SECTION 2. MEDICARE

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OVERVIEW

Medicare is a nationwide health insurance program for the aged and certain disabled persons. The program consists of two parts—part A, hospital insurance (HI) and part B, supplementary medical insurance (SMI). Total program outlays were $212.0 billion in fiscal year 1999. Net outlays after deduction of beneficiary premiums were $190.5 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 1999, part A covered an estimated 38.8 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—$45.50 in 2000. In fiscal year 1999, part B covered an estimated 36.9 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, some home health services, and hospice care. Patients must pay a deductible ($776 in 2000) each time their hospital admission begins a benefit period. (A benefit period begins when a patient enters a hospital and ends when she has not been in a hospital or SNF for 60 days.) Medicare pays the remaining costs for the first 60 days of hospital care. The limited number of beneficiaries requiring care beyond 60 days are subject to additional charges. Patients requiring SNF care are subject to a daily coinsurance charge for days 21–100 ($97 in 2000). 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 (DME), hospital outpatient department (OPD) services, and other medical services. The program generally pays 80 percent of Medicare's fee schedule or other approved amount after the beneficiary has met the annual $100 deductible. The beneficiary is liable for the remaining 20 percent.

PAYMENTS FOR SERVICES

Taken together, spending for inpatient hospital and physicians' and related services accounts for close to 70 percent of Medicare fee-for-service payments (spending for managed care plans is not broken down by service category). 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 U.S. Department of Health and Human Services (DHHS). Much of the day-to-day work of reviewing claims and making payments is done by intermediaries (for part A) and carriers (for part B). These are generally commercial insurers or Blue Cross Blue Shield plans.

FINANCING

Medicare part A is financed primarily through the 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 2000, the premium is $45.50. Beneficiary premiums have generally represented about 25 percent of part B costs; Federal general revenues (i.e., tax dollars) account for the remaining 75 percent.

FEDERAL OUTLAYS

Total program outlays were $212.0 billion in fiscal year 1999. Net outlays (i.e., net of premiums beneficiaries pay for enrollment, largely for part B) were $190.5 billion.

Tables 2–1, 2–2, and 2–3 provide historical spending and coverage data for Medicare. Table 2–4 provides State-by-State information for fiscal year 1998.

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 2000 monthly premium is $301 ($166 for persons who have at least 30 quarters of covered employment).

TABLE 2–1.—MEDICARE OUTLAYS, SELECTED FISCAL YEARS 1967–2010

[In millions of dollars]

Fiscal year	Part A	Part B	Total Medicare outlays	Medicare premium offsets	Net Medicare outlays	Percent increase (over prior year)
1967	$2,597	$798	$3,395	−$647	$2,748	NA
1970	4,953	2,196	7,149	−936	6,213	9.1
1972	6,276	2,544	8,820	−1,340	7,480	13.0
1973	6,842	2,637	9,479	−1,427	8,052	7.6
1974	8,065	3,283	11,348	−1,708	9,640	19.7
1975	10,612	4,170	14,782	−1,907	12,875	33.6
1976	12,579	5,200	17,779	−1,945	15,834	23.0
TQ	3,404	1,401	4,805	−541	4,264	NA
1977	15,207	6,342	21,549	−2,204	19,345	NA
1978	17,862	7,350	25,212	−2,443	22,769	17.7
1979	20,343	8,805	29,148	−2,653	26,495	16.4
1980	24,288	10,746	35,034	−2,945	32,089	21.1
1981	29,248	13,240	42,488	−3,340	39,148	22.0
1982	34,864	15,559	50,423	−3,856	46,567	19.0
1983	38,551	18,317	56,868	−4,253	52,615	13.0
1984	42,295	20,374	62,669	−4,942	57,727	9.7
1985	48,667	22,730	71,397	−5,562	65,835	14.0
1986	49,685	26,217	75,902	−5,739	70,163	6.6
1987	50,803	30,837	81,640	−6,520	75,120	7.1
1988	52,730	34,947	87,677	−8,798	78,879	5.0
1989	58,238	38,316	96,554	−11,590	84,964	7.7
1990	66,687	43,022	109,709	−11,607	98,102	15.5
1991	70,742	47,021	117,763	−12,174	105,589	7.6
1992	81,971	50,285	132,256	−13,232	119,024	12.7
1993	91,604	54,254	145,858	−15,305	130,553	9.7
1994	102,770	59,724	162,494	−17,747	144,747	10.9
1995	114,883	65,213	180,096	−20,241	159,855	10.4
1996	127,683	68,946	196,629	−20,088	176,591	10.5
1997	137,884	72,553	210,437	−20,421	190,016	7.6
1998	137,298	76,272	213,570	−20,747	192,823	1.5
1999	131,500	80,518	212,018	−21,561	190,457	−1.2
2000 [1]	133,100	88,300	221,300	−21,800	199,500	4.7
2001 [1]	140,600	98,800	239,400	−23,300	216,100	8.3
2002 [1]	143,600	103,500	247,100	−25,400	221,700	2.6
2003 [1]	153,500	114,300	267,800	−28,100	239,800	8.2
2004 [1]	163,200	123,800	287,000	−31,100	255,900	6.7
2005 [1]	176,800	136,600	313,400	−34,200	279,200	9.1
2006 [1]	182,400	141,600	324,000	−37,200	286,700	2.7
2007 [1]	198,000	155,300	353,200	−40,300	312,900	9.1
2008 [1]	211,300	167,400	378,800	−43,600	335,300	7.2
2009 [1]	226,100	181,300	407,500	−47,200	360,200	7.4
2010 [1]	241,600	196,800	438,400	−51,000	387,400	7.6

[1] Congressional Budget Office projections.

NA—Not applicable.

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

Source: For 1967–99: Office of the President, 2000.

Part B

Part B of Medicare is voluntary. All persons age 65 or older (even those not entitled to part A) may elect to enroll in the SMI Program by paying the monthly premium. The 2000 premium is $45.50 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 1998, 33.4 million aged and 5.1 million disabled had protection under part A. In fiscal year 1998, 32.3 million aged and 4.4 million disabled were enrolled in part B (table 2–2).

BENEFITS AND BENEFICIARY COST SHARING

PART A

Part A coverage includes:

Inpatient hospital care.—The first 60 days of inpatient hospital services in a benefit period are subject to a deductible ($776 in calendar year 2000). 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 ($194 in calendar year 2000) 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 ($388 in calendar year 2000) is imposed for each reserve day.

Skilled nursing facility care.—SNF care is up to 100 days (following hospitalization) in an SNF 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 ($97 in calendar year 2000) amount.

Home health care.—Home health visits are provided to persons who need skilled nursing care on an intermittent basis, or physical therapy, or speech therapy. The Balanced Budget Act (BBA) of 1997 gradually transfers from part A to part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF (i.e., postinstitutional visits) and during a home health spell of illness. The transfer is being phased in over 6 years, between 1998 and 2003, with the Secretary transferring one-sixth of the aggregate expenditures associated with transferred

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

[Beneficiaries in thousands]

Fiscal year	1975 (actual)	1980 (actual)	1985 (actual)	1990 (actual)	1995 (actual)	1998 (actual)	1999 (actual)	2000 (est.) [1]	2001 (est.) [1]	Average annual growth 1975–85 (percent)	Average annual growth 1985–95 (percent)	Projected average annual growth 1995–2001 (percent)
Part A												
Persons enrolled (monthly average):												
Aged	21,795	24,572	27,121	30,050	32,649	33,384	33,585	33,816	34,059	2.2	1.9	0.7
Disabled	2,047	2,968	2,944	3,313	4,366	5,070	5,259	5,445	5,643	3.7	4.0	4.4
Total	23,842	27,540	30,065	33,363	37,015	38,454	38,844	39,261	39,702	2.3	2.1	1.2
Average annual benefit per person enrolled: [2] [3]												
Aged	$432	$853	$1,563	$1,947	$3,078	$3,550	$3,366	$3,331	$3,577	13.7	7.0	2.5
Disabled	460	948	1,808	2,176	2,955	3,118	3,055	3,042	3,195	14.7	5.0	1.3
Total	434	863	1,587	1,970	3,063	3,493	3,324	3,291	3,523	13.8	6.8	2.4
Part B												
Persons enrolled (average):												
Aged	21,504	24,422	27,049	29,426	31,622	32,257	32,350	32,550	32,759	2.3	1.6	0.6
Disabled	1,835	2,698	2,672	2,907	3,874	4,422	4,582	4,730	4,892	3.8	3.8	4.0

Total	23,339	27,120	29,721	32,333	35,496	36,679	36,932	37,280	37,651	2.4	1.8	1.0
Average annual benefit per person enrolled: [2]												
Aged	153	348	705	1,250	1,728	1,989	2,108	2,395	2,628	16.5	9.4	7.2
Disabled	259	610	1,022	1,603	2,282	2,623	2,388	2,667	2,897	14.7	8.4	4.1
Total	161	374	734	1,282	1,788	2,066	2,143	2,430	2,663	16.4	9.3	6.9

[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 Formulation.

TABLE 2–3.—BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PARTS A AND B, SELECTED FISCAL YEARS 1975–2001

[In millions of dollars]

Service	1975		1980		1985		1990 [1]		1995		2000 (est.) [2]		2001 (est.) [2]		Average annual growth rate (percent)		Projected average annual growth rate (percent)	
	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	1975–85	1985–95	1995–2000	1995–2001
Part A																		
Inpatient hospital ..	70.5	$9,947	67.4	$22,877	65.0	$45,218	55.3	$59,285	49.4	$87,449	40.0	$87,930	38.3	$91,932	16.3	6.8	0.1	0.8
Skilled nursing facility	1.9	273	1.2	392	0.8	550	2.6	2,821	5.1	9,104	5.7	12,598	6.2	14,823	7.3	32.4	6.7	8.5
Home health [3]	0.9	133	1.5	524	2.7	1,908	3.1	3,297	8.5	14,995	1.8	3,876	1.5	3,504	30.5	22.9	−23.7	−21.5
Hospice	0	0	0	0	0	34	0.3	318	1.0	1,854	1.2	2,597	1.1	2,730	NA	49.2	7.0	6.7
Managed care	0	(4)	0	(4)	0	(4)	0	(4)	0	(4)	10.1	22,215	11.2	26,880	NA	NA	NA	NA
Total benefit payments ..	73.3	10,353	70.1	23,793	68.6	47,710	61.3	65,721	64.1	113,402	58.8	129,216	58.2	139,869	16.5	9.0	2.7	3.6
Part B																		
Physician	21.7	3,067	23.0	7,813	24.1	16,788	27.0	28,920	(5)	(5)	(5)	(5)	(5)	(5)	18.5	(5)	(5)	(5)
Outpatient	3.7	529	5.3	1,803	5.6	3,917	7.8	8,365	(5)	(5)	(5)	(5)	(5)	(5)	22.2	(5)	(5)	(5)
Home health	0.5	75	0.7	232	0.1	40	0.3	75	(5)	(5)	(5)	(5)	(5)	(5)	−6.1	(5)	(5)	(5)
Other medical and health	0.7	94	0.9	296	1.5	1,063	3.8	4,090	(5)	(5)	(5)	(5)	(5)	(5)	27.5	(5)	(5)	(5)
Physician fee schedule	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	17.6	31,101	16.2	35,619	15.3	36,647	(5)	(5)	2.8	2.8
Durable medical equipment	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	2.0	3,576	2.0	4,443	2.0	4,714	(5)	(5)	4.4	4.7
Carrier laboratory [6]	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	1.6	2,819	0.9	2,038	0.9	2,062	(5)	(5)	−6.3	−5.1
Other carrier	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	2.6	4,513	3.1	6,852	3.1	7,343	(5)	(5)	8.7	8.4
Hospital [7]	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	4.8	8,449	4.1	9,087	4.7	11,356	(5)	(5)	1.4	5.1

Home health [3]	([5])	([5])	([5])	([5])	([5])	([5])	([5])	([5])	0.1	223	2.6	5,790	2.9	6,884	([5])	([5])	91.8	77.1
Intermediary laboratory [8]	([5])	([5])	([5])	([5])	([5])	([5])	([5])	([5])	0.8	1,437	0.7	1,607	0.7	1,667	([5])	([5])	2.3	2.5
Other intermediary [9]	([5])	([5])	([5])	([5])	([5])	([5])	([5])	([5])	2.9	5,111	2.7	6,037	2.7	6,511	([5])	([5])	3.4	4.1
Managed care	([5])	([5])	([5])	([5])	([5])	([5])	([5])	([5])	3.5	6,253	8.7	19,102	9.63	23,089	([5])	([5])	25.0	24.3
Total benefit payments ..	26.7	3,765	29.9	10,144	31.4	21,808	38.7	41,450	35.9	63,482	41.2	90,574	41.8	100,273	19.2	11.3	7.4	7.9
Total parts A and B	100.0	14,118	100.0	33,937	100.0	69,518	100.0	107,171	100.0	176,884	100.0	219,790	.....	240,142	17.3	9.8	4.4	5.2

[1] Includes part A catastrophic benefits in fiscal year 1990.
[2] Represents current law. Does not include legislative proposals.
[3] Reflects the Balanced Budget Act of 1997's partial shift of home health to part B, beginning January 1, 1998.
[4] Part A managed care amounts for fiscal years 1995 and earlier are reflected within the four other service categories.
[5] Service categories were revised beginning in 1992.
[6] Laboratory services paid under the laboratory fee schedule performed in a physician's office laboratory or an independent laboratory.
[7] Includes the hospital facility costs for Medicare part B services which are predominantly in the outpatient department. The physician reimbursement associated with these services is included on the ''physician fee schedule'' line.
[8] Laboratory fee services paid under the laboratory fee schedule performed in a hospital outpatient department.
[9] Includes end-stage renal disease (ESRD) freestanding dialysis facility payments and payments to rural health clinics, outpatient rehabilitation facilities, psychiatric hospitals, and federally qualified health centers.

