumptions, the fund would become insolvent in 2001. This estimate is a year earlier than projected in the 1995 report, but the same as projected in the 1994 report. The change from the 1995 estimate was attributable to several factors. First, actual 1995 benefits payments were 3.1 percent higher and income was 1.2 percent lower than estimated in the 1995 report. The higher benefit payments primarily reflected more prompt billing by hospitals and other providers and a greater increase in the average complexity of Medicare hospitalizations. Lower income reflected slower than expected growth in wages and salaries subject to payroll taxes and lower revenue gains from the elimination (beginning in 1994) of the maximum contribution base for HI payroll taxes. Future projections also reflect several other factors including: (1) a projected faster increase in spending for home health and skilled nursing facility services; (2) a projection that future hospital patients will be somewhat sicker and more costly than previously projected; and (3) updated long-range economic and demographic assumptions.

The trustees report projected that the fund's shortfall would be $53.0 billion at the end of calendar 2001. The shortfall would continue to build each year, rising to $375 billion at the end of fiscal year 2005 and $407.8 billion at the end of calendar 2005. The trustees report reflected the same general trends as had been reported by the CBO in April 1996. At that time, the CBO also estimated that the HI Trust Fund would become insolvent in fiscal year 2001. It noted that the shortfall would be $331.6 billion at the end of fiscal year 2005 and $443.8 billion at the end of fiscal year 2006 (see table 3–9).

Table 3–10 presents CBO projections of HI Trust Fund growth through 2006 using different growth assumptions. The alternatives are arranged in the table from 5 percentage points below current part A spending growth to 2 percentage points above this level. The table suggests that for the fiscal year 1997–2006 period, growth would have to be reduced nearly 5 percentage points to stabilize the assets of the fund and more than 5 percentage points to maintain a beginning of the year balance of at least 100 percent of outgo for the year. All of these projections assume the same overall economic projections underlying the baseline path.

Long-range financial soundness

The 1996 HI trustees report does not contain actual dollar projections of program operations beyond the year 2005. Instead, the trustees measure long-range financial soundness by comparing: (1) HI payroll tax contributions and income from the taxation of Social Security benefits as a percentage of taxable payroll ("income rate") with (2) HI cost as a percentage of taxable payroll ("cost rate"). The trustees view this measure as more meaningful since the value of the dollar changes over time. The trustees estimate that there is already a gap between the cost rate of the program and the income rate. In 1996 the estimated cost rate is 3.54 percent of taxable payroll, while the estimated income rate is only 3.02 percent. The gap

is thus 0.52 percent of taxable payroll in 1996. Since costs are rising faster than payroll tax receipts, this deficit increases dramatically over the 75-year projection period rising to 2.0 percent in 2010, and 8.38 percent by 2070.

The trustees also average both the income and the cost rates over various time periods to get a picture of trends in the shortfall. Based on intermediate projections, over the first 25-year projection period (1996–2020) the average income rate is 3.07 percent and the average cost rate is 5.01 percent, leaving an actuarial balance of −1.95 percent of taxable payroll. Over the first 50 years (1996–2045) the average income rate is 3.16 percent and the average cost rate is 6.68 percent, leaving an actuarial balance of −3.52 percent of taxable payroll. For the full 75-year projection period (1996–2070), the balance declines to −4.52 percent of taxable payroll (see table 3–11).

The trustees state that to bring the program into actuarial balance even for the first 25 years would require either a reduction in outlays of 39 percent or an increase in total income of 63 percent (or some combination thereof) throughout the 25-year period. If changes were made just to the payroll tax, the rate would have to be increased 0.98 percentage points. This change would raise the payroll tax rate from the current level of 1.45 percent to 2.43 percent for employees and employers each; it would raise the level for the self-employed from the current 2.9 percent to 4.86 percent.

The outlook over the 75-year valuation period is even bleaker. Income over the period is expected to equal only 42 percent of the program's cost. The payroll tax would have to be immediately increased over the entire period from 1.45 to 3.71 percent for both employees and employers to achieve long-term financial solvency.

What the projections reflect

Both the short-range and long-range projections reflect the fact that HI costs are rising faster than HI income. Currently the shortfall is primarily attributable to the increase in hospital payments, which account for about 70 percent of HI payments. Hospital wages and other input costs are expected to continue to exceed the increase in the consumer price index (CPI). Increases in admissions, changes in the complexity of admissions, and other factors will contribute to additional increases.

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 is a shift in the number of covered workers supporting each HI enrollee. In 1995, there were 3.9 workers for every beneficiary; in 2030 there will only be an estimated 2.2.

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 1996 trustees report, the program's cost is expected to rise from 1.6 percent of gross domestic product (GDP) in 1995 to about 5 percent of GDP in 2070.

TABLE 3–9.—PROJECTIONS FOR THE HOSPITAL INSURANCE TRUST FUND OF INCOME AND OUTLAYS, FISCAL YEARS 1995–2005, UNDER CBO AND ADMINISTRATION BASELINE ASSUMPTIONS

[In billions of dollars]

	1995 [1]	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
CBO projections: [2]												
Income	114.8	119.9	126.0	129.7	134.3	138.8	142.8	147.3	151.4	155.1	159.2	163.0
Outlays	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
Net additions to fund	−0.0	−7.2	−13.3	−22.1	−30.0	−38.2	−47.6	−57.1	−68.3	−81.5	−95.8	−112.2
End-of-year balance	129.5	122.3	109.0	86.9	56.9	18.7	−28.9	−88.0	−154.3	−235.8	−331.6	−443.8
Administration projections: [3]												
Income	114.8	118.4	125.7	129.3	133.7	137.9	141.1	145.1	148.9	152.4	158.2	NA
Outlays	114.9	126.6	138.6	151.2	164.6	178.6	193.4	209.1	225.9	241.0	263.3	NA
Net additions to fund	−0.0	−8.2	−13.0	−21.9	−30.8	−40.7	−52.3	−64.0	−77.0	−91.6	−105.1	NA
End-of-year balance	129.5	121.4	108.4	86.5	55.6	14.9	−37.4	−101.4	−178.4	−269.9	−375.0	NA

[1] Actual.
[2] April 1996 baseline projections.
[3] Board of Trustees, Hospital Insurance Trust Fund (1996).

NA—Not available.

TABLE 3–10.—ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES BY FISCAL YEAR, 1995–2006

[In billions of dollars]

	1995 [1]	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
5 percentage points lower HI:												
Outlay growth.												
Outlays	115	127	133	138	143	147	150	154	158	162	166	171
EOY balance	130	122	116	108	102	98	96	98	103	112	125	143
Ratio by BOY assets to outlays	1.13	1.02	0.92	0.84	0.76	0.69	0.65	0.62	0.62	0.64	0.67	0.73
4 percentage points lower HI:												
Outlay growth.												
Outlays	115	127	134	141	147	152	158	163	169	175	182	189
EOY balance	130	122	114	104	93	82	72	63	55	47	42	37
Ratio by BOY assets to outlays	1.13	1.02	0.91	0.81	0.71	0.61	0.52	0.44	0.37	0.31	0.26	0.22
3 percentage points lower HI:												
Outlay growth.												
Outlays	115	127	135	144	151	158	166	173	180	189	198	208
EOY balance	130	122	113	100	84	67	48	27	5	−19	−45	−72
Ratio by BOY assets to outlays	1.13	1.02	0.90	0.79	0.66	0.53	0.40	0.28	0.15	0.03	−0.10	−0.22
2 percentage points lower HI:												
Outlay growth.												
Outlays	115	127	137	146	155	164	174	183	193	204	215	228
EOY balance	130	112	112	95	75	51	23	−10	−47	−89	−138	−194
Ratio by BOY assets to outlays	1.13	1.02	0.89	0.76	0.61	0.46	0.29	0.12	−0.05	−0.23	−0.41	−0.60
1 percentage points lower HI:												
Outlay growth.												
Outlays	115	127	138	149	160	171	182	193	206	220	234	251
EOY balance	130	122	110	91	66	35	−3	−49	−105	−175	−259	−361
Ratio by BOY assets to outlays	1.13	1.02	0.89	0.74	0.57	0.39	0.19	−0.01	−0.24	−0.48	−0.75	−1.03
Baseline:												
HI Trust Fund income	115	120	126	130	134	139	143	147	151	155	159	163
HI Trust Fund outlays	115	127	139	152	164	177	190	204	220	237	255	275
HI Trust Fund surplus	−0	−7	−13	−22	−30	−48	−38	−57	−68	−82	−96	−112
HI Trust Fund balance at end of year	130	122	109	87	57	19	−29	−86	−154	−236	−332	−444

TABLE 3–10.—ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES BY FISCAL YEAR, 1995–2006—Continued

[In billions of dollars]

	1995[1]	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Ratio of BOY assets to outlays	1.13	1.02	0.88	0.72	0.53	0.32	0.10	−0.14	−0.39	−0.65	−0.92	−1.21
1 percentage points higher HI:												
Outlay growth.												
Outlays	115	127	141	155	169	184	199	216	234	255	277	302
EOY balance	130	122	108	83	48	2	−54	−117	−188	−269	−361	−463
Ratio by BOY assets to outlays	1.13	1.02	0.87	0.70	0.49	0.26	0.01	−0.25	−0.50	−0.74	−0.97	−1.20
2 percentage points higher HI:												
Outlay growth.												
Outlays	115	127	142	157	173	190	209	228	250	274	301	331
EOY balance	130	122	106	78	38	−15	−84	−170	−278	−411	−572	−766
Ratio by BOY assets to outlays	1.13	1.02	0.86	0.68	0.45	0.20	−0.07	−0.37	−0.68	−1.01	−1.37	−1.73

[1] Actuals: EOY = End of year; BOY = Beginning of year; HI = Hospital Insurance.

Note.—Changes in outlays begin with fiscal year 1997. During the projection period, those new measures indicate that growth would have to be reduced by between 4 and 5 percentage points to stablize the assets of the trust fund, and by more than 5 percentage points to maintain a solvency ratio of at least 1.00.

Source: Congressional Budget Office.

TABLE 3–11.—ACTUARIAL BALANCES OF THE HOSPITAL INSURANCE PROGRAM UNDER INTERMEDIATE ASSUMPTIONS

	Intermediate assumptions
Projection periods:	
1996–2020:	
Summarized income rate (percent)	3.07
Summarized cost rate [1]	5.01
Actuarial balance [2]	−1.95
1996–2045:	
Summarized income rate	3.16
Summarized cost rate [1]	6.68
Actuarial balance [2]	−3.52
1996–2070:	
Summarized income rate	3.21
Summarized cost rate [1]	7.72
Actuarial balance [2]	−4.52
25-year subperiods:	
1996–2020:	
Summarized income rate (percent)	3.07
Summarized cost rate [3]	4.93
Actuarial balance [2]	−1.86
2021–2045:	
Summarized income rate	3.27
Summarized cost rate [3]	8.70
Actuarial balance [2]	−5.43
2046–2070:	
Summarized income rate	3.36
Summarized cost rate [3]	10.81
Actuarial balance [2]	−7.45

[1] Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the present-value basis, including the cost of attaining a trust fund balance at the end of the period equal to 100 percent of the following year's estimated expenditures, and including an offset to cost due to the beginning trust fund balance.

[2] Difference between the summarized income rate and the summarized cost rate.

[3] Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the present-value basis. Includes neither the trust fund balance at the beginning of the period nor the cost of attaining a nonzero trust fund balance at the end of the period.

Note.—Totals may not add due to rounding.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (1996).

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 rapidly 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 3–12 shows historical information from the 1996 SMI trustees report as well as intermediate projections through 2005.

TABLE 3–12.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), SELECTED FISCAL YEARS 1970–2005

[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 payments	Administrative expenses	Total disbursements	
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
Intermediate estimates:								
1996	18,743	61,319	1,793	81,855	69,378	1,654	71,032	24,697
1997	19,090	59,529	2,181	80,800	77,277	1,718	78,995	26,502
1998	20,811	64,892	2,259	87,962	85,456	1,789	87,245	27,219
1999	21,996	72,245	2,258	96,499	93,856	1,860	95,716	28,002
2000	22,958	80,905	2,242	106,105	103,156	1,937	105,093	29,014
2001	23,983	92,225	2,270	118,478	113,924	2,019	115,943	31,549
2002	25,071	103,896	2,412	131,379	125,969	2,105	128,074	34,854

2003	26,275	116,815	2,590	145,680	139,647	2,199	141,846	38,688
2004	27,616	131,482	2,803	161,901	155,237	2,303	157,540	43,049
2005	29,068	148,183	3,045	180,296	172,949	2,415	175,364	47,981

[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 (1996).

COMPONENTS OF MEDICARE SPENDING GROWTH

Projections of the growth in Medicare spending are based on estimates of changes in utilization, number of beneficiaries, prices, and mix of services. Table 3–13 shows CBO projections, using the April 1996 baseline, of the growth in Medicare spending and the factors underlying those estimates. All projections, including the inflation update projections, are based on current law requirements. Further details on calculation of inflation adjustments are provided in subsequent sections of this chapter.

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 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 are dependent on uncertain projections of future health spending.

The CBO estimates are for illustrative individuals with specified characteristics. Contributions as a percentage of specified benefits would be lower for persons who did not work continuously from 1966 until retirement or who earned less than the average wage. Conversely, contributions as a percent of benefits would be higher for persons who worked continuously and earned more than the average wage.

For a self-insured man who worked continuously at an average wage from 1966 (when Medicaid 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 38 percent; for those retiring in 2005, contributions represent about 42 percent of benefits. 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 current law, after 1998, annual premium increases are limited by the percentage increase in the Social Security COLA, see table 3–14.

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, see table 3–14.

TABLE 3–13.—CONGRESSIONAL BUDGET OFFICE PROJECTIONS FOR MEDICARE PROGRAM COMPONENTS, 1995–2006

[Baseline outlays by fiscal year, dollar amounts in billions]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
PART A: HOSPITAL INSURANCE (HI)												
Total HI outlays [1]	$114.9	$127.1	$139.3	$151.8	$164.2	$177.0	$190.4	$204.5	$219.7	$236.6	$255.0	$276.2
Annual growth rate (percent)		10.7	9.5	9.0	8.2	7.8	7.6	7.4	7.5	7.7	7.7	7.9
Total HI mandatory [2]	$113.6	$126.0	$138.0	$160.5	$162.9	$175.6	$189.0	$203.0	$218.2	$235.0	$253.2	$275.4
Total HI benefits [3]	$113.4	$126.7	$137.8	$150.2	$162.6	$175.3	$188.7	$202.6	$217.8	$234.6	$252.9	$273.0
Annual growth rate (percent)		10.8	9.6	9.1	8.2	7.8	7.6	7.4	7.5	7.7	7.8	8.0
Hospitals	$79.8	$84.1	$88.5	$93.7	$99.2	$104.7	$110.1	$116.3	$120.8	$126.6	$132.5	$138.6
Annual growth rate (percent)		6.4	5.2	5.9	6.0	5.5	5.2	4.7	4.7	4.8	4.7	4.7
HMOs	$7.7	$10.5	$13.6	$16.9	$19.9	$23.3	$27.3	$31.9	$37.3	$43.6	$51.0	$59.7
Annual growth rate (percent)		36.5	29.9	24.0	17.7	17.2	17.0	16.8	16.9	17.0	17.1	17.0
Hospice	$1.9	$2.5	$3.1	$3.7	$4.2	$4.7	$5.2	$5.7	$6.2	$6.7	$7.3	$7.9
Annual growth rate (percent)		32.0	24.0	18.0	15.0	12.0	10.0	9.0	8.5	8.5	8.5	8.5
Home health	$14.9	$17.5	$20.1	$22.5	$24.6	$26.7	$28.9	$31.3	$33.8	$36.5	$39.4	$42.4
Annual growth rate (percent)		17.7	15.0	11.7	9.3	8.6	8.4	8.2	8.1	8.0	7.8	7.8
Skilled nursing facilities	$9.1	$11.0	$12.4	$13.6	$14.7	$16.0	$17.3	$18.6	$20.0	$21.4	$22.9	$24.6
Annual growth rate (percent)		20.6	12.9	9.3	8.5	8.4	8.1	7.7	7.4	7.3	7.1	7.1
PART B: SUPPLEMENTARY MEDICAL INSURANCE (SMI)												
Total SMI outlays [1]	$65.2	$71.9	$79.3	$87.6	$96.5	$106.0	$116.4	$127.9	$141.3	$156.6	$173.4	$192.4
Annual growth rate (percent)		10.2	10.4	10.7	9.9	9.8	9.8	9.9	10.5	10.8	10.9	10.9
Total SMI benefits [3]	$63.5	$70.1	$77.5	$85.9	$94.5	$103.9	$114.2	$125.8	$138.8	$153.9	$170.8	$189.6
Annual growth rate (percent)		10.4	10.5	10.9	10.0	9.9	9.9	10.0	10.6	10.9	11.0	11.0
Benefits paid by carriers [4]	$41.7	$44.6	$47.6	$51.3	$54.8	$58.3	$61.9	$65.6	$69.9	$74.8	$80.1	$85.7
Annual growth rate (percent)		6.9	6.9	7.6	6.8	6.4	8.2	5.9	6.6	7.0	7.1	7.1
Physician fee schedule	$33.0	$35.1	$37.0	$39.3	$41.3	$43.1	$44.8	$46.3	$48.3	$50.7	$53.4	$58.2
Annual growth rate (percent)		6.2	5.6	8.2	5.0	4.4	4.0	3.4	4.3	5.0	5.2	5.3
Benefits paid by Intermediaries [5]	$16.4	$17.3	$19.4	$21.9	$24.6	$27.7	$31.2	$35.0	$39.1	$43.4	$47.9	$52.7
Annual growth rate (percent)		12.5	12.4	12.4	12.7	12.6	12.4	12.2	11.7	11.1	10.4	9.9
Group plans	$6.4	$8.2	$10.4	$12.8	$15.2	$17.9	$21.2	$25.1	$30.0	$35.9	$42.9	51.4