NA—Not available.

Note.—Totals may not add due to rounding.

Source: Health Care Financing Administration, Division of Budget Formulation.

TABLE 2–4.—MEDICARE ESTIMATED BENEFIT PAYMENTS, ENROLLMENT, AND PAYMENTS PER ENROLLEE, BY JURISDICTION, FISCAL YEAR 1998

State	Managed care	Fee for service	Total estimated benefit payments	HI and/or SMI Medicare enrollment	Estimated payments per enrollee
Alabama	$205,426,344	$3,355,291,164	$3,560,717,508	662,299	$5,376
Alaska	NA	159,758,199	159,758,199	36,522	4,374
Arizona	1,239,778,917	1,745,752,051	2,985,530,968	636,450	4,691
Arkansas	49,224,065	1,879,525,269	1,928,749,334	431,020	4,475
California	8,773,118,477	13,784,518,629	22,557,637,106	3,738,081	6,035
Colorado	643,203,173	1,635,431,750	2,278,634,923	442,452	5,150
Connecticut	400,112,935	2,728,217,584	3,128,330,518	507,927	6,159
Delaware	NA	405,179,514	405,179,514	105,693	3,834
District of Columbia	144,373,478	777,918,684	922,292,162	78,151	11,801
Florida	4,524,774,836	13,378,150,436	17,902,925,272	2,727,545	6,564
Georgia	176,623,168	4,110,432,452	4,287,055,620	869,443	4,931
Hawaii	239,875,943	398,863,192	638,739,135	156,103	4,092
Idaho	10,980,148	589,589,258	600,569,407	155,810	3,854
Illinois	834,190,968	7,656,027,597	8,490,218,565	1,622,181	5,234
Indiana	65,964,275	4,197,139,053	4,263,103,328	835,183	5,104
Iowa	12,850,611	1,797,001,383	1,809,851,994	475,786	3,804
Kansas	25,109,448	1,783,589,354	1,808,698,803	387,589	4,667
Kentucky	53,879,786	2,843,156,472	2,897,036,258	602,570	4,808
Louisiana	538,912,807	3,754,572,687	4,293,485,495	592,543	7,246
Maine	366,850	792,926,706	793,293,556	207,784	3,818
Maryland	517,992,313	3,123,552,630	3,641,544,943	619,700	5,876
Massachusetts	1,117,102,982	4,689,557,576	5,806,660,558	946,879	6,132
Michigan	257,643,533	7,452,965,590	7,710,609,123	1,369,629	5,630
Minnesota	355,714,448	2,442,292,853	2,798,007,301	639,293	4,377
Mississippi	NA	2,216,407,663	2,216,407,663	407,440	5,440
Missouri	602,636,855	4,092,810,974	4,695,447,829	844,920	5,557

Montana	4,359,566	529,898,775	534,258,341	133,089	4,014
Nebraska	54,981,437	1,024,707,802	1,079,689,239	251,029	4,301
Nevada	399,145,276	706,198,480	1,105,343,755	213,742	5,171
New Hampshire	43,577,945	603,936,891	647,514,836	161,759	4,003
New Jersey	697,261,271	6,210,460,644	6,907,721,916	1,182,204	5,843
New Mexico	167,306,872	662,125,184	829,432,056	221,061	3,752
New York	2,592,564,064	14,472,498,088	17,065,062,152	2,651,677	6,436
North Carolina	87,759,036	5,207,921,577	5,295,680,613	1,073,564	4,933
North Dakota	1,024,727	479,367,786	480,392,514	102,764	4,675
Ohio	1,175,552,456	7,658,951,361	8,834,503,816	1,683,167	5,249
Oklahoma	170,664,498	2,201,883,236	2,372,547,734	497,066	4,773
Oregon	679,992,754	1,151,812,303	1,831,805.057	477,022	3,840
Pennsylvania	2,783,739,255	10,399,395,849	13,183,135,104	2,084,565	6,324
Puerto Rico	NA	1,085,621,690	1,085,621,690	502,760	2,159
Rhode Island	222,688,282	799,438,068	1,022,126,351	169,359	6,035
South Carolina	8,107,599	2,555,180,022	2,563,287,620	534,827	4,793
South Dakota	NA	503,514,478	503,514,478	117,931	4,270
Tennessee	69,099,978	4,659,088,195	4,728,188,173	796,692	5,935
Texas	1,566,883,357	13,099,231,346	14,666,114,703	2,162,917	6,781
Utah	100,786,356	787,529,116	888,315,472	195,326	4,548
Vermont	1,282,393	287,952,764	289,235,157	85,562	3,380
Virginia	61,555,988	3,595,463,713	3,657,019,701	849,493	4,305
Washington	735,189,539	2,147,994,124	2,883,183,663	708,607	4,069
West Virginia	13,047,291	1,515,162,298	1,528,209,589	333,217	4,586
Wisconsin	89,029,594	3,178,402,378	3,267,431,972	770,405	4,241
Wyoming	NA	218,451,250	218,451,250	62,654	3,487
Outlying areas	NA	53,543,743	53,543,743	323,287	166
Total all areas	32,515,455,895	177,586,359,882	210,101,815,777	38,444,739	5,465

NA—Not available.

Source: Health Care Financing Administration, Office of Information Services.

visits in 1998; two-sixths in 1999; three-sixths in 2000; four-sixths in 2001; five-sixths in 2002; and six-sixths in 2003. Beginning January 1, 2003, part A will cover only postinstitutional home health services for up to 100 visits during a home health spell of illness, except for those persons with part A coverage only, who will be covered for services without regard to the postinstitutional limitation.

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

PART B

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

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

Other medical and health services.—This category includes laboratory and other diagnostic tests, x ray and other radiation therapy, outpatient hospital services, rural health clinic services, DME, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

Specified preventive services.—These services include: an annual screening mammography for all women over age 40; a screening Pap smear and a screening pelvic exam once every 3 years, except for women who are at a high risk of developing cervical cancer; specified colorectal screening procedures; diabetes self-management training services; bone mass measurements for high-risk persons; and prostate cancer screenings.

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

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

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

FINANCING

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

HOSPITAL INSURANCE TRUST FUND—INCOME

The primary source of income to the HI fund is HI payroll taxes. This source accounted for $134.4 billion (87.8 percent) of the total $153.0 billion in income for fiscal year 1999. 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 $76,200 in 2000 continues to apply under Social Security. Table 2–6 shows the history of the contribution rates and maximum taxable earnings base for the HI Program.

Other income

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

1. *Railroad retirement account transfers*.—In fiscal year 1999, $430 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 1999, $652 million was transferred to HI on this basis.

TABLE 2–5.—PART A AND PART B DEDUCTIBLE, COINSURANCE AND PREMIUMS,[1] SELECTED YEARS 1966–2000

Calendar year	Inpatient hospital[2]			Skilled nursing facility 21st–100th day coinsurance per day[5]	HI monthly premium[6]			SMI deductible	SMI premium	
	First 60 days deductible	61st–90th day coinsurance per day[3]	60 lifetime reserve days (nonrenewable) coinsurance per day[4]		Effective date	Full amount	Reduced amount		Effective date	Amount
1966	$40	$10	([7])	([7])	([8])	([8])	NA	$50	7/66	$3.00
1968	40	10	$20	$5.00	([8])	([8])	NA	50	4/68	4.00
1970	52	13	26	6.50	([8])	([8])	NA	50	7/70	5.30
1972	68	17	34	8.50	([8])	([8])	NA	50	7/72	5.80
1973	72	18	36	9.00	7/73	$33	NA	60	[9] 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	([8])	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	([8])	113	NA	75	([8])	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	[10] 560	NA	NA	[11] 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	760	190	380	95.00	1/97	311	187	100	1/97	43.80
1998	764	191	382	95.50	1/98	309	170	100	1/98	43.80
1999	768	192	384	96.00	1/99	309	170	100	1/99	45.50
2000	776	194	388	97.00	1/00	301	166	100	1/00	45.50

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

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

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

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

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

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

[7] Not covered.

[8] Not applicable.

[9] For August 1973 the premium was $6.10.

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

[11] In 1989, the skilled nursing facility coinsurance was on days 1–8 of the 150 days allowed annually; for the other years it is on days 21–100 of 100 days allowed per benefit period.

NA—Not available.

Note.—In addition to the deductible and coinsurance amounts shown in the table, the first three pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physician services for mental illness; 50 percent of approved charges, up to a maximum of $250 in benefits per year, July 1, 1966 through December 31, 1987; $450 in benefits per year, January 1, 1988 through December 31, 1988; $1,100 in benefits per year, January 1, 1989 through December 31, 1989; beginning January 1, 1990, the limit was removed; (2) physical and occupational therapy services furnished by physical therapists in independent practice: maximum annual approved charges July 1, 1973 through December 31, 1981, $80 per year; January 1, 1982 through December 31, 1982, $400 per year; January 1, 1983 through December 31, 1989, $500 per year; January 1, 1990 through December 31, 1993, $750 per year; and January 1, 1994 through December 31, 1998; in 1999 there was an annual $1,500 limit on all physical therapy services (except those provided by a hospital) and an annual $1,500 limit on all occupational therapy services (except those provided by a hospital); and no limit in 2000.

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

TABLE 2–6.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES AND TAXABLE EARNINGS BASES, 1977–2000

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] no limit	no limit
1995	6.20	1.45	7.65	no limit	no limit
1996	6.20	1.45	7.65	no limit	no limit
1997	6.20	1.45	7.65	no limit	no limit
1998	6.20	1.45	7.65	no limit	no limit
1999	6.20	1.45	7.65	no limit	no limit
2000	6.20	1.45	7.65	no limit	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 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 ceiling on the earnings base beginning in 1994.

Source: Health Care Financing Administration.

3. *Premiums from voluntary enrollees*.—Certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described above may obtain protection by enrolling in the program and paying a monthly premium ($309 in 2000; for persons who have at least 30 quarters of covered employment, $170 in 2000). This accounted for an estimated $1.4 billion of financing in fiscal year 1999.
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 the U.S. Department of Health and Human Services (DHHS). These sec-

tions, 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 1999, this adjustment was $67 million.

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 $6.6 billion in fiscal year 1999.
6. *Interest*.—The remaining income to the trust fund consists almost entirely of interest on the investments of the trust fund. Interest amounted to an estimated $9.5 billion in fiscal year 1999.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND—INCOME

Part B is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from general revenues. The premium rate is derived annually based on the projected costs of the program for the coming year. The monthly premium amount in calendar year 2000 is $45.50.

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 (i.e., cost-of-living adjustments). 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 (CPI) on which the Social Security cost-of-living adjustment is based.

Beginning in the early 1980s, Congress regularly voted to set part B premiums at a level to cover 25 percent of program costs, in effect overriding the cost-of-living adjustment limitation. The 25-percent provisions first became effective January 1, 1984. General revenues covered the remaining 75 percent of part B program costs. BBA 1997 permanently sets the part B premium equal to 25 percent of program costs.