TABLE 3–13.—CONGRESSIONAL BUDGET OFFICE PROJECTIONS FOR MEDICARE PROGRAM COMPONENTS, 1995–2006—Continued

[Baseline outlays by fiscal year, dollar amounts in billions]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Annual growth rate (percent)	.....	28.0	26.6	23.0	18.6	18.1	18.3	18.5	19.4	19.6	19.7	19.6
PART A INFORMATION												
Part A FY enrollment (in millions)	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
HI deductible (calendar year, in dollars)	$716	$736	$764	$796	$832	$868	$904	$940	$980	$1,020	$1,064	$1,108
Monthly premium (calendar year, in dollars)	$261	$289	$311	$334	$356	$378	$402	$426	$451	$480	$510	$538
Premiums collected	$1.0	$1.1	$1.2	$1.4	$1.5	$1.6	$1.7	$1.9	$2.0	$2.2	$2.4	$2.6
PPS market basket increase (percent)	3.6	3.5	3.3	3.5	3.5	3.4	3.4	3.3	3.4	3.4	3.4	3.4
PPS update factor (average) percent	1.9	1.5	2.8	3.5	3.5	3.4	3.4	3.3	3.4	3.4	3.4	3.4
Part A hospital inpatient payments:.												
PPS hospitals	69.2	72.6	75.5	78.7	82.3	86.0	89.5	92.9	96.3	99.9	103.4	107.2
Non-PPS hospitals/units	10.6	11.5	13.0	14.9	16.9	18.6	20.6	22.4	24.4	26.7	29.0	31.5
Disproportionate share payments	3.9	4.6	4.8	5.0	5.2	5.4	5.6	5.8	6.0	6.3	6.5	8.7
Indirect medical ed. payments (for patient care)	4.9	5.2	5.5	5.8	6.3	6.7	7.2	7.7	8.2	8.8	9.3	9.9
Inpatient capital payments	7.9	9.6	10.4	11.1	11.8	12.6	13.0	13.3	13.7	14.1	14.4	14.8
Part A and part B hospital inpatient payments; dlrect medical ed. payments (for teaching program)	2.3	2.4	2.5	2.6	2.7	2.9	3.0	3.1	3.3	3.4	3.6	3.7
Part B information: (in calendar years, except as noted):												
Deductible (in dollars)	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100
MEI percentage change	2.1	2.0	2.2	2.1	2.0	2.0	1.8	1.8	1.9	1.8	1.7	1.7

Physician update (weighted average) (percent)	7.4	0.4	1.2	0.0	−3.0	−2.6	−3.2	−2.9	−0.6	0.0	1.2	1.7
Conversion factor	$36.11	$36.28	$36.75	$36.74	$35.65	$34.75	$33.66	$32.68	$32.49	$32.51	$32.91	$33.50
Primary care update (percent)	7.9	−2.7	2.5	7.2	−3.0	−1.0	−3.2	−3.2	−0.5	−0.5	1.5	2.5
Conversion factor	$36.38	$35.42	$36.31	$38.93	$37.77	$37.40	$36.22	$35.08	$34.89	$34.71	$35.24	$36.13
Surgical update (percent)	12.2	3.4	2.2	−2.9	−3.0	−3.0	−3.2	−3.1	−0.6	0.7	1.7	2.2
Surgery conversion factor	$39.45	$40.80	$41.68	$40.48	$39.27	$38.07	$36.87	$35.73	$35.52	$35.76	$38.37	$37.15
Anesthesia conversion factor	$14.77	$15.28	$15.61	$15.16	$14.71	$14.26	$13.81	$13.38	$13.31	$13.39	$13.62	$13.92
Other physician update (percent)	5.2	0.0	0.3	−1.3	−3.0	−3.0	−3.2	−2.7	−0.6	−0.0	0.9	1.2
Conversion factor	$34.62	$34.63	$34.74	$34.30	$33.26	$32.26	$31.24	$30.39	$30.21	$30.21	$30.47	$30.84
Laboratory update (percent)	0	2.9	3.1	3.0	2.9	2.9	2.9	3.0	3.0	3.0	3.0	3.0
DME update (percent)	3.2	2.9	3.1	3.0	2.9	2.9	2.9	3.0	3.0	3.0	3.0	3.0
P&O (percent)	0	2.9	3.1	3.0	2.9	2.9	2.9	3.0	3.0	3.0	3.0	3.0
ASC update (percent)	0	2.9	3.1	3.0	2.9	2.9	2.9	3.0	3.0	3.0	3.0	3.0
Monthly premium (in dollars)	$46.10	$42.50	$44.40	$48.70	$50.20	$51.70	$53.20	$54.70	$58.30	$58.00	$59.70	$61.50
SMI premium (in dollars)[6]	$19.2	$18.8	$19.4	$21.2	$22.5	$23.5	$24.5	$25.5	$26.6	$27.8	$28.7	$29.5
Fiscal year enrollment (in millions)	35.5	36.0	36.5	36.9	37.3	37.7	38.2	38.6	39.0	39.5	40.0	40.6

[1] Includes discretionary administration.

[2] Includes mandatory administration.

[3] Includes the Impact of Public Law 104–121, enacted on March 29, 1996. This impact is not distributed to the components of Medicare benefits.

[4] Includes all services paid under the physician fee schedule, durable medical equipment, independent and physician in-office lab services, ambulance services paid by carriers, and other services.

[5] Includes outpatient hospital services, lab, services in hospital outpatient departments, hospital-provided ambulance services and other services.

[6] Includes the impact of Public Law 104–121, enacted on March 29, 1996.

Source: Congressional Budget Office, April 1996 baseline.

TABLE 3–14.—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
For self-insured men who earned average wages:			
Hospital insurance	32.7	56.1	76.1
Supplementary medical insurance	23.5	16.1	10.2
Medicare total	29.2	38.2	42.2
For self-insured women who earned average wages:			
Hospital insurance	28.2	47.7	65.8
Supplementary medical insurance	23.4	15.3	10.5
Medicare total	26.2	32.4	37.0

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, using historical information and long-term projections presented in the Board of Trustees, Federal Hospital Insurance Trust Fund (1996).

In 1995 dollars, the present discounted value of Medicare benefits net of contributions (that is the net transfer or subsidy value) is estimated at $31,766 for men and $39,443 for women who retired in 1985. For those retiring in 1995, the value is estimated at $49,751 for men and $66,613 for women, see table 3–15.

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).

TABLE 3–15.—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]

	1985	1995	2005
For self-insured men who earned average wages:			
Benefits	$44,839	$80,442	$122,430
Contributions	($13,074)	($30,691)	($51,634)
Net transfer	$31,766	$49,751	$70,796
For self-insured women who earned average wages			
Benefits	$53,465	$98,581	143,145
Contributions	($14,022)	($31,968)	($53,033)
Net transfer	$39,443	$66,613	$90,112

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 funding earnings over the same years. The CPI–U was used to get constant 1995 dollars.

Source: Congressional Budget Office, using historical information and long-term projections presented in the Report of the Board of Trustees, Federal Hospital Insurance Trust Fund (1995).

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 487 diagnosis-related groups (DRGs). Each Medicare case is assigned to one of the 487 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 (ESRD) 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 3–16 provides 1994 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 inpatient hospital or SNF care and ends when the beneficiary has been neither an inpatient of a hospital or 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;

TABLE 3–16.—USE OF INPATIENT HOSPITAL SERVICES BY MEDICARE ENROLLEES BY TYPE OF ENROLLEE AND TYPE OF HOSPITAL, CALENDAR YEAR 1994 [1]

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	Per 1,000 enrollees	Amount in millions	Per bill	Per enrollee
All enrollees:								
All hospitals	12,235	335	89,801	7.3	2,457	$71,842	$5,872	$1,966
Short-stay	11,613	318	83,752	7.2	2,292	69,027	5,944	1,889
Long-stay	622	17	6,049	9.7	166	2,815	4,526	77
Psychiatric	312	9	2,828	9.1	77	932	2,987	26
All other	310	8	3,221	10.4	88	1,883	6,074	52
Aged:								
All hospitals	10,459	323	76,818	7.3	2,370	$62,321	$5,959	$1,923
Short-stay	10,091	311	72,989	7.2	2,252	60,302	5,976	1,861
Long-stay	368	11	3,829	10.4	118	2,019	5,486	62
Psychiatric	95	3	966	10.2	30	345	3,632	11
All other	273	8	2,295	8.4	71	1,674	6,132	52
Disabled:								
All hospitals	1,776	430	12,983	7.3	3,140	$9,521	$5,361	$2,303
Short-stay	1,522	368	10,763	7.1	2,603	8,725	5,733	2,110
Long-stay	254	61	2,220	8.7	537	796	3,134	193
Psychiatric	217	52	1,862	8.6	450	587	2,705	142
All other	37	9	358	9.7	87	209	5,649	51

[1] Preliminary data.
[2] Discharges not available by type of hospital.

Note.—Only services rendered by inpatient hospitals are included. Totals may not add due to rounding.

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

—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

For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries are 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 services, radiology procedures, supplies and other equipment; and (3) capital-related costs.

Routine costs are subject to national average per diem limits. Separate per diem limits are established for freestanding and hospital-based SNFs, by urban or rural area. Freestanding SNF cost limits are set at 112 percent of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limits and 112 percent of the average per diem routine services costs of hospital-based SNFs. The law authorizes the Secretary to allow for exceptions to the limits, based on case mix or circumstances beyond the control of the facility. The Secretary is required to rebase cost limits every 2 years, that is, to develop cost limits using the latest available SNF cost report data. In the interim the Secretary applies a SNF market basket developed by the Health Care Financing Administration (HCFA) to reflect changes in the price of goods and services purchased by SNFs. To reflect differences in wage levels from area to area, the labor-related portion of the limits are also adjusted by the hospital area wage index. For this calculation, HCFA separates the limits into components which reflect the estimated proportion of the limit attributable to labor and nonlabor costs. The labor component is then adjusted by the index applicable to the area in which the SNF is located.

Ancillary services provided as SNF care are paid on the basis of reasonable costs and are not subject to cost limits. However, HCFA has issued salary equivalency guidelines for physical therapy services to provide guidance on the reasonableness of the costs of these services, and prudent buyer guidelines for occupational therapy and speech language pathology services. Capital costs are also paid on the basis of reasonable costs and are not subject to limits the way routine costs are.

SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year, sometimes referred to as low-volume SNFs, have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate covers routine and capital-related costs (not ancillary services) and is calculated separately for urban and rural areas, adjusted to reflect differences in wage levels. Prospective rates can not exceed the routine service cost limit that would be applicable to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility. For these prospective rates, the Secretary is required to re-

flect current SNF costs using the most recent data available from SNF cost reports. For SNFs receiving prospectively determined payment rates, the Secretary may pay for ancillary services on a reasonable charge basis, rather than on a cost basis, if the Secretary determines that a reasonable charge basis provides an equitable level of payment and eases the SNF's reporting burden.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) required that there be no updates in SNF cost limits (including no adjustments for changes in the wage index or updates of data) for cost reporting periods beginning in fiscal year 1994 and fiscal year 1995, or in prospective payment amounts for low-volume SNFs during these cost reporting periods. The Secretary was also required, when granting or extending exceptions to cost limits, to limit any exception to the amount that would have been granted if there were no restriction on changes in cost limits. OBRA 1993 also repealed the requirement that additional payments be made to hospital-based SNFs for costs attributable to excess overhead allocations, effective for cost reporting periods beginning on or after October 1, 1993. Payments to proprietary SNFs for return on equity were also eliminated, effective for cost reporting periods beginning on or after October 1, 1993.

Growth in payments

For the past several years, SNF care has been one of Medicare's fastest growing benefits. SNF spending in fiscal year 1990 stood at $2.8 billion; by fiscal year 1995 it had increased to $9.1 billion, for an average annual growth rate of 27 percent (see table 3–3). Because spending for SNF care has been growing at a faster rate than other benefits, its share of total net Medicare spending has increased from 2.9 percent in 1990 to 5.7 percent in 1995. SNF spending as a percent of total part A expenditures has increased from 4.2 percent in fiscal year 1990 to 7.9 percent in fiscal year 1995. The Congressional Budget Office projects that spending for SNF care will increase to $18.6 billion by fiscal year 2002. Table 3–17 presents historical SNF spending data on a calendar year basis.

Table 3–18 shows that since 1990 the number of Medicare beneficiaries receiving SNF care grew from 638,000 to 990,000 in 1995, or by 55 percent; the number of covered days grew from 25.1 million to 38.8 million, or by 55 percent. Payment per day, however, increased by 170 percent during the period, reaching $265 per day.

Tables 3–17 and 3–18 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 in early 1988. These 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 guide-

lines clarified coverage criteria by providing numerous examples of covered and noncovered care. Furthermore, the guidelines explained that even where a patient's full or partial recovery is not possible, care could be covered because it is needed to prevent deterioration or to maintain current capabilities. Previously, some care had been denied because patients' health status was not expected to improve.

TABLE 3–17.—ESTIMATED MEDICARE PAYMENTS FOR SKILLED NURSING FACILITY CARE BY TYPE OF SERVICE, 1983–95 [1]

	Payments (in billions)	Percent change [2]
Calendar year:		
1983	$0.5	.....
1984	.6	6.9
1985	.6	2.9
1986	.6	.2
1987	.6	8.8
1988	.9	47.1
1989	3.5	275.7
1990	2.5	−29.0
1991	2.9	18.4
1992	4.5	55.3
1993	6.4	42.2
1994	8.3	29.7
1995 [1]	10.3	24.1

[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).

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 3–17 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 70-percent increase, from 7,379 to 12,584, in facilities participating in Medicare between 1988 and 1994.

As noted above, large average annual rates of growth in Medicare SNF spending can be explained not only by increases in vol-

ume 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.

TABLE 3–18.—MEDICARE SKILLED NURSING FACILITY UTILIZATION AND PAYMENTS PER PERSON SERVED, 1983–95

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	34.3	37.8	188	20.1
1994	945,000	26	36.9	39.1	225	20.0
1995[1]	990,000	27	38.8	39.1	265	17.8

[1] Estimated.

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

Prospective payment for SNF care

Currently Medicare reimburses the great bulk of SNF care on a retrospective cost-based basis. This means that SNFs are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to limits noted above. This system has been criticized on a number of grounds. Providers have few incentives to maximize efficiency and minimize costs because they are reimbursed for the reasonable costs of services, after services have been provided. Nor do SNFs have incentives to control the volume of services they provide.

For these reasons, Congress on a number of occasions—in the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Re-

duction Act of 1984, and OBRA 1990—has required the Secretary of Health and Human Services to develop alternative methods for paying for SNF care on a prospective basis. Prospective payment involves establishing a rate or set of rates for a specific amount of services before the service is provided. Because SNFs would know in advance what payments they could expect and would have to keep their costs within these limits or incur losses, prospective payment is expected to improve provider efficiency. In addition, prospective payments could make program spending more predictable and could effectively contain growth in expenditures.

It is generally agreed that an effective prospective payment system for Medicare SNF care must incorporate case-mix adjustments that translate patients' varying service needs into specific reimbursement rates. Case-mix adjustments result in higher payment rates for patients who cost more to serve and lower payments for patients who cost less. With such adjustments, access for sicker patients with heavy care needs would be improved. Without them, providers might admit only those patients with the lowest resource needs and limit access to the severely ill.

Developing case-mix adjustments for a prospective payment system for SNF care has been the major focus of the Health Care Financing Administration's (HCFA) research efforts. Unlike hospital care, diagnosis of a patient is not a very good predictor for distinguishing the service needs of the SNF patient. Research has indicated that several other dimensions must be considered when developing a case-mix adjustment for SNF patients, including medical problems and functional limitations.

To account for variations in resource use, HCFA since 1984 has been sponsoring research to develop a patient classification system for Medicare SNF patients. Specifically HCFA has sought to adapt to Medicare patients a classification system known as resource utilization groups (RUGs), which was developed originally for a Medicaid nursing home population and which used primarily functional disability scores for classifying patients. HCFA found that Medicare SNF patients have different needs than the average Medicaid nursing home patient and that additional case-mix measures are needed to reflect resource use. Research has involved: (1) collecting data on patient characteristics and resource use for Medicare beneficiaries; (2) developing classification systems that are based on these data and that would explain resource use for the Medicare population; and (3) testing the usefulness of these classification systems in predicting resource use. For this research, resource use has been measured in three major categories: (1) nurse staff time, including both licensed nurses and nurse aides, the bulk of costs in nursing homes across all patients; (2) ancillary services, largely therapy services; and (3) other costs, such laboratory procedures and medications.

The version of RUGs that HCFA is currently testing for application to Medicare is known as RUGs–III. RUGs–III is being tested in six States—Kansas, Maine, Mississippi, New York, South Dakota, and Texas. Under RUGs–III, classification is based on residents' clinical conditions; extent of services needed, such as rehabilitation, respirator/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.

HCFA anticipates that 1,000 SNFs will be participating in the demonstration by the time enrollment closes in 1997. Beginning July 1, 1996, the demonstration incorporated therapies into the prospective rates. An interim report is expected in January 1998, and the demonstration is expected to be completed by December 31, 1998.

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 can not 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 which 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 "intermit-

tent" 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.

Reimbursement

Home health care agencies are 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. Costs limits, however, are 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. Limits for the individual services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies (that is, agencies not affiliated with hospitals). Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports. To reflect differences in wage levels from area to area, the labor-related portion of a service limit is adjusted by the current hospital wage index.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) required that there be no updates in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. OBRA 1993 also repealed the requirement that additional payments be made to hospital-based home health agencies for costs attributable to excess overhead allocations, effective for cost reporting periods beginning on or after October 1, 1993.

Growth in payments

For the past several years, the home health benefit has been Medicare's fastest growing benefit. As table 3–19 indicates, spending for home health began to increase in 1989 when the total stood at $2.6 billion. By 1995, spending had increased to $16.0 billion, for an average annual rate of growth of 35 percent. Because spending for home health has been growing at a faster rate than other benefits, its share of total net Medicare spending for all benefits has increased from nearly 3 percent in 1989 to 9.4 percent in 1995. Al-

most all home health claims are paid out of the Medicare Part A Hospital Insurance Trust Fund.

TABLE 3–19.—MEDICARE PAYMENTS FOR HOME HEALTH, 1983–95 [1]

	Payments (in billions)	Percent change [2]
Calendar year:		
1983	$1.6	.....
1984	1.9	17.5
1985	1.9	4.0
1986	1.9	−0.5
1987	1.9	−1.2
1988	2.1	8.6
1989	2.6	23.8
1990	3.9	53.2
1991	5.6	43.6
1992	7.9	41.1
1993	10.3	30.4
1994	13.4	30.1
1995 [3]	16.0	19.4

[1] Includes both part A and part B expenditures.
[2] Rounding in payments may not reflect actual change.
[3] Estimated.

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 3–20 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 97 in 1995, an increase of 94 percent over the period. Average number of visits per person served increased from 27 in 1989 to 70 in 1995, an increase of 159 percent. In addition, much of this volume growth can be attributed to heavy users. By 1992 (the latest year for which data are available), home health users who had more than 100 visits had grown to 18 percent of all users (from 4 percent in 1988) and accounted for over 55 percent of charges (not actual reimbursements) for the benefit. During the period 1991–92 alone, the percent of users having more than 200 visits in the calendar year increased from 3.8 to 6.3 percent.

Increasing costs for home health services have accounted for comparatively little spending growth. Payments per visit increased at a relatively low rate, from $56 per visit in 1989 to $63 in 1995, a 12.5-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.

TABLE 3–20.—MEDICARE HOME HEALTH CARE UTILIZATION AND PAYMENTS PER VISIT, 1983–95

Calendar year of service	People served		Visits			Payment per visit	Percent change [1]
	Number	Per 1,000 entollees	Number (in millions)	Per 1,000 enrollees	Per person served		
1983	1,318,000	45	36.9	1,234	28	$43	
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	51	3.3
1987	1,544,000	48	35.6	1,104	23	54	5.5
1988	1,582,000	48	37.1	1,130	23	56	4.1
1989	1,685,000	50	46.2	1,379	27	56	−0.5
1990	1,940,000	57	69.5	2,038	36	57	1.7
1991	2,223,000	64	100.2	2,875	45	56	−1.8
1992	2,523,000	72	135.6	3,876	54	58	3.6
1993	2,868,000	80	169.4	4,742	59	61	5.2
1994	3,325,000	91	221.9	6,090	67	60	−1.6
1995 [2]	3,615,000	97	252.3	6,800	70	63	5.0

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

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

Prospective payment for home health care

Currently Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to limits noted above. They are also paid for each visit they make. This system has been criticized as providing few incentives to maximize efficiency, minimize costs, or control volume of services. In addition, cost-based reimbursement is believed to contain few incentives for providers to accept severely ill patients who require intensive care and large amounts of service, especially if they find they are exceeding their cost limits. Providers also find the system's reporting requirements administratively burdensome.

For these reasons, Congress on a number of occasions—in the Orphan Drug Act of 1983, OBRA 1987, and OBRA 1990—has re-

quired the Secretary to develop alternative methods for paying for home health care on a prospective basis. Prospective payment involves setting a rate or set of rates for a specific amount of services (for example, a skilled nursing visit, or an entire episode of home health care) before the service is provided. Because agencies would know in advance what payments they could expect and would have to keep their costs within these limits or incur losses, prospective payment is expected to improve provider efficiency. In addition, prospective payments could make program spending more predictable and could effectively contain growth in expenditures.

In 1994, the Office of Research and Demonstration in the Health Care Financing Administration (HCFA) completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits.

HCFA has begun a second project, referred to as Phase II, to test prospective payment on a per episode basis. This project is not scheduled to be completed until December 1998. One of the major goals of the demonstration is to test what impact per episode payments will have on the volume of services reimbursed. Paying a predetermined amount for an episode of care is expected to control for volume since reimbursement would be independent of the number of visits provided. Under the demonstration, separate per episode payment limits would be established for each of 18 different case categories of home health care, defined by a mix of medical conditions and limitations in activities of daily living. These 18 defined categories would serve as a substitute for a true case-mix adjustment not yet available. Case-mix adjustments translate patients' varying service needs into specific reimbursement rates and would result in higher payment rates for patients who cost more to serve and lower payments for patients who cost less.

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 must certify that the individual has a life expectancy of 6 months or less. Persons electing hospice are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration. 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 HHS; (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); and (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).

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, physician 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 physician, one registered professional nurse, and one social worker employed by the hospital 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. Currently, this rate is $92.32.
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 $538.87 for 24 hours or $22.45 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 $95.50.
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 $410.72.

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.

OBRA 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.

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 elected to receive and did receive 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, 1994 through October 31, 1995, is $13,469. Cap amounts are updated annually by the percentage change in the medical care component of the consumer price index (CPI) for urban consumers.

Hospice program data

Table 3–21 shows that the number of hospices participating in Medicare has grown from 553 in 1988 to almost 1,800 in 1995. Table 3–22 indicates that spending for the benefit has increased significantly, rising from $118.4 million in fiscal year 1988 to $1.3 billion in fiscal year 1994—a 49-percent average annual rate of growth during the period. The number of beneficiaries electing Medicare's hospice benefit has increased from about 40,000 in fiscal year 1988 to almost 222,000 in fiscal year 1994. The average number of days a beneficiary spends in hospice care has risen from 37 to 59 days during this period, and the average amount spent per beneficiary has increased from $2,935 to $5,935. The vast majority of units of care paid for by the program is for routine home care.

TABLE 3–21.—NUMBER OF HOSPICES BY PROVIDER TYPE WITH PERCENTAGE OF TOTAL, 1988–95

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

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

TABLE 3–22.—SELECTED MEASURES OF MEDICARE HOSPICE CARE, FISCAL YEARS 1988–94

[By claim approved]

Category	Fiscal year						
	1988	1989	1990	1991	1992	1993	1994
1. Cash outlays by provider type:							
Freestanding	$52.1	$87.1	$130.7	$219.2	$444.2	$620.4	$724.2
Hospital based	13.5	33.0	57.0	92.0	168.0	205.3	226.1
SNF based	4.8	5.9	7.6	8.6	17.1	22.6	17.7
HHA based	47.8	79.3	113.5	125.7	224.3	303.7	348.7
Total	118.4	205.4	308.8	445.4	853.6	1,151.9	1,316.7
2. Cash outlays by care type:							
Routine home care	95.7	175.2	262.8	376.6	720.0	1,004.9	1,158.6
Continuous home care	2.5	2.6	3.1	3.9	10.4	12.2	14.5
Inpatient respite care	0.3	0.6	0.9	1.3	2.5	2.6	2.7
General inpatient care	18.9	25.5	39.6	59.7	114.0	125.5	134.1
Physicians	0.9	1.4	2.4	3.9	6.7	6.7	6.8
Total	118.4	205.4	308.8	445.4	853.6	1,151.9	1,316.7
3. Average dollar amount per beneficiary:							
Freestanding	2,837	3,436	4,237	4,121	5,668	6,085	6,355
Hospital based	3,129	3,217	3,832	4,234	5,296	5,361	5,631
SNF based	3,247	3,260	3,231	4,198	5,538	5,344	5,426
HHA based	2,965	3,395	3,994	3,993	5,169	5,239	5,408
Total	2,935	3,378	4,037	4,108	5,452	5,681	5,935
4. Number of beneficiaries:							
Freestanding	18,396	25,351	30,861	53,184	78,374	102,283	113,959

TABLE 3–22.—SELECTED MEASURES OF MEDICARE HOSPICE CARE, FISCAL YEARS 1988–94—Continued

[By claim approved]

Category	Fiscal year						
	1988	1989	1990	1991	1992	1993	1994
Hospital based	4,315	10,269	14,870	21,717	31,734	38,295	40,156
SNF based	1,494	1,818	2,353	2,040	3,084	4,221	3,262
HHA based	16,151	23,364	28,407	31,472	43,391	57,969	64,472
Total	40,356	60,802	76,491	108,413	156,583	202,768	221,849
5. Average number of days a beneficiary elects hospice care:							
Freestanding	39.26	48.40	52.41	46.15	59.11	62.0	63.7
Hospital based	37.70	41.24	45.85	44.19	54.57	53.8	55.4
SNF based	31.05	37.10	34.51	37.59	44.45	42.7	45.5
HHA based	35.26	43.14	46.46	42.45	52.59	52.2	53.3
Total [1]	37.19	44.83	48.38	44.52	56.09	57.2	58.9
6. 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
Continuous home care—hours	154,989	160,056	166,039	199,309	442,968	565,903	654,667
Inpatient respite care—days	4,223	8,398	12,573	14,867	28,495	27,887	28,769
General inpatient care—days	58,346	83,750	117,989	161,211	297,190	303,245	299,823
Physicians—procedures	19,257	24,442	39,587	53,491	111,716	115,560	110,790

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

Note.—Totals may not add due to rounding.

Source: Health Care Financing Administration.

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. There are three conversion factors—one for surgical services, one for primary care services, and one for other services. The conversion factors in 1996 are $40.80 for surgical services, $35.42 for primary care services, and $34.63 for other services (for a further discussion of physician payment issues, see appendix E).

The conversion factors are 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 is 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 is 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 1994 data were used in determining the calendar year 1996 update.) However, regardless of actual performance during the base period, there is a limit on the actual reduction (but not increase).

Anesthesiologists are paid under a separate fee schedule which uses base and time units. A separate conversion factor ($15.28 in 1996) applies.

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 certain limits. This 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 recognized 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

Physician assistants are paid directly for their 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'' their services).

Nurse practitioners

Nurse practitioners are paid directly for 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.

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 110 percent in 1996, 105 percent in 1997, and 100 percent in 1998 and thereafter. The payments are evenly split between each practitioner.

Clinical psychologists

Therapeutic services provided by clinical psychologists are paid on the basis of a separate fee schedule which is currently equal to 80 percent of the fee schedule for psychiatrists. Diagnostic tests are paid under the physician fee schedule. Payments for services pro-

vided by clinical social workers are equal to 75 percent of the scheduled amount allowed for clinical psychologists. Some services are subject to the psychiatric services limitation which effectively limits Medicare payments for some services to 50 percent of incurred expenses.

Physical or occupational therapists in independent practice

Payments for physical or occupational therapists in independent practice are made under the physician fee schedule, subject to an annual limit of $900 in billed charges for each type of therapist.

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. In calendar year 1995, Medicare paid an estimated $4.5 billion for lab services, of which an estimated $1.9 billion was for services in independent labs, $.9 billion for services in office labs, and $1.7 billion for services in hospital outpatient departments.

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 level 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 is 2.9 percent.

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. The ceiling is now 76 percent of the median.

Effective March 1, 1996, Medicare instituted a new policy for paying for tests in an automated profile. The past policy permitted payment for all tests contained in an automated profile when at least one was covered. Under the new policy, payment is only made for those tests that meet Medicare coverage rules. Where only some of the tests in a profile are covered, payment cannot exceed the amount that would have been paid if only the covered tests had been ordered. However, in no event may the payment for the covered tests exceed the payment allowance for the profile.

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 are required to meet the requirements of the Clinical Laboratory Improvement amendments of 1988. This legislation, which focused on the quality and reliability of medical tests, expanded Federal 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 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, just so long as the institution is not a hospital or skilled nursing facility. This is not an all inclusive definition of covered DME, however. Health Care Financing Administration (HCFA) guidelines implementing the law provide a definition for DME that allows a broad array of 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 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 de-

termining 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 with 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 local payment amounts and the ceiling is 120 percent. Fee schedule amounts are updated annually by the consumer price index for all urban consumers, CPI–U.

Table 3–23 shows total Medicare allowed payment amounts in calendar year 1994 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.

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 completion of a certificate of medical necessity (CMN) to document that an item is reasonable and medically necessary. OBRA 1990 prohibited DME suppliers from distributing completed or partially completed CMNs 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 DME items to Medicare beneficiaries by providing them with completed CMNs for them to submit to their physicians. It was hoped that requiring physicians to complete CMNs would encourage them to take a more active role in considering their patients' needs for DME, while simultaneously reducing DME suppliers' ability to influence DME acquisition.

TABLE 3–23.—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]	$290.5
Items with frequent maintenance [2]	59.8
Customized items [3]	1.8
Capped rental [4]	672.0
Oxygen [5]	1,473.3
Prosthetics/orthotics [6]	887.3
Other [7]	675.3
Total	$4,060.0

[1] Inexpensive 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.

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

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

[4] Items 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.

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

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

[7] This 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.

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 to permit easy imposition of inherent reasonableness adjustments.

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 to the beneficiary must be refunded by the supplier. Further, 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 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.

Under Medicare, 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 $11.9 billion in calendar year 1994. Payments to hospital OPDs constituted approximately 20 percent of all Medicare part B payments in 1994 and about 8 percent of total parts A and B Medicare payments. Table 3–24 provides information on the number of part B enrollees, covered charges, aggregated reimbursements and reimbursements per enrollee for hospital outpatient services from 1974 to 1994. Table 3–25 show the percent distribution of Medicare hospital OPD charges, by type of service for 1994.

OBRA 1993 extended reduced payment for services paid on a cost-related basis, other than capital costs, by 5.8 percent of the recognized costs for payments attributable to cost-reporting periods, through fiscal year 1998. The reduction also applies to cost portions of blended payment limits for ambulatory surgery and radiology services. OBRA 1993 also extended the reduction in reimbursement for capital costs for hospital OPDs by 10 percent for cost reporting periods occurring through fiscal year 1998. Sole community hospitals and rural primary care hospitals are exempt from these reductions.

Proposed modification

OBRA 1990 required the Secretary to submit a proposal to Congress regarding prospective payments for hospital OPDs, and also required the Prospective Payment Assessment Commission (ProPAC) to submit its analysis and comments on the proposal. On March 15, 1995, the Secretary reported on a proposal to replace the current payment system with a prospective payment system (PPS) beginning in fiscal year 1996. The proposal would require the development of a new classification system for paying hospital OPDs using an ambulatory patient group (APG) system for paying prospective rates for all outpatient surgery, radiology, and other diagnostic services. These services account for approximately half of total hospital outpatient charges. The APG system could then be

expanded to a comprehensive system for all OPD services as more data becomes available and further research is completed.

TABLE 3–24.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974–94

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	36,675,637	11,903,180	338	32.5
		Average annual rate of growth			
1974–94	2.1	23.5	19.8	17.3	
1974–83	2.5	24.4	26.4	23.3	
1984–94	1.8	21.7	13.4	11.4	
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	30,211,880	9,206,268	193	30.5
		Average annual rate of growth			
1974–93	1.9	24.2	20.5	16.0	
1974–83	2.3	25.3	28.2	25.8	

TABLE 3–24.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974–94—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
1984–94	1.6	22.0	13.1	6.8	
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
			Average annual rate of growth		
1974–93	3.9	21.1	17.8	13.3	
1974–83	4.9	21.6	21.6	15.9	
1984–94	3.5	20.4	14.3	10.5	

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

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.

ProPAC submitted its report to Congress on July 27, 1995, recommending that Congress reject the Secretary's proposal for a phased-in prospective payment system for OPD services. ProPAC concluded that adding more OPD services to a prospective payment system would be difficult because it would create financial winners and losers under the program. ProPAC argued that hospitals and the Medicare Program would be required to bear the cost of adopting a new PPS. Such a system, partially implemented, would provide few benefits while increasing payment complexity and the administrative burden on hospitals. In addition, ProPAC found that the proposal would do little to control utilization of outpatient services. ProPAC recommended that HCFA submit to the Congress a detailed legislative proposal to implement a PPS covering all outpatient services.

TABLE 3–25.—PERCENT DISTRIBUTION OF HOSPITAL OUTPATIENT CHARGES UNDER MEDICARE BY TYPE OF SERVICE, 1994

Service category	Percent of charges
Radiology	21.2
Laboratory	12.9
Operating room	11.4
End-stage renal disease	11.7
Pharmacy	6.3
Emergency room	3.2
Clinic	1.7
Physical therapy	2.0
Medical supplies	9.2
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.

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 grouped 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 1996 range from $304 for a procedure in payment group one, to $903 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; 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 (IOL) include an allowance for the IOL 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 IOL 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 also provided 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 provided 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.

In 1995, there were 1907 ASCs, a 293 percent increase over the 485 facilities which were participating in Medicare in 1985. Payments for ASC services totaled $659.7 million in 1995 (see table 3–26). Table 3–27 shows the top 10 procedures (by CPT code) performed in ASCs in 1995.

TABLE 3–26.—MEDICARE CERTIFIED AMBULATORY SURGICAL CENTERS: UTILIZATION AND PROGRAM BENEFIT PAYMENTS FOR FACILITY SERVICES, 1993–95

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	1,487,559	830,949,111	659,726,047

Note.—ASC = ambulatory surgical center.