FINANCIAL STATUS OF HOSPITAL INSURANCE TRUST FUND

The Hospital Insurance Trust Fund balance is dependent on total income to the HI Trust Fund exceeding total outlays from the fund. Tables 2–7 and 2–8 show historical information from the 2000

TABLE 2–7.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED FISCAL YEARS 1970–2009

[In millions of dollars]

Fiscal year [1]	Income								Disbursements				
	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	Balance at end of year
1970	$4,785	NA	$64	$617	NA	$11	$137	$5,614	$4,804	$149	$4,953	$661	$2,677
1975	11,291	NA	132	481	$6	48	609	12,568	10,353	259	10,612	1,956	9,870
1980	23,244	NA	244	697	17	141	1,072	25,415	23,790	497	24,288	1,127	14,490
1985	46,490	NA	371	766	38	86	3,182	50,933	47,841	813	48,654	[5] 4,103	21,277
1990	70,655	NA	367	413	113	107	7,908	79,563	65,912	774	66,687	12,876	95,631
1991	74,655	NA	352	605	367	[6] −1,011	8,969	83,938	68,705	934	69,638	14,299	109,930
1992	80,978	NA	374	621	484	86	10,133	92,677	80,784	1,191	81,974	10,703	120,633
1993	83,147	NA	400	367	622	81	[7] 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
1996	106,934	4,069	401	419	1,107	[8] −2,293	10,496	121,135	124,088	1,229	125,317	−4,182	125,338
1997	112,725	3,558	419	481	1,279	70	10,017	128,548	136,175	1,661	137,836	−9,287	116,050
1998	121,913	5,067	419	34	1,320	67	9,382	138,203	[9] 135,487	1,653	137,140	1,063	117,113
1999	134,385	6,552	430	652	1,401	67	9,523	153,011	[9] 129,463	1,979	131,441	21,570	138,683
2000	136,327	7,200	458	470	1,397	68	10,629	156,549	[9] 131,541	2,310	133,851	22,698	161,381
2001	146,921	6,883	463	453	1,403	[10] −1,264	12,176	167,035	[9] 141,106	2,464	143,570	23,465	184,845
2002	153,981	7,446	481	205	1,476	68	13,826	177,484	[9] 144,634	2,603	147,237	30,246	215,091
2003	160,831	8,052	489	176	1,571	68	15,345	186,532	[9] 154,335	2,748	157,083	29,449	244,540
2004	168,031	8,646	494	167	1,681	68	16,834	195,920	163,103	2,829	165,932	29,988	274,529
2005	177,923	9,211	510	174	1,804	69	18,460	208,151	176,833	2,911	179,744	28,407	302,935
2006	185,688	9,856	528	183	1,938	69	20,026	218,288	183,591	2,997	186,588	31,700	334,635
2007	195,121	10,593	548	195	2,078	70	21,619	230,223	199,209	3,091	202,300	27,923	362,558

2008	204,366	11,464	569	204	2,218	71	23,182	242,074	212,680	3,192	215,872	26,203	388,761
2009	214,167	12,534	592	212	2,357	71	24,752	254,685	226,774	3,298	230,072	24,613	413,374

[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. Beginning in 1997, includes fraud and abuse control expenses, as provided for by Public Law 104–191.

[5] Includes repayment of loan principal from the Old-Age and Survivors Insurance Trust Fund of $1,824 million.

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

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

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

[9] For 1998–2003, includes moneys transferred to the SMI Trust Fund for home health agency costs, as provided for by Public Law 105–33.

[10] Includes a preliminary estimate of −$1,332 million for the lump-sum general revenue adjustment provided for by section 151 of Public Law 98–21.

NA—Not applicable.

Note.—Totals do not necessarily equal the sums of rounded components.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (2000) and Health Care Financing Administration unpublished tables.

TABLE 2–8.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, SELECTED CALENDAR YEARS 1970–2009

[In millions of dollars]

Calendar year	Income								Disbursements			Net increase in fund	Balance at end of year
	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		
1970	$4,881	NA	$66	$863	NA	$11	$158	$5,979	$5,124	$157	$5,281	$698	$3,202
1975	11,502	NA	138	621	$7	48	664	12,980	11,315	266	11,581	1,399	10,517
1980	23,848	NA	244	697	18	141	1,149	26,097	25,064	512	25,577	521	13,749
1985	47,576	NA	371	766	41	[4] −719	3,362	51,397	47,580	834	48,414	[5] 4,808	20,499
1990	72,013	NA	367	413	122	[6] −993	8,451	80,372	66,239	758	66,997	13,375	98,933
1991	77,851	NA	352	605	432	89	9,510	88,839	71,549	1,021	72,570	16,269	115,202
1992	81,745	NA	374	621	522	86	10,487	93,836	83,895	1,121	85,015	8,821	124,022
1993	84,133	NA	400	367	675	81	[7] 12,531	98,187	93,487	904	94,391	3,796	127,818
1994	95,280	$1,639	413	506	907	80	10,745	109,570	103,282	1,263	104,545	5,025	132,844
1995	98,421	3,913	396	462	954	61	10,820	115,027	116,368	1,236	117,604	−2,577	130,267
1996	110,585	4,069	401	419	1,199	[8] 2,293	10,222	124,603	128,632	1,297	129,929	−5,325	124,942
1997	114,670	3,558	419	481	1,319	70	9,637	130,154	137,762	1,690	139,452	−9,298	115,643
1998	124,317	5,067	419	34	1,316	67	9,327	140,547	[9] 133,990	1,782	135,771	4,776	120,419
1999	132,306	6,552	430	652	1,447	67	10,139	151,593	[9] 128,766	1,866	130,632	20,961	141,380
2000	141,141	7,200	458	470	1,380	[10] −1,264	11,404	160,789	[9] 134,075	2,336	136,411	24,377	165,757
2001	148,750	6,883	463	453	1,411	68	12,983	171,011	[9] 141,222	2,500	143,721	27,289	193,046
2002	155,748	7,446	481	205	1,497	68	14,582	180,028	[9] 148,682	2,638	151,320	28,708	221,754
2003	162,906	8,052	489	176	1,595	68	16,084	189,370	[9] 156,710	2,768	159,478	29,892	251,646
2004	170,576	8,646	494	167	1,709	68	17,648	199,307	165,857	2,849	168,706	30,601	282,248
2005	179,205	9,211	510	174	1,835	69	19,250	210,254	177,342	2,931	180,273	29,981	312,228
2006	187,868	9,856	528	183	1,972	69	20,825	221,302	189,780	3,019	192,799	28,503	340,732
2007	197,497	10,593	548	195	2,113	70	22,410	233,425	202,840	3,115	205,955	27,470	368,202

2008	207,076	11,464	569	204	2,253	71	23,973	245,610	216,431	3,217	219,648	25,962	394,164
2009	217,557	12,534	592	212	2,391	71	25,466	258,823	230,714	3,325	234,039	24,784	418,948

[1] Other income includes recoveries of amounts reimbursed from the trust fund, receipts from the fraud and abuse control program, 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. Beginning in 1997, includes fraud and abuse control expenses, as provided for by Public Law 104–91.

[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 Old-Age and Survivors Insurance Trust Fund of $1,824 million.

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

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

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

[9] For 1998–2003, includes moneys transferred to the SMI Trust Fund for home health agency costs, as provided for by Public Law 105–33.

[10] Includes a preliminary estimate of −$1,332 million for the lump-sum general revenue adjustment provided for by section 151 of Public Law 98–21.

NA—Not applicable.

Note.—Totals do not necessarily equal the sums of rounded components.

Source: Board of Trustees, Federal Hospital Insurance Trust Fund (2000) and Health Care Financing Administration, unpublished tables.

Trustees' Report (as amended) on the operation of the trust fund. The Trustees' Report also included projections that were subsequently revised. The revised figures are reflected in tables 2–7 and 2–8.

Each year, the HI Trustees make projections for the date the trust fund will become insolvent (table 2–9). The 1997 report stated that under the Trustees intermediate assumptions, the fund would become insolvent in 2001. Subsequent reports significantly delayed the projected insolvency date. The 2000 report (as amended) projects that the fund will become insolvent in 2025. The improve-

TABLE 2–9.—HISTORICAL PROJECTIONS OF HI TRUST FUND INSOLVENCY, 1970–2000

Year of Trustees' Report	Projected year of insolvency	Projected number of years until insolvency
1970	1972	2
1971	1973	2
1972	1976	4
1973	none indicated	NA
1974	none indicated	NA
1975	late 1990s	NA
1976	early 1990s	NA
1977	late 1980s	NA
1978	1990	12
1979	1992	13
1980	1994	14
1981	1991	10
1982	1987	5
1983	1990	7
1984	1991	7
1985	1998	13
1986	1996	10
1986 amended	1998	12
1987	2002	15
1988	2005	17
1989	([1])	NA
1990	2003	13
1991	2005	14
1992	2002	10
1993	1999	6
1994	2001	7
1995	2002	7
1996	2001	5
1997	2001	4
1998	2008	10
1999	2015	16
2000[2]	2025	25

[1] Contained no long-range projections.
[2] As amended.

NA—Not applicable.

Source: Intermediate projections of various HI Trustees' Reports, 1970–2000.

ments can be attributed to a number of factors including improvements in the economy as a whole (which are reflected in higher payroll tax revenues) and a lower rate of growth in program expenditures. A key factor was the enactment of BBA 1997. This legislation provided for the transfer of a portion of home health spending (which at the time was the fastest growing component of part A expenditures) from part A to part B. It also included additional provisions to stem the growth in part A expenditures. These provisions included the implementation of new payment limits for home health services, a prospective payment system (PPS) for skilled nursing facility (SNF) services, and limits on the increases in hospital payments. BBA 1997 also established the Medicare+Choice (M+C) Program and modified the calculation of payments to managed care entities.

Following enactment of BBA 1997, a number of observers claimed that the actual savings achieved by BBA 1997 were larger than was intended when the legislation was enacted. As a result, legislation was enacted in 1999 (Balanced Budget Refinement Act (BBRA) of 1999) which mitigated the impact of BBA 1997 on providers. Notwithstanding enactment of BBRA 1999, the 2000 Trustees' Report (as amended) delays the trust fund insolvency date an additional 10 years over that projected in the 1999 report (from 2015 to 2025).

The 2000 report states that the fund meets the Trustees' test of short-range financial adequacy for the first time since 1991. The projected long-range actuarial balance is moderately improved, but a substantial long-range deficit remains. The Trustees note that future operations will be very sensitive to future economic, demographic, and health cost trends and could differ substantially from the intermediate projections.

Beginning in 2011, the program will begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946 and 1964) begin turning age 65. Second, there will be a shift in the number of covered workers supporting each HI enrollee. In 1999, there were 4 workers for every beneficiary; in 2030 there will only be an estimated 2.3.

Financial Status of Supplementary Medical Insurance Trust Fund

Because the SMI Trust Fund is financed through beneficiary premiums and Federal general revenues, it does not face the prospect of depletion, as does the HI Trust Fund. However, the rising cost of the program is placing a burden on the trust fund, and by extension on beneficiaries (in the form of premiums) and Federal general revenues. Table 2–10 shows historical information from the 2000 Trustees' Report (Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 2000).

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. The Congressional Budget Office (CBO)

TABLE 2–10.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), SELECTED FISCAL YEARS 1970–2000

[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	
1970	$936	$928	$12	$1,876	$1,979	$217	$2,196	$57
1975	1,887	2,330	105	4,322	3,765	405	4,170	1,424
1980	2,928	6,932	415	10,275	10,144	593	10,737	4,532
1985	5,524	17,898	1,155	24,577	21,808	922	22,730	10,646
1986	5,699	18,076	1,228	25,003	25,169	1,049	26,218	9,432
1987	6,480	20,299	1,018	27,797	29,937	900	30,837	6,392
1988	8,756	25,418	828	35,002	33,682	1,265	34,947	6,447
1989	[5] 11,548	30,712	[5] 1,022	[5] 43,282	36,867	[5] 1,450	[5] 38,317	[5] 11,412
1990	[5] 11,494	33,210	[5] 1,434	[5] 46,138	41,498	[5] 1,524	[5] 43,022	[5] 14,527
1991	11,807	34,730	1,629	48,166	45,514	1,505	47,019	15,675
1992	12,748	38,684	1,717	53,149	48,627	1,661	50,288	18,535
1993	14,683	44,227	1,889	60,799	[6] 54,214	1,845	56,059	23,276
1994	16,895	38,355	2,118	57,368	58,006	1,718	59,724	20,919
1995	19,244	36,988	1,937	58,169	63,491	1,722	65,213	13,874
1996	18,731	61,702	1,392	82,025	67,176	1,771	68,946	26,953
1997	19,141	59,471	2,193	80,806	71,133	1,420	72,553	35,206
1998	19,427	59,919	2,608	81,955	[7] 74,837	1,435	76,272	40,889
1999	20,160	62,185	2,933	85,278	[7] 79,008	1,510	80,518	45,649
2000	20,405	65,209	3,054	88,667	[7] 89,571	1,510	91,081	43,235
2001	22,102	71,015	3,048	96,166	[7] 96,043	1,696	97,738	41,663
2002	24,389	78,322	2,976	105,687	[7] 102,855	1,753	104,608	42,742
2003	26,909	86,262	2,917	116,088	[7] 114,036	1,827	115,863	42,967
2004	29,347	92,268	2,898	124,513	[7] 122,053	1,903	123,956	43,524
2005	31,863	99,291	2,916	134,070	133,145	1,981	135,126	42,469

2006	34,319	106,725	2,969	144,013	137,601	2,063	139,665	46,818
2007	36,865	114,591	3,056	154,512	150,385	2,150	152,535	48,795
2008	39,716	124,009	3,192	166,918	161,939	2,242	164,180	51,533
2009	42,885	135,079	3,396	181,360	174,789	2,336	177,125	55,767

[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.