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

OTHER PART B SERVICES

Preventive services

Medicare covers a screening mammography once every 2 years for persons over age 65. The program covers screening 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. 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 1996 limit is $62.10.

A screening pap smear is authorized once every 3 years, except for women who are at a high risk of developing cervical cancer. Payment is based on the clinical diagnostic laboratory fee schedule (see above).

TABLE 3–27.—HIGH VOLUME PROCEDURES PERFORMED AT MEDICARE CERTIFIED AMBULATORY SURGICAL CENTERS, 1995

Current procedural terminology code [1]	Short descriptor	Volume of Medicare cases
66984	Remove cataract, insert lens	504,224
66821	After cataract laser surgery	164,697
43239	Upper GI endoscopy, biopsy	67,737
45378	Diagnostic colonoscopy	55,751
45385	Colonoscopy, lesion removal	39,329
45380	Colonoscopy and biopsy	31,660
43235	Upper GI endoscopy, diagnosis	25,270
52000	Cystoscopy	20,011
45384	Colonoscopy	18,924
66170	Glaucoma Surgery	15,725

[1] The American Medical Association Physicians' Current Procedural Terminology ("CPT") is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. The numeric identifying codes and short descriptors used in this table are copyrighted by the American Medical Association.

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

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 2 years following a covered organ transplant. The coverage period is extended to 3 years beginning in 1997.

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.

Generally, Medicare payment for drugs is based on the lower of the estimated acquisition cost (EAC) or the national average wholesale price. The EAC is determined based on surveys of actual invoice prices. For multiple source drugs, payment is based on the lower of the EAC or the wholesale price. These provisions apply, except when payment is based on reasonable costs. Special limits apply in the case of EPO; the limit is $10 per 1,000 units. Osteoporosis drugs can only be paid on the basis of reasonable costs.

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 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 (BLS) or advance life support (ALS), whether emergency or non-emergency transport was used, and whether specialized ALS services were rendered.

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 1994, 7.7 percent of the population suffering from end-stage renal disease (ESRD) who needed renal dialysis and 9.3 percent who needed kidney transplants did not meet any of these requirements and thus were not covered 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 3–28 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 2001. Total projected program expenditures for the Medicare End-Stage Renal Disease Program for fiscal year 1995 are estimated at $6.9 billion. In fiscal year 1995, there were an estimated 216,828 beneficiaries, including successful transplant patients and persons entitled to Medicare on the basis of disability who also have ESRD.

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 3–29 shows that new enrollment for all Medicare beneficiaries receiving ESRD services grew at an average annual rate

of 8.6 percent from 1988 to 1993. 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 3–7 shows the greatest rate of growth in program participation is in people over age 75, at 14.2 percent, followed by people of ages 65–74 with a growth rate of 11.2 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.

TABLE 3–28.—END-STAGE RENAL DISEASE MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES, 1974–2001

[Expenditures in millions]

Fiscal year	Expenditures (HI & SMI)	HI beneficiaries	Per person cost
1974	$229	15,993	$14,319
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	54,928	22,666
1981	1,464	61,324	23,873
1982	1,640	68,934	23,791
1983	1,984	77,968	25,446
1984	2,325	87,018	26,719
1985	2,154	95,854	22,472
1986	2,527	105,268	24,002
1987	2,740	115,587	23,703
1988	3,128	126,274	24,773
1989	3,659	138,164	26,480
1990	4,065	151,969	26,751
1991	4,511	167,816	26,881
1992	5,145	181,020	28,422
1993	5,671	192,447	29,468
1994	6,201	204,302	30,352
1995	6,890	216,828	31,776
1996	7,587	229,925	32,998
1997	8,362	243,458	34,347
1998	9,221	257,238	35,846
1999	10,155	271,125	37,445
2000	11,165	285,078	39,165
2001	12,254	299,201	40,956

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. HI = hospital insurance; SMI = supplementary medical insurance.

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

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 en-

tered 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, and will continue, to result in steady growth in the number of patients enrolling in Medicare's End-Stage Renal Disease Program.

TABLE 3–29.—MEDICARE END-STAGE RENAL DISEASE PROGRAM NEW ENROLLMENTS BY AGE AND PRIMARY DIAGNOSIS, 1988–93

Age and primary diagnosis	1988	1989	1990	1991	1992	1993	Average annual percent change	Percent change 1992–93
Number of new enrollees:								
Total	38,151	42,885	46,658	50,831	55,583	57,621	8.6	3.7
Age:								
Under 15 years	403	405	461	454	409	440	1.8	7.6
15–24 years	1,268	1,315	1,271	1,242	1,350	1,312	0.7	(2.8)
25–34 years	3,087	3,413	3,438	3,485	3,560	3,601	3.1	1.2
35–44 years	4,340	4,704	5,133	5,501	5,848	5,796	6.0	(0.9)
45–54 years	5,390	5,904	6,230	6,753	7,559	7,962	8.1	5.3
55–64 years	8,456	9,108	9,819	10,587	11,214	11,551	6.4	3.0
65–74 years	9,669	11,302	12,682	14,097	15,629	16,415	11.2	5.0
75 years and over	5,538	6,734	7,624	8,712	10,014	10,736	14.2	7.2
Diagnosis:								
Diabetes	11,717	14,214	15,939	18,249	20,201	20,073	11.4	(0.6)
Glomerulonephritis	5,228	5,643	5,779	5,810	5,984	5,896	2.4	(1.5)
Hypertension	10,325	12,161	13,278	14,633	16,346	15,640	8.7	(4.3)
Polycystic-kidney dis	1,250	1,275	1,402	1,474	1,546	1,460	3.2	(5.6)
Interstit nephritis	1,233	1,378	1,371	1,497	1,515	1,379	2.3	(9.0)
Obstructive nephropat	872	954	916	985	1,042	949	1.7	(8.9)
Other	2,182	2,596	2,788	3,456	3,775	3,961	12.7	4.9
Unknown	2,657	2,443	2,408	2,693	2,876	2,461	−1.5	(14.4)
Not reported	2,687	2,221	2,777	2,034	2,298	5,999	17.4	161.1

Source: Health Care Financing Administration, Bureau of Data Management and Strategy; data from the Program Management and Medical Information System, June 1995 update.

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 3–30 indicates that the number of transplants in 1994 was more than double the number performed in 1980. Despite the significant increases in the number and success of kidney transplants, transplantation will not be 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. Some ESRD patients do not want an organ transplant.

TABLE 3–30.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE CERTIFIED U.S. HOSPITALS, 1979–94

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	1,760	20	7,116	80
1989	8,899	1,823	21	7,006	79
1990	9,796	2,001	21	7,705	79
1991	10,026	2,296	23	7,644	76
1992	10,115	2,391	24	7,579	75
1993	10,934	2,631	26	8,106	74
1994	11,312	2,738	24	8,312	73

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

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. Peritoneal dialysis does not require use of a machine. Instead, 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. To be effective, both types of dialysis generally need to be performed several times a week, usually three times.

REIMBURSEMENT

Medicare reimbursement for facility-based dialysis services (provided by hospital-based and independent facilities) are paid at pro-

spectively determined rates for each dialysis treatment session. The rate, referred to as a composite rate, is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and area wage differences. 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 paid 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 1996, the composite rate is $130 for hospitals and $126 for freestanding facilities.

MANAGED CARE

The Medicare risk-contracting program was authorized by the Tax Equity and Financial Responsibility Act of 1982. The program gives Medicare beneficiaries the option to enroll in health maintenance organizations (HMOs), all of which offer Medicare-covered benefits and most of which also offer coverage of cost sharing and supplemental services. Beneficiaries may choose HMO enrollment when they become Medicare eligible or at other times that Medicare HMOs offer open enrollment. They also are allowed to disenroll from their plans at the end of any given month.

ENROLLMENT

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

Enrollment policies

Medicare enrollees entitled to part B benefits may enroll in a managed care plan with a Medicare contract if they live within the plan's service area. Beneficiaries may enroll in a plan upon becoming eligible for Medicare or during the plan's open enrollment period.

Plans are required to provide an open enrollment period, publicized through appropriate media, for at least 30 consecutive days each year. Many, however, have a continuous enrollment policy.

Plans are required to enroll all eligible beneficiaries (except those with end-stage renal disease or who elect hospice care) on a first come basis until they have met their enrollment capacity.

To forestall discriminatory practices by plans during the enrollment process, the Health Care Financing Administration (HCFA) oversees plan marketing activities. Written descriptions of plan rules, procedures, benefits, fees and charges, services, and other information must be approved by HCFA and provided to interested beneficiaries. The additional benefits or services that the plan provides and any reductions in premiums, deductibles, or copayments also must be documented. In addition, plans are prohibited from misrepresenting themselves to beneficiaries, offering gifts or payments to enrollees, soliciting door-to-door, or distributing marketing materials that have not been approved by HCFA.

Beneficiaries may choose to disenroll at any time for any reason. To disenroll, the beneficiary submits a written request to the plan. The plan, in turn, must submit a disenrollment notice to HCFA. The disenrollment generally is effective the month after the request is made. Plans may disenroll a beneficiary, but only for a limited number of reasons such as the beneficiary moving out of the plan's service area, failing to pay the premium, or providing fraudulent information on the application.

Plan participation requirements

Participation in Medicare's risk-contracting program is limited to federally qualified health maintenance organizations (HMOs) and competitive medical plans (CMPs). Other forms of managed care that have evolved since the risk-contracting program began, such as preferred provider organizations and tightly managed fee-for-service insurance plans, are not currently program options. However, HCFA is in the process of entering into demonstration projects to test different kinds of managed care arrangements.

In general, to participate in Medicare risk contracts, plans must: assume the full financial risk of providing the health care services they have agreed to cover; show that they have sufficient operating experience; and demonstrate that they are capable of furnishing the range of services available to fee-for-service Medicare enrollees in the same area, except hospice services. In addition, plans must maintain a quality assurance program and have a minimum number of commercial members. For urban plans, this enrollment threshold is 5,000; rural plans must have at least 1,500 commercial members. With limited exceptions, plans must also maintain a non-Medicare, non-Medicaid enrollment of at least 50 percent.

Plans also may choose to serve Medicare beneficiaries under a cost-based contract. Under this option, plans receive reasonable costs for providing services rather than capitation payments. Moreover, beneficiaries can use providers outside the plan, in which case the providers are paid on a fee-for-service basis. Two types of cost contracts exist. If a plan opts to cover both part A and part B services, it is known as an 1876 (referring to that section of the Social Security Act) cost contract. Medicare may also separately reimburse plans for their part B costs under rules established for health care prepayment plans (HCPPs). There are no specific statutory

conditions to qualify for a HCPP contract. Some HCPPs are private market HMOs while others are union or employer plans.

Trends in enrollment and plan participation

In April 1996, 3.5 million beneficiaries participated in Medicare's risk-contracting program. Although these enrollees still represent less than 10 percent of Medicare's total population, enrollment in risk-based contracts has grown substantially. Current levels are about triple the 1.2 million beneficiaries enrolled in September 1990, as a result of annual enrollment increases at double digit rates throughout the 1990s (see table 3–31). Enrollment in cost-based HMOs is small (about 473,000) and in HCPPs is smaller (186,000).

The number of Medicare risk contracts has varied over the last 9 years. After holding fairly level through the late 1980s, the number of contracts dipped markedly through the early 1990s. Despite this sharp drop, enrollment continued to grow because plans leaving the risk-contracting program served relatively few beneficiaries. Part of the drop in contracts can be attributed to the market consolidation that occurred in the early 1990s. Recently, plan participation has been increasing. As of April 1996, there were 202 HMOs with risk contracts, 28 with Section 1876 cost contracts, and 53 with HCPP contracts. For 1996, risk contracts grew almost 30 percent over 1995 (see table 3–31).

TABLE 3–31.—MEDICARE RISK PLAN PARTICIPATION, 1990–96

Year	Enrollees (in millions)	As a percentage of total Medicare enrollment	Number of contracts
1990	1.2	3.5	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996[1]	3.5	9.1	202

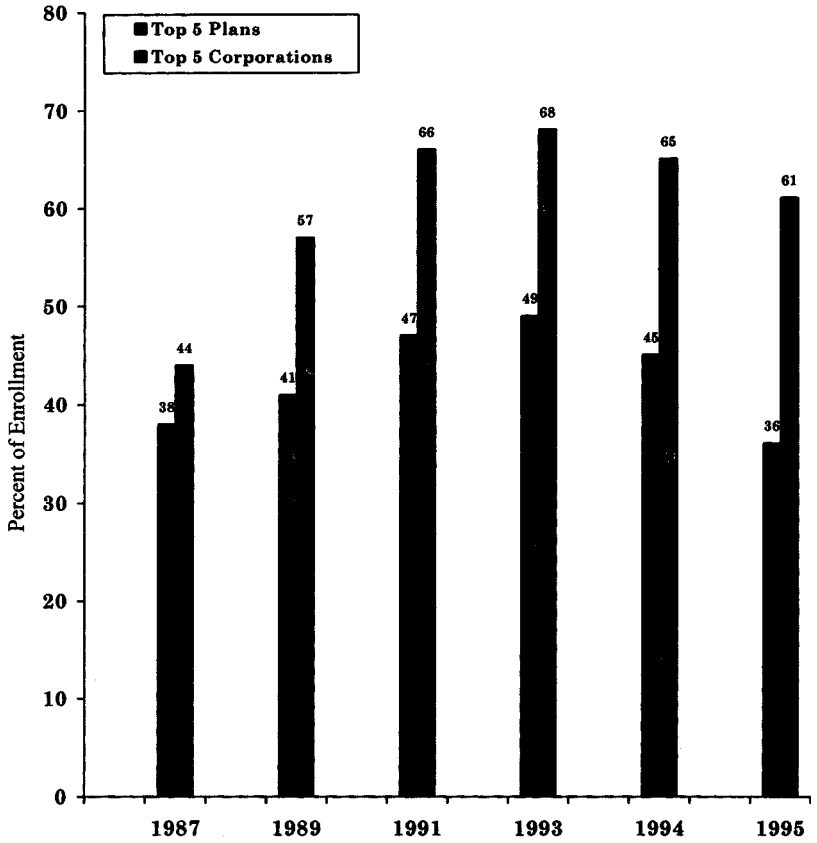
[1] Data are as of April 1996.

Note.—Enrollment data are as of September each year; contract data are as of January each year.

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

Concentration of risk plans.—Risk contracts are concentrated among a few corporate sponsors and are not distributed uniformly across the country. More than 60 percent of all risk contract members are enrolled in plans sponsored by PacifiCare, FHP, Kaiser, Humana, and United Health Care (chart 5–1). While still relatively high, the concentration of enrollment in certain corporations appears to be declining, probably because of the large number of recent new entrants to risk contracting. Further decline likely will be gradual since many new plans serve fewer than 1,000 enrollees. Corporate mergers, however, could lead to increases in enrollment concentration.

CHART 3–1. CONCENTRATION OF MEDICARE RISK ENROLLEES IN PLANS AND CORPORATIONS WITH THE HIGHEST MEDICARE ENROLLMENT, SELECTED YEARS (IN PERCENT)



Note.—Contract counts are as of April of each year.
Source: Group Health Association of America.

The number of managed care plans available to Medicare beneficiaries in a given market is important to assessing both the opportunities to enroll in any plan and the degree of choice. About three-quarters of Medicare beneficiaries have access to a plan, see table 3–32. But only 57 percent of beneficiaries live in areas served by more than one plan. Those beneficiaries who are eligible for Medicare due to disabilities have slightly more limited access to plans than do those who are eligible due to age only.

TABLE 3–32.—DISTRIBUTION OF BENEFICIARIES BY NUMBER OF MEDICARE PLANS THAT SERVE THEIR ZIP CODE OF RESIDENCE, 1995

Number of plans	Percent beneficiaries	Percent old age	Percent disability
No Plans	25	25	30
1	18	18	17
2–5	28	28	27
6–10	21	21	20
11–15	6	6	4
More than 15	3	3	2

Source: Physician Payment Review Commission analysis of Health Care Financing Administration Risk Plan Geographic Area File and the Medicare Master file.

PAYMENT METHODOLOGY

There are two basic components of the risk program payment methodology. 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.

Capitation payments to risk-contracting plans

Medicare pays risk plans based on an actuarial projection of what the program would have paid if the beneficiary had remained in the traditional fee-for-service sector. The Health Care Financing Administration recalculates these HMO payment rates every calendar year based on estimates of national average spending, county spending, and beneficiary characteristics.

National Medicare per capita expenditures.—First, HCFA actuaries use historical program expenditures to project national per capita program expenditures for the coming calendar year. These U.S. per capita costs (USPCC) are needed to update historical spending at the county level. Separate projections are made for part A services and part B services for the aged, the disabled, and people with end-stage renal disease (ESRD). These projections take into account expected inflation and changes in utilization patterns and services covered by the Medicare Program. The USPCCs are reported as monthly per capita expenditures because risk plans are paid on a monthly basis (see table 3–33). Fee-for-service claims for services provided 3 years earlier are used to ensure that the calculation is based on complete data.

TABLE 3–33.—PROJECTED U.S. PER CAPITA MONTHLY COSTS, 1995

Eligibility group	Part A	Part B
Aged	$251.61	$148.91
Disabled	223.99	131.82
End-stage renal disease	1,520.42	2,153.81

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

County-level Medicare per capita expenditures.—In the second stage, HCFA estimates expected per capita program expenditures for the aged and the disabled in each county, and for people with ESRD in each State. To reduce the effect of year-to-year swings in per capita payments, 5 years of fee-for-service claims data are used (that is, the period 3–7 years previously).

County-level per capita spending differs 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 are 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 risk adjusters reflect the relative level of program spending for groups defined on the basis of age, sex, disability status, institutional status, Medicaid enrollment, and working aged with employment-based insurance coverage. These projected risk-weighted per capita payments are known as the adjusted average per capita costs (AAPCC).