[7] Benefit payments less moneys transferred from the HI Trust Fund for home health agency costs, as provided for by the Balanced Budget Act of 1997.

Source: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund (2000).

has estimated (based on the 1999 Trustees' Report) the extent to which Medicare enrollees' contributions (through the HI payroll tax and the SMI premium) cover the expected value of their benefits under the program. Results are presented only for self-insured men and women (i.e., 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 (table 2–11). Three groups are shown—persons who reach 65 as of 1985, 1995, and 2005. All estimates are dependent on uncertain projections of future health spending.

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

Category	Year		
	1985	1995	2005
Self-insured men who earned average wages:			
Hospital insurance (HI)	33.1	69.5	111.3
Supplementary medical insurance (SMI)	24.3	22.8	22.1
Medicare total	29.8	49.6	68.8
Self-insured women who earned average wages:			
Hospital insurance	30.3	62.2	99.1
Supplementary medical insurance	25.3	24.2	23.7
Medicare total	28.3	45.4	62.4

Note.—Contributions include employers' and employees' HI payroll taxes, interest, and 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, unpublished tables.

For a self-insured man who worked continuously at an average wage from 1966 (when Medicare began) until retirement in 1985, the present discounted value of their contributions is about 30 percent of the expected value of lifetime Medicare benefits. For men retiring in 1995, contributions represent about 50 percent of benefits; for those retiring in 2005, contributions represent about 69 percent. Contributions through HI payroll taxes increase 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 (table 2–11).

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

In 1995 dollars, the present discounted value of Medicare benefits net of contributions (i.e., the net transfer or subsidy value) is estimated at $30,742 for men and $35,623 for women who retired in 1985. For those retiring in 1995, the value is estimated at $31,429 for men and $39,069 for women. CBO projects that values will decline in the future, reaching $26,429 for men and $36,354 for women by 2005 (table 2–12).

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

[In constant 1995 dollars]

Category	Year		
	1985	1995	2005
Self-insured men who earned average wages:			
Benefits	$43,780	$62,336	$84,627
Contributions	−13,038	−30,907	−58,198
Net transfer	30,742	31,429	26,429
Self-insured women who earned average wages			
Benefits	49,673	71,570	96,802
Contributions	−14,051	−32,502	−60,448
Net transfer	35,623	39,069	36,354

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. Spouse-insured beneficiaries qualify on the basis of their spouse's work history, not their own. For spouse-insured beneficiaries, contributions as a percent of benefits are lower and the net transfer is larger because spouse-insured beneficiaries paid little or no HI payroll taxes. Estimates assume an expected lifetime at age 65 to 15 years for men (to age 80) and 19 years for women (to age 84). Present discounted values for unexpected benefits were obtained using the average interest rate projected for HI Trust Fund earnings over the same years. The Consumer Price Index for All Urban Consumers (CPI–U) was used to get constant 1995 dollars.

Source: Congressional Budget Office, unpublished tables.

PART A SERVICES—COVERAGE AND PAYMENTS

Inpatient Hospital Services

Medicare part A provides reimbursement for inpatient hospital care through the prospective payment system (PPS), established by Congress in the Social Security Amendments of 1983 (Public Law 98–21). Before the enactment of PPS, Medicare paid hospitals retrospectively for the full costs they incurred, subject to certain limits and tests of reasonableness. Congress had previously acted to contain growing hospital costs by placing certain limits on routine inpatient care operating costs. However, medical costs continued to

grow faster than the rate of inflation in the early 1980s, so PPS was enacted to constrain the growth of Medicare's inpatient hospital costs by providing incentives for hospitals to provide care more efficiently (see appendix D for further information about hospital services).

Under PPS, fixed hospital payment amounts are established in advance of the provision of services on the basis of a patient's diagnosis. Hospitals that are able to provide services for less than the fixed PPS payment may keep the difference. Hospitals with costs that exceed the fixed PPS payment lose money on the case. The system's fixed prices are determined in advance on a cost-per-case basis, using a classification system of about 500 diagnosis-related groups (DRGs). Each Medicare case is assigned to one of the DRGs based on the patient's medical condition and treatment. DRGs are assigned relative weights to reflect the variation in the costs of treating a particular diagnosis. The DRG-based payment rate is designed to represent the national average cost per case for treating a patient with a particular diagnosis. Payments for a particular DRG will vary among different hospitals depending on the hospital's location and certain other characteristics. In a particular hospital, all cases assigned to the same DRG are reimbursed at the same predetermined rate.

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

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

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

Table 2–13 provides calendar year 1998 data on the utilization of inpatient hospital services by type of enrollee and type of hospital.

TABLE 2–13.—USE OF INPATIENT HOSPITAL SERVICES BY MEDICARE ENROLLEES, BY TYPE OF ENROLLEE AND TYPE OF HOSPITAL, CALENDAR YEAR 1998 [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	11,834	308	69,924	5.9	1,819	$74,153	$6,266	$1,929
Short stay	11,335	295	64,454	5.7	1,677	70,813	6,247	1,843
Long stay	499	13	5,470	11.0	142	3,340	6,693	87
Psychiatric	205	5	1,837	9.0	48	712	3,473	19
All other	294	8	3,633	12.4	95	2,628	8,939	68
Aged:								
All hospitals	10,021	300	58,849	5.9	1,761	63,372	6,324	1,897
Short stay	9,249	277	55,133	6.0	1,650	60,868	6,581	1,822
Long stay	772	23	3,716	4.8	111	2,504	3,244	75
Psychiatric	52	2	563	10.8	17	242	4,654	7
All other	720	22	2,295	3.2	69	2,262	3,142	68
Disabled:								
All hospitals	1,775	353	11,075	6.2	2,205	10,780	6,073	2,146
Short stay	1,553	309	9,322	6.0	1,856	9,945	6,404	1,980
Long stay	222	44	1,753	7.9	349	835	3,761	166
Psychiatric	153	30	1,274	8.3	254	470	3,072	94
All other	69	14	479	6.9	95	365	5,290	73

[1] Preliminary data. Totals may not add due to rounding.
[2] Discharges not available by type of hospital.

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

Source: Health Care Financing Administration, Office of Information Services, unpublished data.

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 an SNF 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 nor an SNF for 60 consecutive days. A beneficiary may have more than one spell of illness per year.

In order to be eligible for SNF care, the beneficiary must have been an inpatient of a hospital for at least 3 consecutive days and must be transferred to an 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 an SNF for the care of patients;
—Medical services of interns and residents in training under an approved teaching program of a hospital with which the SNF has a transfer agreement; and
—Other services necessary to the health of patients that are generally provided by SNFs.

Reimbursement

Prior to the Balanced Budget Act (BBA) of 1997 Medicare reimbursed SNF care on a retrospective cost-based basis. This meant that SNFs were paid after services were delivered for the reasonable costs (as defined by program) they incurred for the care they provided. SNFs had few incentives to maximize efficiency and minimize their costs, and little inducement to control the amount or number of services they provided.

Prospective payment system.—In BBA 1997, Congress required that a prospective payment system (PPS) for SNF care be phased in over 3 years, beginning with the SNF's first cost reporting period after July 1, 1998. Prospective payment involves grouping patients according to the type and intensity of services they require and setting a daily payment rate for each payment group before the services are provided. Like other PPSs that pay health care providers for care to Medicare beneficiaries on the basis of predetermined, fixed amounts, Medicare payments to SNFs are intended to pay the provider for its Medicare beneficiary costs on average. That is, al-

though the payment is a fixed daily rate, a facility's actual costs may be above or below that amount for an individual patient. The goal for the facility is to incur costs that, on average, over time, do not exceed the PPS average amounts.

Under BBA 1997 provisions, an SNF is paid a daily rate ("Federal per-diem rate"), prospectively determined, for all covered services provided to beneficiaries while they are eligible for SNF benefits. These include all routine, ancillary, and capital-related costs. An amount is added to this daily rate to cover part B services received by SNF-eligible patients; some part B services are excluded from this "add on"—primarily the services of physicians and certain nonphysician practitioners such as physician assistants, nurse practitioners, and psychologists, who are paid separately under part B.

The SNF PPS required by BBA 1997 reflects the resource utilization group (RUG) design developed by HCFA. It is a hierarchical classification system accounting for the type and level of care needed by SNF patients and the relative amount of resources needed to provide a patient's care. Under the original RUG system implemented in 1998, there were seven basic categories of care, including, in hierarchical order: (1) rehabilitation; (2) extensive services; (3) special care; (4) clinically complex; (5) impaired cognition; (6) behavior problems; and (7) reduced physical function. These seven categories were further broken down into 44 specific patient groupings. The system ascribed a per-diem payment amount for each of the 44 groupings. These amounts are adjusted by a wage index to account for geographic variations in wages among urban and rural areas. The rates are updated annually using an SNF MBI. HCFA issued a final rule implementing the PPS on July 30, 1999 (64 *Federal Register* 41644–701).

Transition period.—BBA 1997 provided that the Federal per-diem rate would apply immediately to all SNFs that received their first Medicare payment on or after October 1, 1995. For those that received their first Medicare payment before that date, a 3-year transition period was established. During the transition period, the PPS has two components: a Federal PPS component under the RUG system and a "facility-specific" component. This latter is computed separately for each SNF to reflect the facility's own average costs under the pre-PPS system. Payments for the first cost reporting period beginning on or after July 1, 1998, are a blend of 75 percent facility-specific rate and 25 percent Federal rate. For the second cost reporting period, the facility-specific percentage is 50 percent and the Federal, 50 percent. For the third period, the facility-specific percentage is 25 percent and the Federal, 75 percent. For all subsequent years, payments will be based entirely on the Federal per-diem rate.

Consolidated billing.—Congress also included a consolidated billing provision in BBA 1997 to address the potential for fraud and duplicate billing for SNF services. Under this provision, the SNF is responsible for billing Medicare for all services (with certain exceptions) provided to its residents under both parts A and B. This provision applies to beneficiaries residing in an SNF or in any part of a nursing home which contains a Medicare-certified SNF portion. It applies both to patients who are in a part A covered stay and

those who are not. Although the SNF might provide these services under arrangements with outside providers, the outside provider must get its payment through the SNF rather than by billing Medicare directly.

BBA 1997 excluded some services from the SNF consolidated billing requirement, including those provided by physicians and certain nonphysician practitioners, and dialysis-related services and supplies. Regulations excluded hospice care related to a beneficiary's terminal illness and certain ambulance trips to and from SNFs. Providers of these services, which are covered under part B, bill Medicare directly.

BBA 1997 established the PPS for SNFs with the purpose of slowing the rate of growth in SNF payments under Medicare. In January 1998, a few months after enactment of BBA 1997, CBO projected that Medicare spending on SNFs for 1998 would remain at 1997 levels. However, actual spending in 1998 was much lower than anticipated. In March 1999, CBO revised its 1998 estimate to indicate a decrease in SNF spending of $900 million. It has also revised downward its 5- and 10-year estimates for total SNF spending. A number of factors contributed to the reductions in Medicare spending for SNFs. These include lower inflation, which results in lower payments to providers; and HCFA's heightened efforts to combat fraud and abuse, resulting in a reduction in incorrect overpayments. However, SNF industry spokespersons said that these reductions indicate that changes made to Medicare's reimbursement policies were too drastic, causing financial problems for SNFs, and that they should be reexamined.

In addition, industry representatives and others (including the Medicare Payment Advisory Commission) were concerned that the RUG system based on 44 payment categories might not adequately cover the costs of treating patients with clinically complex problems requiring skilled nursing care (high acuity patients), and those needing extensive ancillary nontherapy services, such as laboratory tests, drugs and biologicals, imaging services, and transportation.

Balanced Budget Refinement Act (BBRA) of 1999.—In response to concerns about the adequacy of payments under the RUG system, Congress enacted, in BBRA, temporary increases for Medicare payments for 15 of the 44 RUGs. These 20-percent increases apply to SNF care furnished to patients categorized as needing extensive services, special care, clinically complex care, and certain high level and medium level rehabilitation services. The special payments are available beginning April 1, 2000, and ending the later of October 1, 2000, or the date of implementation of a refined, revised RUG system.

BBRA also provided for a 4-percent increase in the Federal per-diem rate for SNF services for fiscal year 2001 and fiscal year 2002. This increase is not to be considered in the base amount used to compute updates to the Federal per-diem rate.

Other changes made by BBRA include the following items:

1. SNFs may elect to receive Medicare payments based 100 percent on the Federal per-diem rate, rather than under the phase-in schedule, if it would be more advantageous for them to do so.

2. Starting April 1, 2000, separate payments above the RUG per-diem rate would be made for certain ambulance services for dialysis patients, certain prostheses, and certain chemotherapy drugs for SNF patients.
3. If at least 60 percent of an SNF's patients are immunocompromised, RUG payments will be based 50 percent on the facility specific rate and 50 percent on the Federal per-diem rate (rather than moving to 100 percent of the Federal rate) until October 1, 2001.

CBO estimates that the changes in payments to SNFs made by BBRA will increase spending for SNF care by $2.2 billion in the first 5 years.

SNF payments and utilization

For a number of years, SNF care was one of Medicare's fastest growing benefits. Tables 2–14 and 2–15 show that SNF utilization and spending first began to increase substantially in 1988 and 1989. These increases can be traced to changes that occurred in the benefit at that time.

TABLE 2–14.—ESTIMATED MEDICARE PAYMENTS FOR SKILLED NURSING FACILITY CARE, 1983–99

	Payments (in billions)	Percent change [1]
Calendar year:		
1983	$0.5	NA
1984	0.5	0.2
1985	0.5	0.7
1986	0.6	4.9
1987	0.6	10.4
1988	0.8	29.3
1989	2.8	242.5
1990	2.5	−11.5
1991	2.5	−0.3
1992	3.5	42.4
1993	5.0	41.0
1994	6.9	38.3
1995	9.2	34.1
1996	11.1	20.2
1997	13.0	17.1
1998	13.5	3.8
1999	11.8	−12.6

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

NA—Not applicable.

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

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

TABLE 2–15.—MEDICARE SKILLED NURSING FACILITY UTILIZATION AND PAYMENTS PER PERSON SERVED, 1983–99

	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	NA
1984	299,000	10	9.6	32.2	58	3.2
1985	314,000	10	8.9	28.4	65	11.1
1986	304,000	10	8.2	26.8	71	9.6
1987	293,000	9	7.4	25.4	84	19.3
1988	384,000	12	10.7	27.8	87	2.6
1989	636,000	19	29.8	46.8	117	34.6
1990	638,000	19	25.1	39.5	98	−16.1
1991	671,000	20	23.7	35.3	123	25.9
1992	785,000	22	29.0	36.9	157	27.1
1993	908,000	25	34.4	37.9	188	20.1
1994	1,068,000	29	37.1	39.7	226	20.1
1995	1,240,000	33	43.3	34.9	222	9.5
1996	1,384,000	37	47.7	34.4	240	8.5
1997	1,570,000	41	50.6	32.2	262	9.1
1998	NA	NA	48.6	NA	268	2.2
1999	NA	NA	50.1	NA	243	−9.3

NA—Not applicable.

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

First, HCFA issued new coverage guidelines that became effective early in 1988. Prior to this time, studies had pointed to a lack of adequate written guidance on coverage criteria that led to inconsistencies in coverage decisions for a benefit that was intended to be uniform across the country. As a result, many SNFs were reluctant to accept Medicare beneficiaries because of the possibility that a submitted claim would be retroactively denied. The 1988 guidelines clarified coverage criteria by providing numerous examples of covered and noncovered care. Furthermore, the guidelines explained that even when a patient's full or partial recovery is not possible, care could be covered if it were needed to prevent deterioration or to maintain current capabilities. Previously, some care had been denied coverage because patients' health status was not expected to improve.

The second major, though temporary, change in Medicare's SNF benefit came in 1988 with the enactment of the Medicare Catastrophic Coverage Act (MCCA). Effective beginning in 1989, this legislation eliminated the SNF benefit's prior hospitalization requirement; revised the coinsurance requirement to be equal to 20 percent of the national average estimated per-diem cost of SNF services for the first 8 days of care; and authorized coverage of up to 150 days of care per calendar year (rather than 100 days per spell of illness). These changes were repealed in 1989, and the SNF benefit's structure assumed its prior form.

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 repeal of MCCA. Table 2–14 shows that SNF spending in calendar year 1990 stood at $2.5 billion; by 1997 it had increased to $13.0 billion, for an average annual growth rate of 27 percent. With implementation of the RUG payment system in mid-1998, however, the rate of increase dropped precipitously: between 1997 and 1998 the increase was 3.8 percent, and payments decreased by 12.6 percent in 1999.

Table 2–15 shows that between 1992 and 1997 the number of Medicare beneficiaries receiving SNF care doubled from 785,000 to 1.57 million. The number of covered days grew from 29 million to 50.6 million, or by 74 percent. Payments per day grew from $157 in 1992 to $262 in 1997, a 67-percent increase. However, in 1998 when the RUG system went into effect, these payments increased by only 2.2 percent to $268, and decreased to $243 per day in 1999, a 9.3 percent decrease. These decreases in payments led to the changes enacted in BBRA described above.

HOME HEALTH SERVICES

Coverage and eligibility

Medicare home health services are covered under part A of the program and, in certain circumstances, under part B. Prior to BBA 1997, home health care was paid under part A unless an individual was ineligible for part A but had purchased part B coverage. In BBA 1997, Congress transferred payment for some home health care from part A to part B. The transfer applies to home visits beyond the first 100 visits that follow a stay in a hospital or an SNF, beginning in 1998, phased in over 6 years. No beneficiary deductibles or coinsurance are required for home health care.

To qualify for home health care under Medicare an individual must be homebound. A homebound individual is defined as one who cannot leave home without a considerable and taxing effort and only with the aid of devices such as a wheelchair, a walker, or through use of special transportation. Absences from home may occur infrequently for short periods of time for such purposes as to receive medical treatment.

Homebound individuals qualify for coverage of home health care if they need intermittent skilled nursing care, physical therapy, or speech-language pathology services. Beneficiaries needing one or more of these "qualifying services" may also receive occupational therapy, the services of a medical social worker, or a home health aide. Occupational therapy can continue to be provided after the need for skilled nursing care, physical therapy, or speech therapy ends, but social work or aide services may not.

Home health care is covered by Medicare as long as the care is medically reasonable and necessary for the treatment of illness or injury. Although the number of home health visits a beneficiary may receive is unlimited, services must be provided pursuant to a plan of care that is prescribed and periodically reviewed by a physician. In general, Medicare's home health benefit is intended to serve beneficiaries needing acute medical care requiring the services of skilled health care personnel. It was never envisioned as providing coverage for the nonmedical supportive care and personal

care assistance needed by chronically impaired persons. It is not a long-term care program for the disabled or the frail elderly.

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

1. Part-time or intermittent 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. Part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;
5. Medical supplies (excluding drugs and biologicals) and durable medical equipment (DME);
6. Medical services provided by an intern or resident in training under an approved training program with which the agency may be affiliated; and
7. Certain other outpatient services which involve the use of equipment that cannot readily be made available in the beneficiary's home.

Home health services are provided by private or public home health agencies (HHAs) that specialize in provision of such services and that are certified to participate in Medicare by HCFA. HHAs may be public or government-sponsored entities, private nonprofit agencies, or proprietary for-profit agencies. Hospitals may own or sponsor an HHA. Home health care givers may be employees of the HHA or may work for an agency under contract. HCFA characterizes a typical HHA as having 486 Medicare admissions and 30,000 visits per year and an 18 person staff. Often, Medicare beneficiaries constitute the great majority of an HHA's caseload, although other users include individuals covered by Medicaid and those with private insurance or who pay out of pocket.

According to HCFA data, the overall average number of home health care visits received by Medicare home health patients in 1997 was 82, up from 23 in 1987. On average, Medicare beneficiaries qualifying for home health care have one episode of covered care, and the average number of visits received in one episode of coverage is 36.

Background of the Medicare home health benefit

In the early years of the program, Medicare part A covered up to 100 home health visits for beneficiaries who had an immediate prior hospitalization or care in an SNF. Home health care was also covered under part B, up to 100 visits, for beneficiaries who had no prior hospitalization, or who had exhausted their 100 part A visits, or who had part B coverage only. It was required that a physician determine that the individual could be discharged to his or her home but would require skilled nursing care on less than a full-time basis, or physical therapy, or speech therapy.

The Omnibus Budget Reconciliation Act of 1980 (Public Law 96–499) made several liberalizing changes in the rules governing Medicare's coverage of home health services, including elimination of the requirement for a prior hospitalization and removal of the limitation on the number of visits. It also allowed the need for occupa-

tional therapy to trigger coverage of home health services furnished after June 1981, although less than a year later, as part of a larger strategy to meet budget targets for reductions in Medicare spending, Congress removed occupational therapy as a qualifying trigger for home health care (Public Law 97–35, the Omnibus Reconciliation Act of 1981).

Growth in volume of services and payments.—During the first 10 years of the Medicare Program, home health care accounted for less than 2 percent of total Medicare spending. Between 1977 and about 1990 it accounted for 2–3 percent of total program spending. This small increase reflected the 1980 liberalizations and, many say, the delayed response to implementation in 1983 of a PPS for hospital inpatient care under Medicare. Some analysts had predicted that the inpatient PPS would lead to large growth in home health care utilization by Medicare beneficiaries. However, home health care spending increases that might have occurred as a result of the inpatient PPS were offset by changes in the law and in certain administrative procedures. For instance, the 1984 Deficit Reduction Act required HCFA to reduce the number of "fiscal intermediaries" with which HCFA contracts to process Medicare home health care claims. These entities approve or deny beneficiary eligibility for home health care as well as HHA claims for payment. As HCFA reduced the number of fiscal intermediaries, eligibility and claims decisions became more standardized. HCFA also intensified educational programs for claims processors, required HHAs to submit increased documentation with each claim, and increased the number of claims subjected to indepth medical reviews. Some say these actions tempered the effect of early hospital discharges prompted by the hospital inpatient PPS, noting that the home health care claims denial rate rose from 3.4 percent in 1985 to 7.9 percent in 1987.

A significant event in the history of the Medicare home health benefit was settlement of a class action lawsuit filed in 1988 (*Duggan* v. *Bowen*) which sought to liberalize HCFA's interpretation of benefit coverage requirements. As a result of the suit, in 1989, HCFA revised the home health eligibility criteria to cover patients needing "part-time or intermittent care" instead of the previous requirement that patients need "part-time and intermittent care." This change allowed the number of visits to be increased because they no longer had to be "intermittent" but could be made on a daily basis. HCFA's revised guidelines also loosened the claims procedures that had been tightened between 1985 and 1987. 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.

Home health spending rose from $2.1 billion in 1988 to $18.1 billion in 1996, an average annual increase of over 31 percent (table 2–16). Medicare payment increases were driven by the increase in the number of beneficiaries served and the average number of visits per beneficiary served. The number of beneficiaries served more than doubled during this time period, and the average number of visits per home care patient increased more than threefold, from 23 visits in 1987 and 1988 to 82 in 1997 (table 2–17). The number of

HHAs participating in Medicare also increased sharply, growing from 5,686 agencies in 1989 to 10,492 in 1997. However, the average cost per home care visit rose relatively modestly, from $55 in 1988 to $71 in 1999, an increase of only 16 percent.

TABLE 2–16.—MEDICARE PAYMENTS FOR HOME HEALTH, 1983–99

Calendar year	Payments (in billions)	Percent change
1983	$1.6	NA
1984	1.8	15.4
1985	1.9	7.6
1986	2.0	1.6
1987	1.7	−12.6
1988	2.1	19.2
1989	2.5	20.4
1990	3.7	51.0
1991	5.3	40.8
1992	7.2	37.0
1993	10.3	42.6
1994	13.3	28.9
1995	16.6	25.2
1996	18.1	8.9
1997	17.9	−0.8
1998	12.0	−33.4
1999	9.3	−22.3

NA—Not applicable.

Source: Health Care Financing Administration.

Medicare payment policies for home health care.—Prior to the changes made by BBA 1997, Medicare reimbursed HHAs for the lesser of: (1) their reasonable costs; or (2) a limited amount per visit, applied in the aggregate. The per-visit limit was set at 112 percent of the national average cost, which was calculated separately for each type of service (nursing, therapy, etc.). It was based on costs for freestanding agencies (i.e., agencies not affiliated with hospitals) and varied according to whether an agency was located in an urban or rural area and according to wage level differentials from area to area. Per-visit cost limits were updated annually by applying an MBI to base-year data derived from HHA cost reports. These limits, however, were applied to aggregate agency payments and not to individual visits; that is, an aggregate cost limit was set for each agency equal to the sum of the agency's limit for each type of service multiplied by the number of visits of each type provided by the agency.

This cost-based reimbursement system was criticized as providing few incentives for HHAs to maximize efficiency or control the volume of services they delivered because HHAs were paid for every visit their workers made.

Balanced Budget Act of 1997

The Balanced Budget Act (BBA) of 1997 made several changes to home health eligibility, coverage, and payment rules. In general,

through these changes, Congress sought to curtail the steep annual rates of increase in the volume of Medicare home health services and payments. In addition, BBA 1997 provided for the transfer of some home health spending from part A to part B; the purpose of this transfer was to reduce part A spending and thereby extend the solvency period of the part A trust fund.