Enrollee-level payment to plans.—Finally, HCFA calculates what it will pay a risk plan for each individual enrollee. This payment is based on 95 percent of the AAPCCs for the enrollee's county of residence, adjusted by the national risk adjusters to reflect each enrollee's demographic characteristics (see table 3–34). Medicare also pays plans 95 percent of the State-level end-stage renal disease AAPCCs for enrollees with this condition.

TABLE 3–34.—CALCULATION OF 1995 RISK PLAN MONTHLY PAYMENT FOR NONINSTITUTIONALIZED, NONMEDICAL, NONWORKING MALES AGE 68 IN LOS ANGELES COUNTY, CALIFORNIA

Medicare part	95 percent of AAPCC		Demographic risk adjuster		Subtotal
Part A	$340.59	×	0.70	=	$238.41
Part B	218.17	×	0.80	=	174.54
Total program payment to risk plan				=	412.95

Note.—AAPCC = adjusted average per capita costs.

Source: Prospective Payment Assessment Commission calculations using data from the Health Care Financing Administration, Office of the Actuary.

Adjusted community rate requirements

HCFA calculates the AAPCC for each county and the risk adjusters for each demographic group and provides this information to potential risk contractors. A plan uses this payment information together with its own estimates of the number and mix of Medicare enrollees it expects to enroll to determine the amount of Medicare Program payments it would receive. Plans that wish to enter into or continue risk contracts are then required to submit an adjusted community rate (ACR) proposal for the following calendar year.

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 and intensity of services and covered benefits. The plan's commercial revenues are used to calculate an allowance for administrative costs and profits.

If expected Medicare revenues exceed projected costs, a plan is required either to return the surplus to Medicare or to spend it by providing additional benefits to Medicare enrollees. The ACR process is used to calculate the value of these required, noncovered benefits. The process also is used to calculate premiums that Medicare enrollees will pay to risk plans.

Expected cost of Medicare-covered services.—The ACR proposal is based on the average monthly revenue per member for a plan's commercial business. This revenue is allocated to direct patient care expense and administration. The direct patient care expense categories include part A line items (inpatient hospital, skilled nursing, and home health services), part B line items (physician, outpatient laboratory, and outpatient radiology services), and noncovered Medicare services (such as routine physical examinations). Administrative expense is the difference between total revenue (commercial premiums plus other revenue) and direct patient care expenses. Thus, administration includes both overhead costs and profits on the plan's commercial business.

The direct costs of providing Medicare-covered services are adjusted to reflect the higher volume and complexity of services provided to Medicare beneficiaries as compared to commercial members. 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.

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 from the commercial base rate allocation. 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.

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 (as discussed under the ACR calculation above). 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.

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.

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 national 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. Over half of the plans charge no additional premiums.

Payment issues

There are several issues involving the current AAPCC-based payment methodology. Payment rates vary widely across the country. Risk plans also have been paid fee-for-service medical education and disproportionate share hospital (DSH) payments for costs they may not actually have incurred.

Geographic variation and volatility.—Current policies lead to significant variation in risk payments across communities. Because Medicare risk payments are county based, three problems arise. First, neighboring counties often have substantially different AAPCCs that may not be explained by differences in plan costs. For example, the AAPCC varies by $180 per month in the counties adjacent to Washington, DC and by more than $100 in the counties that comprise both the Miami and Minneapolis markets (see table 3–35).

Second, geographic variation in AAPCCs reflects local differences in fee-for-service Medicare expenditures due to service use patterns (volume and intensity), provider input prices (for example, cost of wages or supplies), and Medicare payments for special purposes (for example, DSH payments). In 1995, the published AAPCCs ranged from $177 to $679. AAPCCs for urban counties were higher on average than for rural counties ($428 versus $323; see table 3–36).

Different patterns of service use are the source of much of this variation. When local differences in Medicare provider input prices are removed, the resulting standardized AAPCCs still vary substantially (see table 3–36). The 1995 input-price-adjusted AAPCC rates ranged from $324 to $530. On average, the actual AAPCC rates are higher for urban counties and lower for rural locations than the input-price-adjusted rates. The much larger variation in the AAPCC rates across the country, compared with input-price-adjusted rates, reflects large differences in utilization of services.

Third, despite the use of 5 years of expenditure data to smooth changes in per capita spending, many counties experience substantial changes in the AAPCC from year to year. The volatility of county-level risk payments over time is related to the size of a county's Medicare population. Per capita costs for small Medicare populations fluctuate more over time. The average volatility of payment rates is significantly greater for rural than for urban counties (table 3–36); volatility exceeds 20 percent for some rural counties.

Both the levels of AAPCC-based payment rates and their volatility over time have influenced Medicare risk-plan enrollment rates. PPRC's analysis indicates 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 a weaker but measurable effect, with lower enrollment rates where volatility is high.

TABLE 3–35.—STANDARDIZED PER CAPITA MONTHLY RATES OF PAYMENT FOR AGED ENROLLEES IN SELECTED AREAS, 1995

Area	Rate of payment
Washington, DC—Maryland—Virginia:	
Washington, DC	$540
Prince Georges County, MD	543
Montgomery County, MD	426
Manassas Park City, VA	464
Falls Church City, VA	408
Alexandria City, VA	407
Arlington County, VA	396
Fairfax City, VA	367
Fairfax County, VA	361
Minneapolis-St. Paul, MN, metro area:	
Ramsey (St. Paul)	380
Hennepin (Minneapolis)	363
Anoka	342
Dakota	334
Washington	324
Carver	285
Scott	277
Southern Florida:	
Dade	616
Broward	544
Palm Beach	473
Southern California:	
Los Angeles	559
Orange	523
San Diego	459

Note.—The 1995 U.S. per capita cost for aged enrollees is $401; 95 percent of the U.S. per capita cost is $380, which corresponds to the standardized per capita rate of payment.

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

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. These payments are retained in the expenditures used to calculate the AAPCCs. As a result, an AAPCC reflects a county's average monthly per capita cost for fee-for-service medical education and DSH. 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.

TABLE 3–36.—AVERAGE MEDICARE RISK-PLAN MONTHLY PAYMENT RATES, PAYMENT VOLATILITY, AND ENROLLMENT RATES BY URBAN AND RURAL LOCATION, 1995

	AAPCC rate (standard deviation)	Input-price-adjusted rate (standard deviation)	Payment volatility [1] (percent)	Enrollment rate (percent)
All counties	$402 (92)	$402 (46)	2.2	7.3
Urban counties	428 (87)	418 (42)	2.1	9.4
Central urban	499 (83)	441 (40)	1.8	16.8
Other urban	393 (64)	406 (37)	2.2	5.8
Rural counties	323 (50)	357 (20)	2.9	0.6
Urban fringe	330 (51)	357 (18)	2.7	0.7
Other rural	317 (48)	354 (21)	3.1	0.5

[1] Payment volatility is measured as the annual average magnitude of change (higher or lower) in a county's payment index for 1991–95 as a percentage of its 5-year average index for that time period. The payment index is the ratio of the county's AAPCC rate to the national average rate per beneficiary.

Note.—AAPCC = adjusted average per capita cost.

Source: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1991–95 and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

Medical education and DSH payments are an estimated 5.5 percent of the AAPCC rates overall, but their share of total payment rates varies across the country (table 3–37). On average, medical education and DSH payments represent only 3.6 percent of capitation rates for rural counties but 6.1 percent of the rates for urban ones. They average 8.4 percent of payment rates for the most densely populated, central urban counties.

TABLE 3–37.—ESTIMATED MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENTS AS COMPONENTS OF MEDICARE RISK-PLAN PAYMENT RATES, BY URBAN AND RURAL LOCATION, 1995

[In percent]

	Medical education	Disproportionate share	Total percentage
All counties	3.4	2.1	5.5
Urban counties	3.8	2.3	6.1
Central urban	5.3	3.1	8.4
Other urban	3.1	1.9	5.0
Rural counties	2.1	1.5	3.6
Urban fringe	2.2	1.6	3.8
Other rural	1.9	1.5	3.4

Source: Physician Payment Review Commission analysis of Medicare part A expenditures for the 5 percent sample of beneficiaries for 1993, published adjusted average per capita cost rates for 1995, and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

Medicare beneficiaries, and in particular those who are risk-plan enrollees, tend to live in counties where medical education and DSH payments are larger shares of the payment rates. More than

30 percent of risk-plan enrollees are in counties with medical education and DSH shares of 7 percent or greater, and another 37 percent are in counties with 4–6 percent shares (table 3–38).

TABLE 3–38.—ESTIMATED MEDICAL EDUCATION AND DISPROPORTIONATE SHARE (DSH) PAYMENTS FOR COUNTIES, BENEFICIARIES, AND PLAN ENROLLEES, 1995

[In percent]

Medical education/ DSH share of capitation rate	Counties	Beneficiaries	Risk-plan enrollees
0 percent	7.8	1.1	0.1
1–3 percent	48.4	33.3	29.4
4–6 percent	30.2	34.1	36.6
7–9 percent	9.4	19.2	24.2
10 percent or more	4.2	12.3	9.7

Source: Physician Payment Review Commission analysis of Medicare part A expenditures for the 5-percent sample of beneficiaries for 1993, published adjusted average per capita cost rates for 1995, and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

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, Puerto Rico, 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 (e.g., 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 HHS 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 will be 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. OBRA 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 HHS 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 1995 totaled $190 million; in 1996, spending is expected to be $268 million. Spending varies considerably from year to year depending on where the PROs are in their contract cycles. HCFA projections for fiscal year 1997 are $270 million. 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 apportionments 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 provider(s), physician(s), 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 of care. This provision, however, has never been used.

Each of the contracts between HHS 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, basically using local clinical criteria. 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) will no longer be required. Instead, each PRO will be required to conduct 4–18 quality improvement projects each year, depending on the size of their beneficiary populations.

FINANCING GRADUATE MEDICAL EDUCATION

Medicare is the largest explicit Federal source of financing for graduate medical education through the program's support of medical residency training in teaching hospitals. Private payers also support graduate medical education through higher payments to teaching hospitals. However, the contributions of other private, third-party payers for graduate medical education are not specifically identified in their payments. Medicare recognizes the costs of graduate medical education under two mechanisms: direct graduate medical education (GME) payments and an indirect medical education (IME) adjustment. In fiscal year 1995, Medicare paid approximately $2.3 billion in GME payments and $4.9 billion in IME adjustments for its share of the costs of beneficiary treatment at teaching hospitals.

Today policymakers are concerned with a number of issues related to the Nation's supply of physicians and the Federal role in subsidizing graduate medical education. There is a general consensus that the future physician work force will not match the future health care needs of the Nation. The concern is focused on the future surplus of physicians, comprised of too few generalist physicians and too many specialists to meet the Nation's future health care needs. In a health care economy shifting markedly toward managed care arrangements, many argue that HMOs and other managed care plans that use large numbers of generalist physicians as gatekeepers and primary care providers will face shortages of such physicians. In 1995, about 35 percent of all physicians were generalists, and most experts agree that the future proportion of generalists needs to increase relative to specialist physicians.

Medicare support for residency training has generally allowed hospitals to determine the specialty distribution and number of physicians to be trained. Hospitals make those decisions based largely on hospital service needs rather than on the broader health and medical needs of the community. While in 1960 the physician-to-population ratio had been 142 to 100,000, the total number of

physicians grew at a rate that was almost four times faster than that of the total population, reaching 263 physicians per 100,000 population by 1994. The Bureau of Health Professions at HHS projects that at the current rate of growth, by 2020 the total number of physicians will reach 875,800, or 269 physicians per 100,000 population.

International medical graduates (IMGs), physicians receiving their training in medical schools in countries outside the United States and Canada, make up a significant part of the Nation's physician work force. The number of IMGs has increased from just over 10 percent of all physicians in 1963, to 18 percent in 1970, and 23 percent in 1994 (144,783 of the 619,751 physicians in practice). Not all IMGs are foreign-born; about 3.2 percent of the total physician work force is U.S.-born IMGs who have attended medical schools abroad.[3]

The growing number of IMGs in residency training in the United States in recent years has been an important component in the overall increase in the total number of physicians. The training of IMGs was spurred by the perceived shortage of physicians during the 1960s. However, the current concern about a physician surplus in the early 1980s has not changed Federal incentives provided through the Medicare GME payments to hospitals that encourage expanding residency positions which are increasingly filled by IMG residents.

In addition, the increasing supply of physicians has not eliminated concerns about the geographic distribution of physicians. According to the American Medical Association (Randolph, Seidman, & Pasko, 1996), in 1994 there were 149 counties without an active physician in patient care. Over one-half million (581,040) people resided in these counties. Despite the overall increases in the numbers of physicians, there continue to be growing numbers of areas across the country that are designated as health professions shortage areas (HPSAs) based on the ratio of population to physicians. According to the Division of Shortage Designation at HHS, as of December 1995, there were 2,617 areas designated as primary medical HPSAs that would require the placement of 5,280 primary care physicians in order to eliminate the shortage designation. HHS estimates that the underserved population residing in these HPSAs is over 26.6 million.

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 she accepts the coverage, the employer's

[3] Primarily medical schools in the Dominican Republic, Grenada, Mexico and Montserrat.

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" (i.e., is an employee or is treated as an employee by the employer). The MSP provision for the disabled population expires October 1, 1998.

Secondary payer provisions also apply to ESRD individuals with employer group health plans (regardless of employer size). The group health plan is the primary payer for 18 months for persons who become eligible for Medicare ESRD benefits. The employer's role as primary payer is limited to a maximum of 21 months (18 months plus the usual 3-month waiting period for Medicare ESRD coverage). The secondary payer provisions for the ESRD population expire October 1, 1998.

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 (SSA) and Internal Revenue Service (IRS) 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 authority for the program expires October 1, 1998. Recent court action has, however, lessened the ability to make collections in certain situations.

Table 3–39 shows savings attributable to these Medicare secondary payer provisions. In fiscal year 1995, combined Medicare part A and B savings are estimated at $3 billion.

Health Insurance Protection that Supplements Medicare Coverage

The vast majority of aged Medicare beneficiaries have other coverage to supplement their Medicare protection. In 1991, an estimated 89 percent had such coverage through private insurance or public programs. An estimated 33 percent had employer-sponsored coverage, either through a current or former employer; 37 percent had individually-purchased coverage; and 5 percent had both types of protection. In addition, 12 percent had Medicaid protection, with an additional 2 percent reporting other types of coverage.

TABLE 3–39.—MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS, BY TYPE OF PROVISIONS, FISCAL YEARS 1988–95

[In millions of dollars]

Year and Medicare part	Workers compensation	Working aged	End-stage renal disease	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

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

Policies purchased by individuals to supplement their Medicare coverage are known as Medigap policies. These polices offer coverage for Medicare's deductibles and coinsurance and pay for some services not covered under Medicare. In 1990, Congress 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. The standardized package covers a "core" benefits package. Each of the other nine includes the core package plus a different combination of additional benefits.

In 1992, nearly 27 million elderly and disabled persons living outside institutions (78 percent of all such people) had some form of private supplementary coverage. About 12.5 million had only individually purchased policies (primarily Medigap), 11.8 million had only employer-sponsored coverage, and 2.4 million had both types of protection. The average annual premium was $1,014 for persons with individually-purchased policies only, $728 for those with employer-sponsored insurance only; and $1,369 for persons who had both types of coverage (see table 3–40).

Over 80 percent of Medicare enrollees over age 65 living in the community had private supplementary insurance protection in 1992; only 27 percent of the disabled under 45, and 46 percent of the disabled 45–64, had such protection. For aged persons, the share of persons with Medigap increased with age, while the share of those with employer-sponsored coverage declined with age. This later finding reflects the fact that health insurance for retirees did not become widespread until after the 1960s; thus more recent retirees are more likely to qualify for coverage. There is however, some concern that employer support for retiree health benefits is decreasing.

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 that it 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 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 iden-

tify options, if necessary, for modifying the Medigap market to make sure that continuously insured beneficiaries are able to switch plans without medical underwriting.

TABLE 3–40.—NUMBER AND PERCENT OF MEDICARE ENROLLEES LIVING IN THE COMMUNITY WITH PRIVATE SUPPLEMENTAL INSURANCE, AVERAGE PREMIUMS PAID, PERCENT WITH DRUG COVERAGE, AND PERCENT WITH NURSING HOME COVERAGE, BY TYPE OF SUPPLEMENTAL INSURANCE, 1992

Item	
All private health insurance:	
Number of persons in thousands	26,788
Percent of persons	100.0
Average premium per person	$914
Percent with drug coverage	50
Percent with nursing home coverage	21
Individually based only:	
Number of persons	12,528
Percent of persons	100.0
Average premium per person	$1,014
Percent with drug coverage	25
Percent with nursing home coverage	25
Employer-sponsored only:	
Number of persons	11,832
Percent of persons	100.0
Average premium per person	$728
Percent with drug coverage	72
Percent with nursing home coverage	15
Both individually based and employer-sponsored:	
Number of persons	2,428
Percent of persons	100.0
Average premium per person	$1,369
Percent with drug coverage	73
Percent with nursing home coverage	38

Note.—Includes persons ever enrolled for Medicare who did not enter a long-term care facility during 1992. Numbers may not add to totals due to rounding.

Source: Health Care Financing Administration, Office of the Actuary; and Chulis, Eppig, & Poisal (1995).

Impact of supplemental insurance on Medicare spending

Medicare cost-sharing requirements are in part intended to encourage cost-conscious utilization of services. However, since private supplementary insurance covers many of these charges, beneficiaries may be insulated from the costs of care. This insulation translates into higher utilization and thus higher Medicare costs. Analysis of 1993 data shows that beneficiaries with supplemental private insurance protection cost Medicare 28 percent more than beneficiaries without this coverage. Additional service use for those with supplemental protection varies by type of service and may be influenced by the urgency of the need for care, Medicare copayment policies, or both. Beneficiaries with supplemental coverage use roughly twice as much preventive care (which by definition does not treat an immediate medical need) as those beneficiaries with-

out this coverage. Physicians' services (which may used for a range of conditions) are used more by those with supplemental protection. However, utilization of inpatient hospital services (which typically address serious or urgent conditions) is only slightly higher for those with supplemental insurance. On the other hand, home health care (which requires no cost-sharing) is actually used more frequently by those who lack supplemental insurance than those who have it (see table 3–41).

TABLE 3–41.—MEASURES OF MEDICARE SERVICE USE FOR BENEFICIARIES WITH DIFFERENT TYPES OF SUPPLEMENTAL INSURANCE COVERAGE, 1993

Measure of service use	Medicare only	Supplemental insurance coverage	
		Employer-provided	Individually purchased
Total payment	$2,356	$3,027	$3,042
Total part A reimbursement	1,618	1,800	1,763
Inpatient reimbursement	1,331	1,560	1,451
Home health reimbursement	247	197	233
Skilled nursing facility reimbursement	38	35	63
Hospice reimbursement	0	11	15
Total part B reimbursement	739	1,227	1,279
Physician reimbursement	573	928	971
Outpatient reimbursement	166	295	307
Percentage of beneficiaries:			
With at least one office visit	61	86	88
Receiving flu shot	30	52	52
Percentage of female beneficiaries receiving:			
Mammogram	18	38	33
Pap smear	15	31	27

Source: Physician Payment Review Commission (1996, p. 291).

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 except that their income is slightly in excess of the poverty line (the specified low-income beneficiary (SLMB) population; 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 ($7,740 for a single, $10,360 for a couple in 1996); and (2) resources below 200 percent of the resources limit set for the Supplemental Security Income (SSI) Program (the specific 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 must be 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 HHS).

As of March 1995, 29 States were reported to be using payment rates below those applicable under Medicare. However, the U.S. Court of Appeals for four judicial circuits issued decisions which require 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.

Buy-in

All States have buy-in agreements with the Secretary. Under buy-in agreements, States 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 agreement for the QMB population is in addition to the traditional buy-in agreement 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 (SLIMBs)

States are also required to pay Medicare part B premiums for SLIMBs. These are persons meeting the QMB criteria except that their income is slightly over the QMB limit. The SLIMB income 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.

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 February 1996, Medicare reported that there were 295,980 Medicare part A beneficiaries for whom QMB payments were being made. As of the same date, States reported a total of 4,840,442 part B buy-ins of which 2,430,755 were separately identified as QMBs; however, this number is low due to reporting problems (see table 3–42). The QMB numbers include persons who were eligible for the full Medicaid benefit package. No QMB-only number is available.

Nationwide there were 192,544 SLMBs and 13 QDWIs in April 1996; this information is not broken down by State.

TABLE 3–42.—QUALIFIED MEDICARE BENEFICIARIES BY STATE, FEBRUARY 1996

State	Part A QMBs	Part B buy-ins	Part B buy-ins identified as QMBs by State
Alabama	3,615	119,456	27,918
Alaska	599	6,408	2
Arizona	333	46,183	30,504
Arkansas	4,286	79,415	21,559
California	62,778	758,494	493,528
Colorado	543	48,759	13,432
Connecticut	2,472	48,188	39,332
Delaware	489	7,361	1,532
District of Columbia	1,316	14,413	138
Florida	40,168	288,280	191,076
Georgia	6,001	163,544	45,446
Hawaii	4,467	17,466	3,861
Idaho	284	13,366	7,702
Illinois	4,012	241,081	112,791
Indiana	2,031	75,141	50,378
Iowa	1,423	49,523	35,757
Kansas	506	35,167	11,491
Kentucky	3,125	100,760	28,455
Louisiana	5,621	114,366	25,784
Maine	9	30,683	10,007
Maryland	6,472	59,531	53,218
Massachusetts	12,339	125,181	102,558
Michigan	4,019	129,925	37,091
Minnesota	2,753	53,048	21,273
Mississippi	7,651	103,702	80,288
Missouri	638	75,481	55,875
Montana	495	11,442	9,872
Nebraska	1	16,658	0
Nevada	907	15,275	11,145
New Hampshire	19	5,618	1,459
New Jersey	6,846	129,457	86,307
New Mexico	586	31,549	6,608
New York	119	336,570	164,977
North Carolina	11,447	195,765	28,860
North Dakota	7	5,476	1,371
Ohio	7,138	170,302	89,158
Oklahoma	5,032	61,242	56,648
Oregon	30	46,124	25,655
Pennsylvania	15,416	168,093	119,684
Rhode Island	925	16,418	2,216
South Carolina	1,947	97,793	68,520
South Dakota	766	12,544	4,560
Tennessee	8,689	153,120	59,353
Texas	40,994	321,975	89,630
Utah	170	14,067	9,184
Vermont	269	12,613	2,980

TABLE 3–42.—QUALIFIED MEDICARE BENEFICIARIES BY STATE, FEBRUARY 1996—Continued

State	Part A QMBs	Part B buy-ins	Part B buy-ins identified as QMBs by State
Virgin Islands	0	214	0
Virginia	2,685	105,236	38,432
Washington	3,285	75,149	33,290
West Virginia	3,880	41,845	38,351
Wisconsin	4,139	77,105	17,490
Wyoming	219	5,490	1,809
South Marianas	0	316	0
Other	0	683	0
Total	295,980	4,540,442	2,430,755

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

Source: Health Care Financing Administration.

LEGISLATIVE HISTORY, 1980–93

This section summarizes major Medicare legislation enacted into law, beginning with the Social Security disability amendments of 1980 and continuing chronologically through the Omnibus Budget Reconciliation Act of 1993. Since only technical changes were included in the Social Security amendments of 1994, it is not included 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

Medigap

Established a voluntary certification program for Medicare supplemental policies in States that failed to establish equivalent or more stringent standards. (Federal program would be 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)

Pneumococcal vaccine

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 (e.g., laboratory, operating room, pharmacy, etc.) and costs of special care units (e.g., 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 fur-

nished 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 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 areawide 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

Payment freezes

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 nonparticipating 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. (Ef-

fective 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

Payment freezes

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 21–100 days; covering up to 150 days per year, and eliminating the prior hospitalization requirement. Modified home health benefit by expanding definition of intermittent care and permitted 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

Repeal provisions

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 1980 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 nonprimary 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, and 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.)

Medicare and Medicaid coverage data bank

Established system to identify and collect payments from liable third party payers for services to beneficiaries. (Employers were required to report 1994 information no later than February 1995. Public Law 100–333 suspended application of the provision for fiscal year 1995.)

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.)

Table 3–43 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 3–43.—MEDICARE SAVINGS ESTIMATES, 1981–93

[In billions of dollars]

Legislative act	Savings
Omnibus Budget Reconciliation Act of 1981:	
Spending reductions: (FY 1982–FY 1984)	$4.3
Tax Equity and Fiscal Responsibility Act of 1982:	
Spending reductions: (FY 1983–FY 1987)	23.1
Social Security Amendments of 1983:	
Spending reductions: (FY 1983–FY 1988)	0.2
Revenue increases: (FY 1983–FY 1988)	11.5
Deficit Reduction Act of 1984:	
Spending reductions: (FY 1984–FY 1987)	6.1
Consolidated Omnibus Budget Reconciliation Act of 1985:	
Spending reductions: (FY 1986–FY 1981)	12.6
Omnibus Budget Reconciliation Act of 1986:	
Spending reductions: (FY 1987–FY 1989)	1.0
Omnibus Budget Reconciliation Act of 1987:	
Spending reductions: (FY 1988–FY 1990)	9.8
Omnibus Budget Reconciliation Act of 1989:	
Spending reductions: (FY 1990–FY 1994)	10.9
Omnibus Budget Reconciliation Act of 1990:	
Spending reductions: (FY 1991–FY 1995)	43.1
Revenue increases: (FY 1991–FY 1995)	26.9

TABLE 3–43.—MEDICARE SAVINGS ESTIMATES, 1981–93—Continued

[In billions of dollars]

Legislative act	Savings
Omnibus Budget Reconciliation Act of 1993:	
Spending reductions: (FY 1994–FY 1998)	55.8
Revenue increases (FY 1994–FY 1998)	53.8

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 3–44 through 3–55 present detailed historical data on the Medicare Program. Tables 3–44, 3–45, and 3–46 present detailed enrollment data. Table 3–47 describes the percentage of enrollees participating in a State buy-in agreement. Tables 3–48 and 3–49 show the distribution of Medicare payments by type of coverage and by type of service. Tables 3–50 and 3–51 show the number of persons served and the average reimbursement per person served and per enrollee. Tables 3–52 shows the utilization of hospital services. Table 3–53 presents Medicare utilization and reimbursement by State. Table 3–54 shows the number of participating institutions and organizations.

TABLE 3–44.—NUMBER OF MEDICARE ENROLLEES BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, SELECTED YEARS 1968–94

[In thousands]

Type of entitlement and coverage	Year																	Average annual rate of growth (percent)		
	1968	1975	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1968–75	1975–83	1984–94
Total:																				
HI[1] and/or SMI[2]	19,821	24,959	28,478	29,010	29,494	30,026	30,456	31,083	31,750	32,411	32,980	33,579	34,203	34,870	35,579	36,306	36,935	3.3	2.3	2.2
Total HI:	19,770	24,640	28,067	28,590	29,069	29,587	29,996	30,589	31,216	31,853	32,413	33,040	33,719	34,429	35,153	35,904	36,543	3.2	2.3	2.2
HI only	1,016	1,054	1,079	1,069	1,082	1,052	1,040	1,094	1,160	1,241	1,363	1,481	1,574	1,633	1,645	1,694	1,768	0.5	0.0	6.1
Total SMI	18,805	23,905	27,400	27,941	28,412	28,975	29,416	29,989	30,590	31,170	31,617	32,099	32,629	33,237	33,933	34,612	35,167	3.5	2.4	2.0
SMI Only	51	318	411	420	425	439	460	493	534	558	567	539	484	441	425	425	392	29.9	4.1	−1.8
Aged:																				
HI and/or SMI	19,821	22,790	25,515	26,011	26,540	27,109	27,571	28,176	28,791	29,380	29,879	30,409	30,948	31,485	32,010	32,462	32,801	2.0	2.2	1.9
Total HI	19,770	22,472	25,104	25,591	26,115	26,670	27,112	27,683	28,257	28,822	29,312	29,869	30,464	31,043	31,584	32,060	32,409	1.8	2.2	2.0
HI only	1,016	845	835	829	833	816	807	865	928	998	1,098	1,192	1,263	1,300	1,297	1,315	1,353	−2.6	−0.4	5.9
Total SMI	18,805	21,945	24,680	25,182	25,707	26,292	26,765	27,311	27,863	28,382	28,780	29,216	29,686	30,185	30,712	31,147	31,447	2.2	2.3	1.8
SMI Only	51	318	411	420	425	439	459	493	534	558	567	539	484	441	425	401	392	29.9	4.1	−1.7
All disabled:																				
HI and/or SMI	(4)	2,168	2,963	2,999	2,954	2,918	2,884	2,907	2,959	3,031	3,102	3,171	3,255	3,385	3,568	3,844	4,135	NA	3.8	4.1
Total HI	(4)	2,168	2,963	2,999	2,954	2,918	2,884	2,907	2,959	3,031	3,101	3,171	3,255	3,385	3,568	3,844	4,135	NA	3.8	4.1
HI Only	(4)	209	244	239	249	235	233	229	232	243	265	288	311	333	348	378	807	NA	1.5	14.8
Total SMI	(4)	1,959	2,719	2,759	2,705	2,682	2,651	2,678	2,727	2,788	2,837	2,883	2,943	3,052	3,220	3,466	3,720	NA	4.0	3.8
SMI Only[3]	(4)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
ESRD[5] only:																				
HI and/or SMI	(4)	13	28	27	27	28	30	31	39	47	53	58	65	69	72	226	235	NA	10.1	25.2
Total HI	(4)	13	28	27	27	28	30	31	39	47	53	58	65	69	72	224	233	NA	10.1	25.0
HI Only	(4)	1	1	1	2	2	2	2	3	3	4	5	6	6	7	11	10	NA	9.1	20.9
Total SMI	(4)	12	27	26	26	26	28	29	36	44	49	54	59	62	65	215	225	NA	10.1	25.4
SMI Only[3]	(4)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

[1] Hospital insurance. [2] Supplementary medical insurance. [3] Disabled and end-stage renal disease only must have HI to be eligible for SMI coverage. [4] Medicare disability entitlement began in 1973. [5] End-stage renal disease.

NA—Not available.

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

TABLE 3–45.—GROWTH IN NUMBER OF AGED MEDICARE ENROLLEES BY SEX AND AGE, SELECTED YEARS 1968–94

Sex and age	Year										Average annual growth rate (percent)			Total aged population 1994 [1]	Enrollees as percent of total aged population 1994
	1968	1975	1980	1984	1986	1990	1991	1992	1993	1994	1968–75	1975–84	1986–94		
All persons	19,496	22,548	25,515	27,571	28,791	30,948	31,485	32,011	32,462	32,801	2.1	2.3	1.6	33,702	97.3
65–69	6,551	7,642	8,459	8,784	9,163	9,695	9,690	9,692	9,683	9,594	2.2	1.6	0.6	9,930	96.6
70–74	5,458	5,950	6,756	7,300	7,564	7,951	8,163	8,373	8,509	8,706	1.2	2.3	1.8	8,824	98.7
75–79	3,935	4,313	4,809	5,327	5,573	6,058	6,175	6,261	6,369	6,399	1.3	2.4	1.7	6,759	94.7
80–84	2,249	2,793	3,081	3,382	3,559	3,957	4,065	4,166	4,257	4,367	3.1	2.2	2.6	4,510	96.8
85 and over	1,303	1,850	2,410	2,778	2,932	3,286	3,393	3,519	3,643	3,734	5.1	4.6	3.1	3,680	101.5
Males	8,177	9,201	10,268	11,044	11,525	12,416	12,650	12,886	13,095	13,262	1.7	2.0	1.8	13,780	96.2
65–69	2,944	3,420	3,788	3,942	4,109	4,352	4,358	4,374	4,386	4,364	2.2	1.6	0.8	4,514	96.7
70–74	2,322	2,504	2,841	3,088	3,214	3,406	3,505	3,604	3,670	3,762	1.1	2.4	2.0	3,834	98.1
75–79	1,596	1,669	1,854	2,061	2,160	2,382	2,441	2,485	2,542	2,564	0.6	2.4	2.2	2,782	92.2
80–84	864	1,005	1,062	1,161	1,221	1,369	1,411	1,454	1,495	1,544	2.2	1.6	3.0	1,635	94.4
85 and over	450	604	722	793	822	906	934	968	1,003	1,029	4.3	3.1	2.8	1,034	99.5
Females	11,319	13,347	15,247	16,526	17,266	18,532	18,835	19,125	19,367	19,539	2.4	2.4	1.6	19,922	98.1
65–69	3,606	4,222	4,671	4,842	5,054	5,343	5,332	5,317	5,298	5,230	2.3	1.5	0.4	5,416	96.6
70–74	3,136	3,446	3,914	4,212	4,350	4,545	4,657	4,769	4,839	4,945	1.4	2.3	1.6	4,989	99.1
75–79	2,338	2,644	2,954	3,266	3,414	3,676	3,734	3,776	3,827	3,835	1.8	2.4	1.5	3,997	95.9
75–84	1,386	1,788	2,019	2,222	2,339	2,588	2,653	2,713	2,762	2,824	3.7	2,4	2.4	2.874	98.3
85 and over	853	1,246	1,689	1,985	2,110	2,380	2,459	2,551	2,640	2,705	5.6	5.3	3.2	2,646	102.2

[1] Total aged population data reflect U.S. residents.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy; and U.S. Department of Commerce, Bureau of the Census.