TABLE 2–17.—MEDICARE HOME HEALTH CARE UTILIZATION AND PAYMENTS PER VISIT, 1983–99

Calendar year of service	People served		Visits			Payment per visit	Percent change
	Number	Per 1,000 enrollees	Number (in millions)	Per 1,000 enrollees	Per person served		
1983	1,318,000	45	36.9	1,264	28	$43	(1)
1984	1,498,000	50	40.4	1,378	27	46	7.2
1985	1,549,000	51	39.4	1,327	25	49	6.4
1986	1,571,000	51	38.0	1,263	24	50	3.4
1987	1,544,000	49	35.6	1,163	23	53	5.2
1988	1,582,000	49	37.1	1,193	23	55	3.8
1989	1,685,000	51	46.3	1,459	27	55	−0.4
1990	1,940,000	58	69.4	2,146	36	56	1.7
1991	2,223,000	65	98.6	2,996	44	56	1.1
1992	2,523,000	72	132.5	3,958	53	58	3.9
1993	2,868,000	80	167.8	4,939	59	61	4.1
1994	3,175,000	87	218.8	6,388	69	62	2.2
1995	3,457,000	93	266.3	7,801	77	62	0.7
1996	3,583,000	95	284.4	8,439	79	63	1.7
1997	3,370,000	88	276.5	8,390	82	64	0.6
1998	NA	NA	161.0	4,980	NA	67	5.1
1999	NA	NA	97.0	3,027	NA	71	6.2

[1] Not applicable.

NA—Not available.

Source: Health Care Financing Administration.

Clarification of coverage rules.—BBA 1997 included several provisions that clarified coverage criteria for home health care, including:

1. Clarification of the definition of "part-time" and "intermittent" regarding skilled nursing care and home health aide services for purposes of eligibility for, and coverage of home health care. First, patients needing skilled nursing care are eligible for Medicare's home health benefit if the need is for "intermittent" care, defined as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable). Second, for beneficiaries who qualify for home health care and who need both skilled nursing and home health aide services, coverage is provided only to the extent that these two services combined is "part-time or intermittent," defined as skilled nursing and home health aide services furnished any number of days per week as long as they are fur-

nished (in combination) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-care basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week);
2. Elimination of eligibility based solely on needing a skilled nurse to draw blood;
3. A requirement that claims include a physician identifier;
4. A requirement that home health workers report their activities during a visit in 15-minute intervals (the data are used in designing a home health PPS);
5. Extension of savings from a July 1994–June 1996 freeze on home health cost limit updates;
6. A requirement for a study of the definition of "homebound" and a study to establish guidelines to standardize the frequency and duration of home health services for patients with similar needs and circumstances ("normative guidelines"). (The Secretary determined that no change was needed for the definition of homebound, and the first results from the study of normative guidelines will be available in fall 2000);
7. A requirement for "consolidated billing" for services to home health patients, under which payment for any Medicare-covered service or item provided for a beneficiary during a spell of home health care coverage is to be made to the HHA. The HHA would then pay the provider of the service or item. (BBRA 1999 later excluded the supply of DME from consolidated billing.)

Transfer certain coverage from part A to part B.—BBA 1997 transfers from part A to part B payments for home health visits that are not part of the first 100 visits following a hospitalization. Part A benefits are financed through the Hospital Insurance (HI) Trust Fund, whereas part B benefits are financed by beneficiary premiums and general revenues. Thus, the solvency of the HI Trust Fund is extended by removing from it some of the costs of home health benefits. The transfer is being phased in over 6 years, between 1998 and 2003, with the Secretary transferring one-sixth of the aggregate expenditures associated with transferred visits in 1998 and an additional one-sixth each year thereafter until fully implemented in 2003. Beginning January 1, 2003, part A coverage for home health care will apply only to postinstitutional home health services for up to 100 visits during a spell of illness, except for those persons with part A coverage only, who will be covered for services without regard to the postinstitutional limitation.

Moving home health care costs to part B could increase beneficiary premiums for that component of Medicare. The increase in the part B premium attributable to transferred expenditures will be phased in over a period of 7 years, between 1998 and 2004. For 1998 the part B premium was increased by one-seventh of the extra costs due to the transfer; for 1999 it was increased by two-sevenths, etc., until 2004 when the total cost of the transfer will be included in the part B premium. The increases have been very small, only slightly over $1 a month in 1999.

Postinstitutional home health services are defined for these purposes as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least 3

consecutive days, initiated within 14 days after discharge; or (2) after a stay in an SNF, initiated within 14 days after discharge. A home health spell of illness is defined as the period beginning when a patient first receives postinstitutional home health services and ending when the beneficiary has not received inpatient hospital, SNF, or home health services for 60 days.

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

Requirement for a PPS.—BBA 1997 required that a PPS be implemented for home health care beginning in 1999 and required that the PPS be designed to reduce home health payments by 15 percent. It specified that the 15-percent reduction was to go into effect even if the PPS was not ready for implementation in 1999. In Public Law 105–277 (the Omnibus Consolidated and Emergency Supplemental Appropriations Act for fiscal year 1999) Congress delayed the implementation date for the PPS until October 1, 2000, and moved the 15-percent reduction to coincide with commencement of the PPS. BBRA 1999 subsequently postponed the 15-percent reduction to 12 months after implementation of the PPS.

Implementation of an interim payment system.—Because of concern about the rapidly rising costs of Medicare's home health benefit, Congress included in BBA 1997 an "interim payment system" (IPS) for home health care in order to achieve immediate spending reductions prior to implementation of the PPS. This interim system was effective for HHA cost reporting periods starting on or after October 1, 1997, and will remain in effect until the PPS is implemented in October 2000.

Table 2–16 shows the substantial reductions in Medicare payments for home health services that have coincided with implementation of the IPS. In 1999, total payments were almost half the 1996 level. The IPS achieves cost savings by establishing a new methodology for limiting aggregate annual Medicare payments to individual HHAs. Under this procedure, an agency receives payments totaling the least of three amounts (pre-IPS payments were the lesser of the first two of these amounts): (1) the agency's reasonable costs; or (2) payments determined under the per-visit limits, with the limit set at 106 percent of the national median cost per visit by service type (pre-IPS limit was 112 percent of the national average cost per visit);[1] or (3) aggregate payments under a new formula based on per-beneficiary limits.

HCFA estimates that 79 percent of HHAs are subject to the new per-beneficiary limit; the others receive less under the reasonable cost or per-visit limit. Determining an agency's aggregate Medicare payment limit under the new per-beneficiary formula includes four steps:

1. Divide the total payments the agency received from Medicare for cost reporting periods ending in fiscal year 1994 by the number of Medicare patients it served that year to get an average amount per beneficiary (certain wage adjustments and cost updates are applied to bring the amount up to values in the year to which the limits are being applied, e.g., in 2000). Per-

[1] Public Law 105–277 increased the limit from 105 percent of the national median cost of a service (estimated at the time of BBA 1997 enactment to be about 98 percent of the mean) to 106 percent of the median.

beneficiary limits for agencies that were not operational in 1994 are set at the national median;
2. Reduce that average amount per beneficiary to 75 percent of the full amount;
3. Add a sum that is 25 percent of the average Medicare per-beneficiary costs of all agencies in the same census region to get a new average cost per beneficiary;
4. Multiply the agency's average cost per beneficiary from step three by the number of Medicare patients the agency is serving in the current year or cost reporting period. The result is an aggregate annual payment limit that an agency is held to for serving all its Medicare patients in a cost reporting period under the IPS.

If an agency's average costs for its patients are lower than others in the region, it benefits from the sum that is added based on the average regional per-beneficiary limits (step 3, above); if an agency's costs are higher than others in the area, it loses money from the regional component of the formula. This regional component of the formula also decreases disparities that had existed among agencies in the same general area.

The per-beneficiary aggregate limit does not restrict the amount an HHA can spend on any individual beneficiary. It is simply a technique for arriving at an aggregate budget amount for an agency's Medicare patients. However, many HHAs misunderstood how this limit works, and there are reports that some agencies ended a patient's care when spending for that individual reached the amount of the per-beneficiary payment (i.e., the amount arrived at by step three above). In reality, agencies have some patients whose costs are below the per-beneficiary average and some whose costs are above it. The idea behind the new formula was that payments on behalf of patients whose costs were lower than average would "subsidize" more costly patients; the balance of low and high cost patients would determine whether an agency would exceed its aggregate per beneficiary cap.

Congress based the per-beneficiary calculation on fiscal year 1994 levels of operation in order to discount the large volume growth that still appeared to be occurring after that year (program costs grew by nearly 25 percent from 1994 to 1995). Using fiscal year 1994 as the base year caused agencies that had increased their costs per patient after that time (generally by increasing the number of visits per patient) to have a larger reduction in their Medicare revenues under the IPS than agencies that had maintained relatively constant average costs per beneficiary.

Response to BBA 1997 and the IPS.—Table 2–16 shows the significant decrease in Medicare spending for home health care that occurred with implementation of the provisions in BBA 1997 and the IPS. Table 2–17 shows the sharp drop after 1997 in the number of home health visits covered by Medicare. At the same time, the average payment per visit increased. Most analysts agree that the reduction in the number of home health visits is attributable largely to the IPS, but note also that the provision of BBA 1997 that eliminated venipuncture (the drawing of a blood specimen) as the sole home health service qualifying an individual for home care also contributed to the reduction in visits. Presumably, elimination

of less costly visits (e.g., home health aide visits) resulted in an increase in the average payment per visit from $64 in 1997 to $71 in 1999. Moreover, the Health Insurance Portability and Accountability Act of 1996 included civil money penalties for physicians who falsely certify that a beneficiary needs home health care, a provision some say has had a chilling effect on physician referrals.

As the apparent effects of the IPS began to be evident, representatives of the home health industry claimed that (1) the IPS was limiting HHAs' ability to provide necessary care; (2) agencies with low average costs per beneficiary in the fiscal year 1994 base period were realizing the severest reductions; and (3) these older agencies were being paid inequitably in comparison with newer agencies because agencies that had not been in business long enough to have had a cost reporting period ending in fiscal year 1994 were assigned a per-beneficiary limit equal to the national median.

Because the payment limits imposed by the IPS induce agencies to balance the number of expensive patients against the number of inexpensive patients they serve in order to stay within their total Medicare payment limit, questions arose about whether the IPS created incentives for HHAs to refuse to serve beneficiaries with the most serious medical needs and who require extensive home health visits. An HHA might refuse to accept certain expensive patients if it were concerned that the balance of patients in its caseload would be tipped too far toward costly cases and result in expenditures exceeding the agency's total funding limit.

In January 1998, the Congressional Budget Office (CBO) projected 10-year BBA 1997 home health care savings of almost $75 billion. In March 1999, CBO reestimated the effects of BBA 1997, and the new projections showed an additional $56 billion in savings. The original CBO estimate reflected an annual rate of growth in home health spending of 8.3 percent a year over 10 years, but the revised estimate showed an annual increase of 5.6 percent a year. (Under the old law, in the early 1990s, Medicare home health spending had been growing at rates of between 20 and 30 percent a year.) However, CBO's revised estimates included changes in their underlying economic assumptions as well as revised estimates of the effects of BBA 1997. Additionally, HCFA officials cautioned that reduced Medicare payments for home health care since 1997 reflect an intensified case review process HCFA required claims processors to implement along with the IPS as well as stepped-up fraud and abuse detection activities.

To address concerns about the impact of the IPS and the large decrease in estimates of program payments for home health care, in Public Law 105–277, Congress modified the IPS formula to increase per-visit limits for HHAs from 105 percent of the median to 106 percent and increased payments to agencies whose per-beneficiary limits under the IPS were less than the national median per-beneficiary limits. The per-beneficiary limits for older agencies (those in operation in fiscal year 1994) were increased by one-third of the difference between the agency's per-beneficiary limit and the national median of per-beneficiary limits; per-beneficiary limits for agencies starting operation after fiscal year 1994 but before fiscal year 1999 were set at the national median limit; new HHAs that

began treating Medicare patients on or after October 1, 1998, were set at 75 percent of the national median, with a 2-percent reduction. These modifications to home health payments were estimated to increase Medicare payments to 65 percent of HHAs.

Home health prospective payment system

As noted above, BBA 1997 required a prospective payment system (PPS) to be implemented for Medicare payments for home health care. Final PPS rules were published in the *Federal Register* on July 3, 2000. Under those rules, beneficiaries are categorized into one of 80 home health resource groups, each of which carries a standard payment for a 60-day episode of care for a beneficiary. The standard payment is computed using the average national cost per visit (computed and weighted by visit type, that is, skilled nursing, physical therapy, etc.) multiplied by the national average number of visits (by type) in a 60-day period. Average costs for nonroutine medical supplies, certain therapy services, and administration of the outcome and assessment information set (OASIS) interview questionnaire are added.[2] The payments include adjustments to reflect geographic wage levels among HHAs, to account for unusually costly patients ("outlier" payments), and to achieve "budget neutrality." The budget neutrality adjustment ensures that total home health payments under the PPS in fiscal year 2001 will be equal to the estimated total payments that would have been made by Medicare in that year had the IPS continued in effect in fiscal year 2001, including limits on the market basket index (MBI). Total fiscal year 2001 payments will equal the IPS projected to that year minus 1.1 percentage points.