TABLE 3–46.—GROWTH IN NUMBER OF DISABLED MEDICARE ENROLLEES WITH HI COVERAGE BY TYPE OF ENTITLEMENT AND AGE, SELECTED YEARS 1975–94

Type of entitlement and age	Year									Average annual percent growth rate		
	1975	1980	1984	1988	1990	1991	1992	1993	1994	1975–82	1982–88	1982–94
All disabled persons	2,058,424	2,425,231	2,884,410	3,101,482	3,254,983	3,385,439	3,568,625	3,844,178	4,134,604	2.3	4.3	4.6
Under age 35	238,070	193,392	388,240	471,129	483,262	494,285	512,495	545,644	574,003	−2.7	15.7	9.4
35–44	251,142	258,374	422,207	572,408	654,953	711,364	762,759	834,426	908,076	1.0	13.4	10.7
45–54	508,345	572,823	584,214	670,131	741,193	790,435	874,797	974,589	1,083,945	0.7	3.9	6.1
55–64	1,060,967	1,400,642	1,489,749	1,397,814	1,375,575	1,389,355	1,418,574	1,489,519	1,568,580	4.2	−0.2	0.8
All disabled workers	1,638,662	2,396,897	2,309,866	2,456,135	2,579,097	2,693,502	2,856,517	3,100,532	3,367,187	5.5	0.5	2.9
Under age 35	100,439	184,619	193,094	249,291	257,760	268,392	286,486	317,876	345,322	9.3	4.9	5.2
35–44	164,439	253,186	290,395	414,749	482,071	530,417	576,549	642,386	710,431	7.0	7.8	8.6
45–54	426,451	565,846	485,378	552,442	612,692	657,358	731,713	823,552	926,390	3.0	0.8	4.8
55 to 64	947,333	1,393,246	1,340,999	1,239,653	1,226,574	1,237,335	1,261,769	1,316,718	1,385,044	5.9	−2.1	−0.2
Adults disabled as children	324,864	409,072	459,620	519,009	542,416	553,388	566,336	580,439	595,750	4.4	2.8	2.6
Under age 35	151,708	173,684	186,003	207,311	208,901	208516	208,710	210,760	212,944	2.4	2.2	1.1
35–44	84,508	105,092	126,252	146,460	158,725	165,569	170,363	176,182	182,861	4.8	3.8	3.8
45–54	71,484	80,381	87,380	99,444	107,092	110,279	117,333	122,435	127,622	2.4	2.8	3.5
55–64	45,164	49,910	59,985	65,774	67,698	69,004	69,930	71,062	72,323	3.2	2.7	2.1
Widows and widowers	83,771	110,785	85,227	73,101	68,793	69,753	74,157	91,643	101,247	2.5	−5.0	0.3
Under age 35	1	0	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
35–44	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
45–54	7,445	7,576	4,608	5,685	5,615	6,112	7,399	9,811	11,458	−3.5	−0.4	5.8
55–64	76,325	103,208	80,618	67,416	63,178	63,641	66,758	81,832	91,789	2.9	−5.3	−0.2
End-stage renal disease only	11,127	28,334	29,697	53,237	64,677	68,796	71,615	71,564	68,420	13.7	11.7	7.9
Under age 35	3,729	8,773	9,143	14,507	16,601	17,357	17,299	17,008	15,737	12.3	9.5	5.4
35–44	2,187	5,188	5,559	11,199	14,157	15,378	15,847	15,858	14,784	12.3	14.7	9.6
45–54	2,966	6,977	6,848	12,560	15,794	16,686	18,352	18,791	18,475	12.2	11.2	8.9
55 to 64	2,245	7,396	8,147	14,971	18,125	19,375	20,117	19,907	19,424	18.6	12.5	8.4

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

TABLE 3–47.—MEDICARE ENROLLMENT: NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OF 1994 AREA OF RESIDENCE, SELECTED YEARS 1968–94

Year of 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
Area of residence: [1]						
United States	4,624	13.3	3,242	10.4	1,382	37.8
Alabama	124	20.5	86	16.4	31	37.8
Alaska	6	21.4	4	16.7	2	50.0
Arizona	46	8.6	29	5.9	14	28.0
Arkansas	83	20.5	57	16.2	20	37.7
California	783	22.9	548	17.7	195	60.7
Colorado	49	12.8	31	9.1	15	37.5
Connecticut	45	9.3	28	6.3	17	45.9
Delaware	6	6.5	4	4.8	3	33.3
District of Columbia	15	19.2	11	16.5	4	57.1
Florida	284	11.6	202	8.9	68	37.4
Georgia	170	22.0	117	17.6	43	40.6
Hawaii	18	13.2	13	10.3	4	44.4
Idaho	14	10.1	8	6.3	5	41.7
Illinois	144	9.1	86	6.0	49	34.3
Indiana	84	10.6	51	7.2	27	32.5
Iowa	53	11.4	33	7.7	17	45.9
Kansas	36	9.7	24	7.0	11	37.9
Kentucky	101	18.2	65	13.8	31	37.3
Louisiana	114	20.7	78	16.5	31	39.7
Maine	29	16.3	18	10.7	11	52.4
Maryland	64	11.3	42	8.1	17	34.7
Massachusetts	122	13.6	77	9.5	43	51.8
Michigan	145	11.3	71	6.2	48	34.0
Minnesota	67	9.4	33	5.9	20	40.8

TABLE 3–47.—MEDICARE ENROLLMENT: NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OF 1994 AREA OF RESIDENCE, SELECTED YEARS 1968–94—Continued

Year of 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	29.4	78	24.5	28	48.3
Missouri	77	9.6	46	6.4	25	30.5
Montana	11	8.9	6	5.5	4	30.8
Nebraska	17	7.0	9	4.0	7	38.9
Nevada	15	9.3	9	6.2	4	26.7
New Hampshire	6	4.1	3	2.3	2	15.4
New Jersey	127	11.3	87	8.4	35	38.0
New Mexico	31	16.1	22	12.9	9	40.9
New York	313	12.2	220	9.5	97	39.4
North Carolina	177	18.8	124	15.0	43	36.8
North Dakota	6	5.9	3	3.2	2	25.0
Ohio	173	10.8	111	7.8	47	28.3
Oklahoma	65	13.9	44	11.0	16	36.4
Oregon	45	10.1	27	6.6	14	36.8
Pennsylvania	166	8.2	103	5.6	60	36.4
Rhode Island	15	9.3	9	6.1	6	40.0
South Carolina	103	22.0	69	17.1	28	43.8
South Dakota	13	11.5	8	7.7	4	44.4
Tennessee	150	20.8	101	16.1	45	47.9
Texas	322	16.7	240	13.8	68	37.6
Utah	15	8.8	8	5.1	6	40.0
Vermont	12	15.6	7	10.0	5	62.5
Virginia	110	14.5	72	10.7	30	35.7
Washington	76	11.8	44	7.5	26	44.1
West Vriginia	40	12.6	25	9.3	14	29.8
Wisconsin	86	11.7	48	7.2	30	44.1
Wyoming	5	9.1	3	6.0	2	40.0
Puerto Rico	0	0.0	0	0.0	0	0.0
Guam and Virgin Islands [2]	1	11.8	1	12.5	0	6.3
All areas	4,625	13.2	3,243	10.3	1,382	37.2

[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 3–48A.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE AND TYPE OF SERVICE, SELECTED YEARS 1975–94

Type of coverage and type of service	Amount in millions and distribution of payments for all enrollees															
	1975 amount	Percent	1980 amount	Percent	1981 amount	Percent	1982 amount	Percent	1983 amount	Percent	1984 amount	Percent	1985 amount	Percent	1986 amount	Percent
Total payment	$15,588	100.0	$35,686	100.0	$43,442	100.0	$51,086	100.0	$57,443	100.0	$62,870	100.0	$70,391	100.0	$75,844	100.0
Hospital insurance	$11,315	72.6	$25,051	70.2	$30,329	69.8	$35,631	69.7	$39,337	68.5	$43,209	68.7	$47,444	67.4	$49,605	65.4
Inpatient	$10,877	69.8	$24,116	67.6	$29,161	67.1	$33,947	66.5	$37,252	64.9	$40,878	65.0	$44,940	63.8	$47,008	62.0
Skilled nursing facility	$254	1.6	$395	1.1	$410	0.9	$484	0.9	$543	0.9	$544	0.9	$548	0.8	$575	0.8
Home health agency	$104	0.7	$540	1.5	$758	1.7	$1,200	2.3	$1,542	2.7	$1,779	2.8	$1,913	2.7	$1,945	2.6
											$8	0.0	$43	0.1	$77	0.1
Supplementary medical insurance	$4,273	27.4	$10,635	29.8	$13,113	30.2	$15,455	30.3	$18,106	31.5	$19,661	31.3	$22,947	32.6	$26,239	34.6
Physicians [1]	$3,416	21.9	$8,187	22.9	$10,086	23.2	$11,893	23.3	$14,062	24.5	$15,434	24.5	$17,312	24.6	$19,213	25.3
Outpatient hospital	$643	4.1	$1,897	5.3	$2,406	5.5	$2,994	5.9	$3,385	5.9	$3,452	5.5	$4,319	6.1	$5,157	6.8
Home health agency	$95	0.6	$234	0.7	$193	0.4	$54	0.1	$25	0.0	$30	0.0	$38	0.1	$31	0.0
Group practice plan	$80	0.5	$203	0.6	$274	0.6	$335	0.7	$410	0.7	$464	0.7	$720	1.0	$1,113	1.5
Independent laboratory	$39	0.3	$114	0.3	$154	0.4	$179	0.4	$224	0.4	$281	0.4	$558	0.8	$725	1.0

[1] Includes other services.

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

TABLE 3–48B.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE AND TYPE OF SERVICE, SELECTED YEARS 1975–94

Type of coverage and type of service	Amount in millions and distribution of payments for all enrollees															
	1987 amount	Percent	1988 amount	Percent	1989 amount	Percent	1990 amount	Percent	1991 amount	Percent	1992 amount	Percent	1993 amount	Percent	1994 amount	Percent
Total payments	$80,162	100.0	$86,317	100.0	$98,097	100.0	$108,518	100.0	$118,653	100.0	$132,951	100.0	$147,269	100.0	$161,711	100.0
Hospital insurance	$49,342	61.6	$52,347	60.6	$59,803	61.0	$66,050	60.9	$71,317	60.1	$83,691	62.9	$93,290	63.3	$103,093	63.8
Inpatient	$46,905	58.5	$49,265	57.1	$54,221	55.3	$59,383	54.7	$62,640	52.8	$71,000	53.4	$76,182	51.7	$81,517	50.4
Skilled nursing facility	$635	0.8	$848	1.0	$2,879	2.9	$2,620	2.4	$2,632	2.2	$4,051	3.0	$5,797	3.9	$7,596	4.7
Home health agency	$1,690	2.1	$2,078	2.4	$2,465	2.5	$3,689	3.4	$5,484	4.6	$7,760	5.8	$10,252	7.0	$12,559	7.8
Hospice	$112	0.1	$156	0.2	$238	0.2	$358	0.3	$561	0.5	$880	0.7	$1,059	0.7	$1,421	0.9
Supplementary medical insurance	$30,820	38.4	$33,970	39.4	$38,294	39.0	$42,468	39.1	$47,336	39.9	$49,260	37.1	$53,979	36.7	$58,618	36.2
Physicians [1]	$22,618	28.2	$24,372	28.2	$27,056	27.6	$29,609	27.3	$32,313	27.2	$32,394	24.4	$35,282	24.0	$37,435	23.1
Outpatient hospital	$5,916	7.4	$6,549	7.6	$7,676	7.8	$8,482	7.8	$9,783	8.2	$10,990	8.3	$11,539	7.8	$13,497	8.3
Home health agency	$40	0.0	$47	0.1	$60	0.1	$74	0.1	$65	0.1	$71	0.1	$112	0.1	$144	0.1
Group practice plan	$1,361	1.7	$2,019	2.3	$2,308	2.4	$2,827	2.6	$3,531	3.0	$3,933	3.0	$5,002	3.4	$5,465	3.4
Independent laboratory	$885	1.1	$983	1.1	$1,194	1.2	$1,476	1.4	$1,644	1.4	$1,872	1.4	$2,044	1.4	$2,077	1.3

[1] Includes other services.

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

TABLE 3–49.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE, TYPE OF SERVICE, AND TYPE OF ENROLLEE, 1994

Type of coverage and service	Type of enrollee					
	All enrollees		Aged		Disabled	
	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution
Total payments	$161,711	100.0	$141,710	100.0	$20,001	100.0
Hospital insurance	103,093	70.0	91,097	64.3	11,996	60.0
Inpatient	81,517	55.4	70,861	50.0	10,656	53.3
Skilled nursing facility	7,596	5.2	7,294	5.1	302	1.5
Home health agency	12,559	8.5	11,592	8.2	967	4.8
Hospice	1,421	1.0	1,350	1.0	71	0.4
Supplementary medical insurance	58,618	39.8	50,613	35.7	8,005	40.0
Physicians [1]	37,435	25.4	33,252	23.5	4,183	20.9
Outpatient hospital	13,497	9.2	10,528	7.4	2,969	14.8
Home health agency	144	0.1	144	0.1	0	0.0
Group practice plan	5,465	3.7	4,855	3.4	610	3.0
Independent laboratory	2,077	1.4	1,834	1.3	243	1.2

[1] Includes other services.

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

TABLE 3–50.—PERSONS SERVED AND REIMBURSEMENTS FOR AGED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND BY 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1968–94

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

TABLE 3–50.—PERSONS SERVED AND REIMBURSEMENTS FOR AGED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND BY 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1968–94—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
1985–94	1.6	6.2	7.8	−0.1	7.5	7.4	1.7	6.9	8.7
Age:									
65 and 66 years	818.6	$3,014.06	$2,467.31	134.0	$11,146.10	$1,493.82	893.6	$1,216.70	$1,087.20
67 and 68 years	749.3	3,735.35	2,798.73	141.6	11,820.17	1,674.16	792.3	1,532.80	1,214.86
69 and 70 years	773.4	3,929.28	3,038.79	157.2	11,784.69	1,852.45	809.5	1,568.08	1,269.35
71 and 72 years	801.1	4,280.82	3,429.51	175.9	12,135.43	2,135.10	828.1	1,655.06	1,370.48
73 and 74 years	809.5	4,628.87	3,746.84	192.0	12,232.54	2,348.54	829.1	1,770.49	1,467.95
75–79 years	857.1	5,173.87	4,434.61	234.9	12,242.76	2,875.92	869.4	1,868.11	1,624.22
80–84 years	890.2	5,823.22	5,183.68	300.7	11,795.31	3,546.93	901.1	1,904.48	1,716.14
85 years and over	910.3	6,416.43	5,840.81	376.4	11,196.61	4,214.11	947.3	1,860.01	1,762.06
Sex:									
Male	789.5	5,125.14	4,046.50	213.7	12,354.05	2,640.54	828.5	1,823.24	1,510.64
Female	857.4	4,498.92	3,867.40	219.8	11,422.80	2,510.57	882.5	1,619.11	1,428.92
Race:									
White	837.7	4,611.30	3,862.70	216.0	11,558.04	2,496.00	866.0	1,659.52	1,437.14
All other	759.5	6,094.26	4,628.90	231.7	13,829.43	3,204.08	806.3	2,040.84	1,645.54

Census region:									
Northeast	866.1	5,289.77	4,581.71	224.5	13,518.55	3,035.37	897.7	1,843.88	1,655.35
North central	883.2	4,247.31	3,751.08	224.4	10,701.87	2,401.46	904.1	1,552.54	1,403.72
South	869.7	4,841.61	4,210.91	243.1	11,330.09	2,754.70	891.2	1,704.77	1,519.37
West	691.9	4,657.49	3,222.47	162.3	12,916.68	2,096.06	710.1	1,722.06	1,222.78

NA—Not available.

Note.—Data for 1994 are considered preliminary.

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

TABLE 3–51.—PERSONS SERVED AND REIMBURSEMENTS FOR DISABLED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND BY 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1968–94

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	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	$266.32
1980	594.1	2,544.04	1,511.34	245.7	3,798.09	933.16	633.8	994.18	630.06
1981	615.2	2,880.99	1,772.39	251.4	4,400.27	1,106.16	655.9	1,103.92	724.04
1982	608.9	3,431.26	2,089.35	256.9	5,109.65	1,312.85	650.5	1,303.37	847.90
1983	628.8	3,658.08	2,300.24	257.7	5,549.82	1,430.30	670.1	1,412.07	946.23
1984	639.5	NA	NA	242.6	NA	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	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	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	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	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	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	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	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	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	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	1,966.96

Annual percentage change in period:									
1968–1975	NA	NA	NA	NA	NA	NA	NA	NA	NA
1975–1985	4.05	9.55	13.99	0.39	13.28	13.72	4.26	9.61	14.28
1985–1994	1.37	5.08	6.52	−0.77	6.82	6.00	1.69	5.88	7.67
Age:									
Under 35 years	735.8	6,091.87	4,482.52	202.4	13,489.71	2,730.36	798.4	2,403.11	1,918.64
35–44 years	724.7	5,868.13	4,252.89	197.1	13,017.77	2,565.49	801.0	2,351.40	1,883.38
45–54 years	727.8	5,908.27	4,300.19	199.0	12,909.59	2,569.46	811.5	2,403.36	1,950.37
55–59 years	764.8	6,187.13	4,728.57	220.5	13,168.69	2,904.09	841.1	2,411.60	2,028.35
60–64 years	828.7	6,119.86	5,071.49	245.6	13,030.39	3,200.74	901.0	2,281.53	2,055.62
Sex:									
Male	709.9	6,021.09	4,274.13	200.4	13,370.44	1,781.04	783.7	2,272.64	1,781.04
Female	826.5	6,020.49	4,975.73	231.3	12,700.66	2,247.98	904.2	2,486.05	2,247.98
Race:									
White	756.9	5,433.16	4,112.61	204.4	12,468.61	1,739.90	833.8	2,086.60	1,739.90
All other	764.0	7,849.94	5,997.49	243.7	14,660.52	2,673.36	832.6	3,210.78	2,673.36
Census region:									
Northeast	779.1	6,763.59	5,269.76	215.0	15,501.85	2,167.41	862.0	2,514.41	2,167.41
North central	770.3	5,414.67	4,171.09	210.7	12,153.34	1,787.44	846.9	2,110.60	1,787.44
South	786.8	5,923.59	4,660.77	235.5	12,086.61	1,958.79	842.0	2,326.40	1,958.79
West	699.1	6,535.07	4,568.62	179.2	15,100.23	2,051.13	763.1	2,687.84	2,051.13

NA—Not available.

Note.—Data for 1994 are considered preliminary.

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

TABLE 3–52.—USE OF SHORT-STAY HOSPITAL SERVICES BY MEDICARE EMPLOYEES BY YEAR AND 1994 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1975–94

Calendar year, period, and 1994 characteristic	Hospital insurance enrollees in thousands	Discharges		Total days of care			Program payments			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
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 [1]	33,681	11,471	341	85,734	7.5	2,545	70,623	6,157	824	2,097
Annual percentage change in period:										
1975–1984	2.4	4.8	2.4	1.0	−2.8	−1.5	18.7	14.2	17.6	15.8
1984–1994	1.8	−1.3	−3.1	−1.2	−1.7	−2.3	6.3	5.7	7.5	5.0
1975–1994 [1]	0.4	2.5	2.1	−0.2	−2.1	−1.8	11.0	8.9	11.2	9.2
Age:										
Less than 65 years	4,028	1,489	370	11,508	7.7	2,857	8,929	5,997	776	2,217

65–69 years	8,695	2,096	241	14,506	6.9	1,668	13,776	6,573	950	1,584
70–74 years	7,812	2,250	288	16,039	7.1	2,053	14,581	6,480	909	1,866
75–79 years	5,753	2,116	368	15,983	7.6	2,778	13,385	6,326	837	2,327
80–84 years	3,955	1,761	445	13,737	7.8	3,473	10,331	5,867	752	2,612
85 years or over	3,438	1,759	512	13,961	7.9	4,061	9,621	5,470	689	2,798
Sex:										
Male	14,414	5,075	352	37,411	7.4	2,595	32,929	6,488	880	2,285
Female	19,267	6,396	332	48,323	7.6	2,508	37,694	5,893	780	1,956
Race:[2]										
White	29,268	9,797	335	71,649	7.3	2,448	59,346	6,058	828	2,028
All other	4,150	1,516	365	12,886	8.5	3,105	10,323	6,809	801	2,487
Census region:										
Northeast	7,381	2,549	345	23,603	9.3	3,198	18,098	7,100	767	2,452
North central	8,327	2,903	349	20,257	7.0	2,433	17,033	5,867	841	2,046
South	11,483	4,275	372	31,058	7.3	2,705	24,531	5,738	790	2,136
West	6,254	1,628	260	9,725	6.0	1,555	10,575	6,496	1,087	1,691

[1] Does not reflect discharges for beneficiaries who received covered services but for whom program payments were reported during the year; e.g., beneficiaries who received inpatient services in health maintenance organizations were not included in the denominator used to calculate the average program payments per discharge.
[2] Excludes unknown race.

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

TABLE 3–53.—MEDICARE UTILIZATION AND REIMBURSEMENT: 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 (persons served per 1,000 enrolled)					Annual percent change				Year (reimbursement per person served)					Annual percent change			
	1967	1985	1990	1993	1994	1967–85	1985–90	1990–93	1993–94	1967	1985	1990	1993	1994	1967–85	1985–90	1990–93	1993–94
Total, all areas [1]	366.5	722.1	801.6	825.4	830.0	3.8	2.1	1.0	0.6	$592	$2,762	$3,578	$4,264	$4,740	8.9	5.3	6.0	11.2
United States [2]	370.9	731.2	810.5	834.2	838.7	3.8	2.1	1.0	0.5	593	2,772	3,592	4,280	4,750	8.9	5.3	6.0	11.0
New England	380.4	767.4	829.0	864.7	871.7	4.0	1.6	1.4	0.8	680	2,708	3,573	4,527	5,018	8.0	5.7	8.2	10.8
Maine	330.1	756.1	868.8	916.9	920.0	4.7	2.8	1.8	0.3	586	2,369	2,744	3,304	3,704	8.1	3.0	6.4	12.1
New Hampshire	391.6	739.7	810.5	871.3	874.3	3.6	1.8	2.4	0.3	467	2,374	2,974	3,524	3,820	9.5	4.6	5.8	8.4
Vermont	411.7	742.8	841.0	875.1	888.8	3.3	2.5	1.3	1.6	515	1,990	2,569	3,201	3,494	7.8	5.2	7.6	9.2
Massachusetts	394.2	766.5	813.6	848.1	851.8	3.8	1.2	1.4	0.4	708	2,971	4,029	5,182	5,891	8.3	6.3	8.8	13.7
Rhode Island	375.4	829.6	853.6	840.9	849.2	4.5	0.6	−0.5	1.0	625	2,619	3,236	4,451	4,563	8.3	4.3	11.2	2.5
Connecticut	390.9	764.1	838.1	879.3	893.1	3.8	1.9	1.6	1.6	711	2,570	3,511	4,392	4,759	7.4	6.4	7.7	8.4
Middle Atlantic	388.1	768.2	834.7	857.1	864.3	3.9	1.7	0.9	0.8	578	2,771	3,933	4,749	5,384	9.1	7.3	6.5	13.4
New York	406.9	765.7	830.4	835.7	841.3	3.6	1.6	0.2	0.7	610	2,533	4,119	4,799	5,347	8.2	10.2	5.2	11.4
New Jersey	399.0	759.8	826.7	859.7	879.4	3.6	1.7	1.3	2.3	526	2,650	3,483	4,711	4,973	9.4	5.6	10.6	5.6
Pennsylvania	365.0	776.4	844.7	882.2	884.2	4.3	1.7	1.5	0.2	533	3,147	3,948	4,712	5,657	10.4	4.6	6.1	20.1
East North Central	350.2	725.9	834.4	874.3	888.3	4.1	2.8	1.6	1.6	614	2,906	3,595	4,070	4,414	9.0	4.3	4.2	8.5
Ohio	353.6	718.4	846.3	880.8	897.4	4.0	3.3	1.3	1.9	585	2,792	3,824	4,078	4,368	9.1	6.5	2.2	7.1
Indiana	343.7	672.2	837.0	872.7	885.5	3.8	4.5	1.4	1.5	545	2,510	3,234	3,906	4,314	8.9	5.2	6.5	10.4
Illinois	339.2	693.4	788.1	825.5	840.1	4.1	2.6	1.6	1.8	703	3,313	3,760	4,387	4,750	9.0	2.6	5.3	8.3
Michigan	379.5	804.3	871.4	914.9	929.3	4.3	1.6	1.6	1.6	532	2,991	3,749	4,258	4,675	10.1	4.6	4.3	9.8
Wisconsin	354.7	736.9	843.2	896.8	903.6	4.1	2.7	2.1	0.8	639	2,527	2,877	3,270	3,487	7.9	2.6	4.4	6.6
West North Central	363.2	693.4	979.7	858.8	871.9	3.7	7.2	−4.3	1.5	558	2,627	3,108	3,463	3,876	9.0	3.4	3.7	11.9
Minnesota	389.0	624.8	682.5	778.7	796.3	2.7	1.8	4.5	2.3	601	2,447	3,101	3,254	3,341	8.1	4.9	1.6	2.7
Iowa	365.9	715.3	850.6	915.1	918.8	3.8	3.5	2.5	0.4	505	2,282	2,753	3,121	3,226	8.7	3.8	4.3	3.4
Missuori	364.8	712.0	816.6	857.1	871.8	3.8	2.8	1.6	1.7	544	3,118	3,514	3,979	4,523	10.2	2.4	4.2	13.7
North Dakota	441.2	730.7	853.4	907.8	917.7	2.8	3.2	2.1	1.1	492	2,466	2,949	3,103	3,514	9.4	3.6	1.7	13.2
South Dakota	358.0	694.2	815.1	866.8	877.6	3.7	3.3	2.1	1.2	514	2,281	2,714	3,030	6,296	8.6	3.5	3.7	107.8
Nebraska	352.5	634.2	808.8	866.9	886.3	3.3	5.0	2.3	2.2	540	2,449	2,719	2,939	3,181	8.8	2.1	2.6	8.2

Kansas	365.3	765.4	850.0	901.5	914.0	4.2	2.1	2.0	1.4	540	2,553	3,144	3,710	3,987	9.0	4.3	5.7	7.5
South Atlantic	350.5	740.4	827.7	856.6	862.3	4.2	2.3	1.2	0.7	554	2,531	3,438	4,248	4,705	8.8	6.3	7.3	10.8
Delaware	368.2	770.9	843.6	907.6	935.3	4.2	1.8	2.5	3.1	552	2,612	3,526	4,064	4,878	9.0	6.2	4.8	20.0
Maryland	349.4	757.6	838.3	868.4	875.6	4.4	2.0	1.2	0.8	564	2,975	4,190	5,075	5,498	9.7	7.1	6.6	8.3
District of Columbia	452.8	739.4	772.7	774.3	784.3	2.8	0.9	0.1	1.3	570	3,774	5,019	6,053	6,553	11.1	5.9	6.4	8.3
Virginia	317.3	729.7	848.5	881.7	891.0	4.7	3.1	1.3	1.1	516	1,976	3,127	3,636	4,054	7.7	9.6	5.2	11.5
West Virginia	342.2	692.0	828.6	876.4	890.7	4.0	3.7	1.9	1.6	489	2,575	3,197	3,662	4,064	9.7	4.4	4.6	11.0
North Carolina	324.0	727.9	852.3	898.1	908.1	4.6	3.2	1.8	1.1	515	1,982	2,799	3,478	3,691	7.8	7.1	7.5	6.1
South Carolina	296.2	680.6	832.2	890.7	896.8	4.7	4.1	2.3	0.7	523	2,340	2,689	3,541	4,137	8.7	2.8	9.6	16.8
Georgia	320.2	743.5	843.8	890.2	899.5	4.8	2.6	1.8	1.0	474	2,479	3,456	4,427	4,848	9.6	6.9	8.6	9.5
Florida	420.9	759.1	805.8	813.7	813.5	3.3	1.2	0.3	0.0	588	2,773	3,709	4,665	5,223	9.0	6.0	7.9	12.0
East South Central	332.1	698.1	846.9	888.0	901.7	4.2	3.9	1.6	1.5	489	2,570	3,413	4,254	4,758	9.7	5.8	7.6	11.8
Kentucky	365.9	671.9	837.3	880.9	901.1	3.4	4.5	1.7	2.3	458	2,395	3,424	3,832	4,273	9.6	7.4	3.8	11.5
Tennesse	354.8	678.7	853.4	892.4	897.7	3.7	4.7	1.5	0.6	502	2,816	3,402	4,494	4,974	10.1	3.9	9.7	10.7
Alabama	322.7	743.8	848.9	890.4	906.6	4.7	2.7	1.6	1.8	490	2,502	3,596	4,379	4,959	9.5	7.5	6.8	13.2
Mississippi	283.2	699.9	845.1	886.6	902.6	5.2	3.8	1.6	1.8	471	2,480	3,122	4,188	4,711	9.7	4.7	10.3	12.5
West South Central	374.8	687.4	825.0	852.2	863.7	3.4	3.7	1.1	1.3	504	2,811	3,624	4,434	5,163	10.0	5.2	7.0	16.4
Arkansas	319.3	715.4	862.9	883.1	897.2	4.6	3.8	0.8	1.6	466	2,550	3,155	3,681	4,211	9.9	4.3	5.3	14.4
Louisiana	343.4	653.5	821.1	858.7	877.1	3.6	4.7	1.5	2.1	446	3,167	4,368	5,235	6,208	11.5	6.6	6.2	18.6
Oklahoma	416.1	677.8	878.3	867.1	877.5	2.7	5.3	−0.4	1.2	486	2,482	3,127	3,957	4,507	9.5	4.7	8.2	13.9
Texas	393.7	693.2	805.1	840.7	850.2	3.2	3.0	1.5	1.1	522	2,860	2,652	4,489	5,232	9.9	5.0	7.1	16.6
Mountain	417.1	716.6	772.7	769.8	760.7	3.1	1.5	−0.1	−1.2	560	2,637	3,992	3,713	4,188	9.0	8.6	−2.4	12.8
Montana	416.5	679.7	823.5	875.8	895.1	2.8	3.9	2.1	2.2	505	2,348	3,000	3,343	4,122	8.9	5.0	3.7	23.3
Idaho	408.8	714.5	862.5	906.1	905.2	3.2	3.8	1.7	−0.1	467	2,384	2,556	3,104	3,320	9.5	1.4	6.7	7.0
Wyoming	395.0	681.7	782.7	846.8	877.7	3.1	2.8	2.7	3.6	432	2,804	3,182	3,943	3,932	11.0	2.6	7.4	−0.3
Colorado	475.4	704.0	740.8	775.3	778.0	2.2	1.0	1.5	0.3	578	2,521	3,223	3,834	4,167	8.5	5.0	6.0	8.7
New Mexico	377.6	689.8	736.4	767.0	735.1	3.4	1.3	1.4	−4.2	513	2,462	3,154	3,115	3,552	9.1	5.1	−0.4	14.0
Arizona	431.7	758.1	774.3	695.6	670.5	3.2	0.4	−3.5	−3.6	612	2,896	3,692	4,006	4,781	9.0	5.0	2.8	19.3
Utah	346.0	713.1	808.2	846.6	865.8	4.1	2.5	1.6	2.3	580	2,225	2,799	3,549	3,556	7.8	4.7	8.2	0.2
Nevada	414.9	688.9	721.2	707.2	687.2	2.9	0.9	−0.7	−2.8	532	3,243	3,903	4,299	5,023	10.6	3.8	3.3	16.8
Pacific	468.9	739.7	713.8	687.7	665.4	2.6	−0.7	−1.2	−3.2	630	6,153	3,853	4,540	4,864	13.5	−8.9	5.6	7.1
Washington	433.0	731.1	760.8	794.2	875.4	3.0	0.8	1.4	−1.1	507	2,522	3,218	3,555	3,738	9.3	5.0	3.4	5.1
Oregon	392.6	716.2	707.8	712.9	701.7	3.4	−0.2	0.2	−1.6	583	2,459	2,833	3,162	3,288	8.3	2.9	3.7	4.0
California	490.7	745.7	710.3	666.8	640.0	2.4	−1.0	−2.1	−4.0	653	3,379	4,138	5,001	5,416	9.6	4.1	6.5	8.3
Alaska	307.2	678.4	759.0	806.8	818.2	4.5	2.3	2.1	1.4	376	3,554	4,007	4,111	4,463	13.3	2.4	0.9	8.6

TABLE 3–53.—MEDICARE UTILIZATION AND REIMBURSEMENT: 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 (persons served per 1,000 enrolled)					Annual percent change				Year (reimbursement per person served)					Annual percent change			
	1967	1985	1990	1993	1994	1967–85	1985–90	1990–93	1993–94	1967	1985	1990	1993	1994	1967–85	1985–90	1990–93	1993–94
Hawaii	407.4	709.3	589.9	602.8	585.7	3.1	−3.6	0.7	−2.8	572	2,334	3,095	3,430	3,321	8.1	5.8	3.5	−3.2

[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 3–54.—MEDICARE PARTICIPATING INSTITUTIONS AND ORGANIZATIONS, 1984 AND 1995

Institution or organization	Year	
	1984	1995
Hospitals	6,675	6,403
Short stay	6,038	5,271
Long stay	637	1,132
Skilled nursing facilities	5,952	13,122
Home health agencies	4,684	8,258
Independent laboratories	3,801	7,532
Laboratories registered under the Clinic Laboratory Improvement Act (CLIAs)	NA	158,090
Outpatient physical therapy providers	791	2,190
Portable x ray suppliers	269	558
Rural health clinics	420	1,879
Comprehensive outpatient rehab. facilities	48	284
Ambulatory surgical centers	155	2,040
Hospices	108	1,862
Facilities prov. svcs. to renal disease benefit	1,335	2,863
Hospital certified as both renal transplant and renal dialysis center	147	163
Hospital certified as renal transplant centers	16	73
Hospital dialysis facilities	117	244
Nonhospital rental dialysis facilities	645	2,000
Dialysis centers only	359	340
Inpatient care	51	43
Hospital and skilled nursing facility beds:		
Hospitals	1,144,142	1,060,318
Short stay	1,023,465	929,026
Long stay	120,677	131,292
Skilled nursing facilities	530,403	652,357

NA—Not available.

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

REFERENCES

Board of Trustees, Federal Supplementary Medical Insurance Trust Fund. (1996, June 5). *The 1996 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (U.S. House of Representatives Document 104–226). Washington, DC: U.S. Government Printing Office.

Board of Trustees, Federal Hospital Insurance Trust Fund. (1995, April 3). *The 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (U.S. House of Representatives Document 104–56). Washington, DC: U.S. Government Printing Office.

Board of Trustees, Federal Hospital Insurance Trust Fund. (1996, June 1). *The 1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (U.S. House of Representatives Document 104–227). Washington, DC: U.S. Government Printing Office.

Chulis, G.S., Eppig, F.J., & Poisal, J.A. (1995). Ownership and average premiums for Medicare supplementary insurance policies. *Health Care Financing Review, 17* (1), 255–75.

Committee on Ways and Means. (1988). *1988 Green book: Overview of entitlement programs* (WMCP 100–29). Washington, DC: U.S. Government Printing Office.

Committee on Ways and Means. (1989). *1989 Green book: Overview of entitlement programs* (WMCP 101–4). Washington, DC: U.S. Government Printing Office.

Committee on Ways and Means. (1991). *1991 Green book: Overview of entitlement programs* (WMCP 102–9). Washington, DC: U.S. Government Printing Office.

Committee on Ways and Means. (1994). *1994 Green book: Overview of entitlement programs* (WMCP 103–27). Washington, DC: U.S. Government Printing Office.

Office of the President. (1996 and various years). *Budget of the U.S. Government: Fiscal Year 1996* (Historical Tables Volume). Washington, DC: U.S. Government Printing Office.

Office of the President. (1996 and various years). *Budget of the U.S. Government: Fiscal Year 1996* (Analytical Perspective Volume). Washington, DC: U.S. Government Printing Office.

Physician Payment Review Commission. (1996). *Annual report to Congress: 1996.* Washington, DC: Author.

Prospective Payment Assessment Commission. (1995, March). *Report and recommendations to the Congress.* Washington, DC: Author.

Prospective Payment Assessment Commission. (1996, March). *Report and recommendations to the Congress.* Washington, DC: Author.