Special payment arrangements are made for beneficiaries receiving fewer than five visits, or who transfer from one HHA to another, or who have a significant change in their condition during an episode of illness.

HHAs will be paid 60 percent of the PPS amount after completing an OASIS questionnaire for each new or renewing patient and receiving a physician's certification and plan of care. The remainder of the payment will be made when the episode is completed (or, if earlier, when care is completed). If, at the end of an initial 60-day episode, a physician orders care to be continued, payment for the subsequent episode (or episodes) is split to provide 50 percent of the payment at the start of the episode and 50 percent at the end of care or the episode.

Balanced Budget Refinement Act (BBRA) of 1999

As a result of concern that many provisions of BBA 1997 had caused unanticipated reductions in Medicare payments across the spectrum of health care providers, Congress included modifications to Medicare in BBRA 1999. That act included the following provisions pertaining to Medicare home health care:

1. Delays the 15-percent payment reduction required under the PPS by BBA 1997 until 12 months after implementation of the

[2] OASIS is a data collection instrument on which a home health worker records, for new or renewing patients, clinical and other data required to plan the individual's course of care. Data from OASIS are also used in the definition of the payment categories under the home health PPS.

PPS and requires the Secretary to report within 6 months after implementation of the PPS on the need for the 15 percent or some other reduction.

2. Provides HHAs with a payment of $10 per beneficiary for administration of the OASIS questionnaire to new home health patients for services furnished during cost reporting periods in fiscal year 2000. One-half of the payment will be made in April 2000 and the remainder at cost report settlement. It requires GAO to study the costs of collecting these data and to report by April 2000.
3. Requires that per-beneficiary limits under BBA 1997 IPS be increased by 2 percent in cost reporting periods starting in fiscal year 2000 for those HHAs for which the per-beneficiary limit is below the national median; the increase will not be included in the base for determining the budget neutral PPS amounts.
4. Establishes the surety bond requirement for HHAs as the lesser of $50,000 or 10 percent of an HHA's Medicare payments in the previous year and requires the bond to be in effect for 4 years (or longer if ownership of the HHA changes). Prior periods covered by a bond may be counted and Medicare and Medicaid bond requirements are to be coordinated.
5. Excludes DME from the home health consolidated billing requirement of BBA 1997.
6. Clarifies that the increase in the home health PPS in fiscal year 2002 and fiscal year 2003 will be the MBI minus 1.1 percentage points.
7. Requires the Medicare Payment Advisory Commission to study and report within 2 years of enactment on the feasibility and advisability of excluding rural HHAs and beneficiaries living in rural areas from the home health PPS.

Because the new PPS will go into effect in fiscal year 2001, the BBRA 1999 provisions pertaining to home health care under Medicare were not extensive. However, the provision that had caused substantial concern in the industry was the requirement that the PPS be designed to reduce total Medicare payments for home health care by 15 percent compared with pre-PPS levels. Because of the sharp declines in payments to HHAs under the IPS, some said that a further 15-percent reduction would affect the availability of home health services and make care inaccessible to beneficiaries, particularly those with extensive and costly care needs. Congress addressed that issue in BBRA 1999 by delaying implementation of the 15-percent reduction until 12 months after implementation of the PPS and requiring the Secretary to evaluate and report, within 6 months of implementation of the PPS, on the need for payment reductions.

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 Eq-

uity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97–248, first authorized Medicare part A coverage for hospice care (for the period November 1, 1983 to October 1, 1986); in 1986, Congress made the hospice benefit a permanent part of the Medicare Program, effective April 7, 1986.

For a person to be considered terminally ill and eligible for Medicare's hospice benefit, the beneficiary's attending physician and the medical director of the hospice (or physician member of the hospice team) must certify that the individual has a life expectancy of 6 months or less. As a result of an amendment in BBA 1997, persons electing hospice are covered for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice team must recertify at the beginning of each new election period that the beneficiary is terminally ill. Services must be provided under a written plan of care established and periodically reviewed by the individual's attending physician and by the medical director of the hospice.

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

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 serv-

ices 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 and directly provide substantially all of the following "core" services: nursing care, medical social services, and counseling services. The remaining hospice services may be provided either directly by the hospice or under arrangements with others. If services are provided through arrangements with other providers, the hospice must maintain professional management responsibility for all such services, regardless of the facility in which the services are furnished.

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

Reimbursement

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

The four rate categories for reimbursing hospices are:

1. *Routine home care day*.—Routine home care day is a day on which an individual is at home and is not receiving continuous home care. The routine home care rate is paid for every day a patient is at home and under the care of the hospice regardless of the volume or intensity of the services provided on any given day as long as less than 8 hours of care are provided. This rate is $98.96 for services provided between October 1, 1999 and September 30, 2000.
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 $577.59 for 24 hours or $24.07 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 $102.37.
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 (SNF), or inpatient unit of a freestanding hospice. Currently this rate is $440.22.

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, SNFs, and HHAs. HCFA separates each of the national payment rates for hospice care into components which reflect the estimated proportion of the rate attributable to wage and nonwage costs. The wage component of each rate is then adjusted by the index applicable to the area in which the hospice is located.

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

BBA 1997 reduced the hospice payment update to market basket minus 1.0 percentage point for each of fiscal years 1998–2002.

Medicare law requires that payments to a hospice for care furnished over the period of a year be limited to a "cap amount." The cap amount is applied on an aggregate rather than a case-by-case basis. Therefore, each individual hospice's cap amount is calculated by multiplying the yearly cap amount by the number of Medicare beneficiaries who received hospice care from the hospice during the cap period. Medicare defines a cap year as the period from November 1 through October 31 of the following year. The cap amount for the period November 1, 1999 through October 31, 2000, is $15,313.

Updates to hospice payment amounts

Hospice daily payment rates for routine home care, continuous home care, inpatient respite care, and general inpatient care are updated annually by the increase in the hospital MBI. BBA 1997 reduced these updates to the market basket increase minus 1.0 percentage point for fiscal years 1998–2002. However, BBRA 1999 increased the rates otherwise in effect for fiscal year 2001 by 0.5 percentage points and for fiscal year 2002 by 0.75 percentage points.

The hospice cap amount is adjusted annually by the percentage change in the medical care component of the Consumer Price Index for All Urban Consumers (CPI–U).

Hospice program data

Table 2–18 shows that the number of hospices participating in Medicare grew from 553 in fiscal year 1988 to 2,293 in fiscal year 1998.

Total Medicare payments for hospice care in fiscal year 1988, 2 years after it became a permanent part of the Medicare Program, totaled less than $120 million. Daily payment rates in effect in 1989 were increased by 20 percent in 1990, which led to more serv-

TABLE 2–18.—NUMBER OF HOSPICES BY PROVIDER TYPE, 1988–98

Provider type	Month and year										
	7/88	7/89	5/90	9/91	1/92	5/93	8/94	6/95	10/96	12/97	12/98
Freestanding	191	220	260	394	404	499	608	656	762	875	897
Hospital based	138	182	221	282	291	341	401	447	507	559	567
Skilled nursing facility based	11	13	12	10	10	10	12	18	21	23	22
Home health agency based	213	286	313	325	334	438	583	674	800	829	807
Total	553	701	806	1,011	1,039	1,288	1,604	1,795	2,090	2,286	2,293

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

ices becoming available. As shown in table 2–19, Medicare payments for hospice care increased to $445.4 million in fiscal year 1991 and subsequently to nearly $2.2 billion in fiscal year 1998.

From fiscal year 1991 through fiscal year 1998 the number of beneficiaries using Medicare's hospice benefit increased nearly fourfold, from 108,413 to 401,140, although the average payment per beneficiary increased by less than one-third, from $4,108 to $5,412.

The data show that the average number of days of hospice utilization increased sharply from fiscal year 1991 to fiscal year 1992, reflecting the 20-percent increase in payment rates and concomitant increase in availability and utilization of this care. However, after 1995 the average duration of coverage declined. The decline may be the result of: (1) continued reluctance of physicians to refer patients to hospice rather than continue treatment; (2) the availability of new treatment therapies; and (3) increased regulatory scrutiny and focused medical reviews.

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. The 2000 conversion factor is $36.61.

The annual percentage update to the conversion factor equals the Medicare economic index (which measures inflation) subject to an adjustment to match spending for physicians services under the sustainable growth rate system. This adjustment sets the conversion factor at a level so that projected spending for a year will meet allowed spending by the end of the year. Allowed spending for a year is calculated using the sustainable growth rate. However, in no case can the conversion factor update be more than 3 percentage points above, nor more than 7 percentage points below, the Medicare economic index.

For a discussion of how Medicare calculates payments to physicians, see appendix D.

Anesthesiologists are paid under a separate fee schedule which uses base and time units. A separate conversion factor ($17.77 in 2000) 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-

TABLE 2–19.—SELECTED MEASURES OF MEDICARE HOSPICE CARE, FISCAL YEARS 1991–98

[By claim approved]

Category	Fiscal year							
	1991	1992	1993	1994	1995	1996	1997	1998
Cash outlays by provider type:								
Freestanding	$219.2	$444.2	$620.4	$724.2	$977.1	$1,042.3	$1,123.1	$1,205.7
Hospital based	92.0	168.0	205.3	226.1	319.3	331.1	345.3	373.4
Skilled nursing facility based	8.6	17.1	22.6	17.7	26.0	24.5	12.9	16.8
Home health agency based	125.7	224.3	303.7	348.7	508.1	546.1	543.0	575.1
Total	445.4	853.6	1,151.9	1,316.7	1,830.5	1,944.0	2,024.5	2,171.0
Cash outlays by care type:								
Routine home care	376.6	720.0	1,004.9	1,158.6	1,611.6	1,701.5	1,769.5	1,888.7
Continuous home care	3.9	10.4	12.2	14.5	25.6	29.2	28.5	32.1
Inpatient respite care	1.3	2.5	2.6	2.7	4.4	4.7	4.8	5.4
General inpatient care	59.7	114.0	125.5	134.1	179.1	197.6	209.5	231.7
Physician services	3.9	6.7	6.7	6.8	9.8	11.0	12.1	13.1
Total	445.4	853.6	1,151.9	1,316.7	1,830.5	1,944.0	2,024.5	2,170.9
Average dollar amount per beneficiary:								
Freestanding	4,121	5,668	6,065	6,355	6,451	6,157	5,796	5,689
Hospital based	4,234	5,296	5,361	5,631	5,740	5,333	5,028	5,129
Skilled nursing facility based	4,198	5,538	5,344	5,428	6,079	5,953	5,079	5,122
Home health agency based	3,993	5,169	5,239	5,408	5,569	5,313	4,949	5,084
Total [1]	4,108	5,452	5,681	5,935	6,049	5,747	5,402	5,412
Number of beneficiaries:								
Freestanding	53,184	78,374	102,283	113,959	151,466	169,285	193,765	211,952

TABLE 2–19.—SELECTED MEASURES OF MEDICARE HOSPICE CARE, FISCAL YEARS 1991–98—Continued

[By claim approved]

Category	Fiscal year							
	1991	1992	1993	1994	1995	1996	1997	1998
Hospital based	21,717	31,734	38,295	40,156	55,631	62,081	68,688	72,804
Skilled nursing facility based	2,040	3,084	4,221	3,262	4,272	4,124	2,547	3,288
Home health agency based	31,472	43,391	57,969	64,472	91,239	102,783	109,723	113,096
Total	108,413	156,583	202,768	221,849	302,608	338,273	374,723	401,140
Average number of days a beneficiary elects hospice care:								
Freestanding	46.2	59.1	62.0	63.7	62.9	58.5	63.4	50.8
Hospital based	44.2	54.6	53.8	55.4	56.7	51.6	47.9	44.1
Skilled nursing facility based	37.6	44.5	42.7	45.5	49.3	47.7	39.9	41.0
Home health agency based	42.5	52.6	52.2	53.3	53.8	50.0	45.9	44.0
Total [1]	44.5	56.1	57.2	58.9	58.8	54.5	50.1	47.6
Number of units by care type:								
Routine home care—days	4,667,703	8,564,904	11,324,524	12,699,617	17,257,734	17,862,843	18,189,764	18,454,749
Continuous home care—hours	199,309	442,968	565,903	654,667	1,129,697	1,193,623	1,190,982	1,303,204
Inpatient respite care—days	14,867	28,495	27,887	28,769	45,932	47,218	47,790	47,905
General inpatient care—days	161,211	297,190	303,245	299,823	418,093	451,396	470,593	502,199
Physicians—procedures	53,491	111,716	115,560	110,790	165,066	185,970	200,376	204,624

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

Note.—Totals may not add due to rounding.

Source: Health Care Financing Administration.

pocket costs other than standard deductible and coinsurance payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge, subject to limits. This process is known as balance billing.

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

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

SERVICES OF NONPHYSICIAN PRACTITIONERS

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

Physician assistants and nurse practitioners

Separate payments are made for physician assistant services, when provided under the supervision of a physician. Separate payments are also made for nurse practitioner services, provided in collaboration with a physician.

Payment for these services can only be made if no facility or other provider charges are paid in connection with the service. Payment equals 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment equals 80 percent of the lesser of either the actual charge or 85 percent of the amount that would have been recognized for a physician serving as an assistant-at-surgery. The physician assistant may be in an independent contractor relationship with the physician.

Certified nurse midwife services

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

Certified registered nurse anesthetists

Certified registered nurse anesthetists 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 certified registered nurse anesthetist are capped at 100 percent of the amount that would be paid if the an-

esthesiologist were practicing alone. The payments are evenly split between each practitioner.

Clinical psychologists and clinical social workers

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

Physical or occupational therapists

Payments for physical therapy and occupational therapy services are made under the physician fee schedule. In 1999, an annual $1,500 per-beneficiary limit applied to all outpatient physical therapy services (including speech-language pathology services), except for those furnished by a hospital outpatient department (OPD). A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital OPDs. Therapy services furnished as incident to physicians professional services were included in these limits.

The $1,500 limits were to apply each year. However, BBRA 1999 suspended application of these limits in 2000 and 2001. Thus, no limits apply in these 2 years. The limits are slated to apply again in 2002.

CLINICAL LABORATORY SERVICES

Medicare provides coverage for diagnostic clinical laboratory services. These services may be provided by an independent laboratory, a physician's office laboratory, or a hospital laboratory to outpatients. Since 1984, Medicare has paid for clinical laboratory services on the basis of a fee schedule. Fee schedules have been established on a carrier service area basis. The law set the initial payment amount for services performed in physicians' offices or independent laboratories at the 60th percentile of the prevailing charge established for the 12-month period 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 (PPS)) 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. The Balanced Budget Act (BBA) of 1997 eliminated the updates for 1998–2002. It also set the national ceiling on payment amounts at 74 percent of the median for all fee schedules for that test. BBA 1997 required the Secretary to adopt uniform coverage, administration, and payment policies for laboratory tests using a negotiated rulemaking process.

The policies would be designed to eliminate variation among carriers and to simplify administrative requirements. A proposed rule was issued March 10, 2000.

BBA 1997 also required the Secretary to divide the country into no more than five regions and designate a single carrier for each region to process laboratory claims (excluding those for services provided to inpatients of hospitals and SNFs). The allocation of claims to a particular carrier would be based on whether the carrier served the geographic area where the specimen was collected by another method selected by the Secretary. The requirement would not apply to those physicians' office laboratories that the Secretary determined would be unduly burdened by the application of billing responsibilities with respect to more than one carrier. This requirement has not been implemented.

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

Laboratories must meet the requirements of the Clinical Laboratory Improvement Act 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, under part B of the program, covers a wide variety of medical supplies if they are medically necessary and are prescribed by a physician. Under the program, durable medical equipment (DME) includes such items as hospital beds, intermittent positive pressure breathing machines, blood glucose monitors, and wheelchairs. Guidelines define DME as equipment that: (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. All of these requirements must be met before an item can be covered. The benefit also includes related supplies, such as drugs and biologicals that are necessary for the effective use of the product.

Medicare also covers prosthetic devices. These are defined as items that replace all or part of an internal body organ, such as colostomy bags, pacemakers, breast prostheses for postmastectomy patients, parental and enteral nutrients, and intraocular lenses. Prosthetics and orthotics include such items as leg, arm, back and neck braces, and artificial legs, arms, and eyes.

Reimbursement for durable medical equipment

Medicare pays for DME on the basis of a fee schedule originally established by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Under the DME fee schedule, Medicare pays the lower of either 80 percent of the item's actual charge or the fee schedule amount. For payment purposes, covered DME items are classified into five groups: (1) inexpensive or routinely purchased

DME (defined as equipment that costs less than $150, or 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 DME (frequently referred to as the "capped rental" category); and (5) oxygen and oxygen equipment. Some items that do not meet the definition of DME, such as disposable surgical dressings, are also covered under the fee schedule.

In general, the fee schedule payment rates for DME are determined locally (on a statewide basis). However, these local payments are subject to floor and ceiling limits determined nationally. Medicare will not pay less than 85 percent of the median of all local payment amounts (floor), and will not pay more than 100 percent of this median (ceiling).

Prosthetics and orthotics are also paid according to a fee schedule similar to the DME fee schedule. The payment rates are determined regionally and are subject to national limits which also have ceilings and floors. The floor is 90 percent of the weighted average of all regional payment amounts, and the ceiling is 120 percent of this weighted average.

The fee schedules are generally updated annually by the CPI–U. However, BBA 1997 froze payments for DME at the 1997 level for fiscal years 1998–2002. For oxygen and oxygen equipment, BBA 1997 reduced payment limits beginning in fiscal year 1999 to 70 percent of 1997 levels. The update for prosthetics and orthotics was limited to 1.0 percent through fiscal year 2002. The Balanced Budget Refinement Act (BBRA) of 1999 amended this provision as it related to DME (including oxygen), allowing an update for fiscal year 2001 equal to 0.3 percent over fiscal year 2000 levels; for fiscal year 2002 the update is 0.6 percent over fiscal year 2000 levels. Prosthetics and orthotics updates were not affected by BBRA 1999.

Medicare pays for a few items of medical equipment on a reasonable cost basis, rather than under the fee schedule. These include splints, casts, home dialysis equipment, therapeutic shoes, and blood products. BBA 1997 authorized the Secretary to establish fee schedules for these items; regulations were proposed in July 1999.

Table 2–20 shows total Medicare spending in calendar year 1998 for DME, prosthetics and orthotics, and certain other items.

Inherent reasonableness authority.—If the Secretary determines that using standard procedures to calculate payment for an item under the fee schedule results in an amount which is "grossly excessive or grossly deficient and not inherently reasonable," the Secretary is authorized to increase or decrease the payment amount accordingly. The authority to make these adjustments is generally referred to as the inherent reasonableness authority. It involves a complex procedure of investigation, commentary, and notification.

BBA 1997 sought to simplify the procedure and widen the application of this authority, requiring HCFA to publish criteria for determining if a fee schedule charge was inherently unreasonable, and the factors to be used in determining charges that are realistic and equitable. Using these criteria, the Secretary would be permitted to adjust payment levels. HCFA published interim final regulations (63 *Federal Register* 687, January 7, 1998) naming criteria

such as competitiveness in a particular marketplace, changes in technology or supplier costs, and amounts paid by other purchasers in the same area. However, industry voiced concerns about how use of this authority might affect prices and beneficiary access to services. As a result, in BBRA 1999, Congress prohibited use of the inherent reasonableness authority until the GAO reports on how the authority is used.

TABLE 2–20.—MEDICARE SPENDING FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND CERTAIN OTHER ITEMS, CALENDAR YEAR 1998

[In millions of dollars]

Category	Medicare spending
Inexpensive/routinely purchased [1]	$633.9
Items with frequent maintenance [2]	168.1
Customized items [3]	43.5
Capped rental [4]	1,102.3
Oxygen [5]	1,621.3
Prosthetics/orthotics [6]	937.5
Surgical dressings	54.3
Supplies/accessories	64.6
Parenteral/enteral nutrients	803.0
Other	8.0
Total	5,436.6

[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 paid 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).

Source: Health Care Financing Administration, Office of Information Services. Data from the Division of Information Distribution.

Administering the DME benefit

HCFA enters into contracts with insurance companies known as carriers under part B of Medicare, to administer the program, i.e., to process claims and make payments. In the case of DME, administration is centralized in four regional carriers (known as DME regional carriers, or DMERCs) who are responsible for processing claims for all beneficiaries living within their areas. As a result of the consolidation, which occurred in 1992, variation in coverage policy and utilization patterns has been reduced.

Suppliers provide Medicare beneficiaries with medical equipment and bill the regional carrier in their area. Most suppliers are small

entities located in areas where the demand is greatest. Before being issued a Medicare supplier number, suppliers must comply with various standards. These include maintaining a physical location, filling orders from their own inventories or under contract with another company, being responsible for deliveries to beneficiaries and honoring all product warranties, and providing proof of appropriate liability insurance. BBA 1997 required that suppliers provide a $50,000 surety bond issued by a company approved by the Treasury Department. Although regulations have been proposed for this requirement, they have not been finalized.

Competitive bidding

Investigations have shown that Medicare pays higher prices for certain medical supplies than those paid by other health care insurers and other government agencies, including the Department of Veterans Affairs. In order to lower payments, the Secretary currently must initiate the inherent reasonableness process or rely on legislation. Many observers suggested granting HCFA the authority to engage in a competitive bidding arrangement similar to the one used by the Department of Veterans Affairs. BBA 1997 provided such authority on a limited basis. HCFA was authorized to establish five 3-year competitive bidding demonstration projects.

With the demonstration projects, HCFA intends to test how effective competitive bidding is for the Medicare Program. Goals for the projects are to maintain beneficiary access to services and limit their out-of-pocket expenses while lowering Medicare's payment for medical equipment. The projects will also prevent Medicare from dealing with suppliers who engage in fraudulent business practices.

The first demonstration project site selected was in Polk County, FL. Beginning in 1999, suppliers submitted bids to HCFA, competing for the right to supply certain medical equipment to the 92,000 Medicare beneficiaries in the area. Bids were evaluated on the basis of quality and price. To maintain beneficiary access to the medical equipment, HCFA named between 4 and 13 companies for each item. HCFA expects that savings will average 17 percent on medical equipment overall, and will be as high as 30 percent for some products.

A second demonstration project is expected to begin in January 2001 in the San Antonio area of Texas. The project, involving about 112,000 Medicare beneficiaries, will be similar to the Polk County project, although different products will be involved. In 1998, Medicare paid an average of $287 per beneficiary in the San Antonio area for medical equipment.

HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Hospital outpatient department (OPD) services for Medicare beneficiaries are paid under Medicare part B. Services provided in OPDs include: (1) emergency room and clinic services; (2) surgery and operating rooms; (3) laboratory and pharmacy services; (4) physical therapy and rehabilitation services; (5) DME; and (6) chemotherapy and radiation therapy. OPDs also provide diagnostic and preventive procedures such as radiology, computer axial tomography (CAT) scans, magnetic resonance imaging, endoscopies, and colonoscopies.

Table 2–21 shows the percent distribution of hospital OPD charges by type of service provided to Medicare beneficiaries in 1998. For example, it shows that, of the $50.6 billion in hospital outpatient charges (table 2–22) for Medicare beneficiaries, 20.6 percent were for radiology services, 12.8 percent were for laboratory services, and so forth.

TABLE 2–21.—PERCENT DISTRIBUTION OF HOSPITAL OUTPATIENT DEPARTMENT CHARGES UNDER MEDICARE, BY TYPE OF SERVICE, 1998

Service	OPD charges
Radiology	20.6
Laboratory	12.8
Operating room	11.4
End-stage renal disease	6.6
Pharmacy	6.1
Emergency room	3.3
Clinic	1.6
Rehabilitation	2.7
Medical/surgical supplies	9.1
All other [1]	25.9
Total	100.0

[1] Includes computerized axial tomography, durable medical equipment, blood, and so forth.

Note.—Total may not add due to rounding.

Source: Health Care Financing Administration.

TABLE 2–22.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974–98

Type of enrollment and year of service	Number of SMI [1] enrollees (in thousands)	Charges for covered services (in thousands)	Program payments		
			Amount (in thousands)	Per enrollee	Percent of covered 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	316	34.2

TABLE 2–22.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974–98—Continued

Type of enrollment and year of service	Number of SMI [1] enrollees (in thousands)	Charges for covered services (in thousands)	Program payments		
			Amount (in thousands)	Per enrollee	Percent of covered charges
1994	35,178,600	36,323,649	11,813,522	336	32.6
1995 [2]	31,806,740	40,476,180	12,933,358	407	31.9
1996	31,775,280	44,564,665	13,896,048	437	31.2
1997	31,022,040	47,888,129	14,382,561	464	30.0
1998	30,304,340	50,607,564	14,212,983	469	28.1
Average annual rate of growth:					
1974–98	1.1	20.9	17.1	15.8	NA
1974–84	2.4	25.4	26.5	23.4	NA
1984–98	0.2	17.8	10.8	10.6	NA
Aged:					
1974	21,421,545	394,680	220,742	10	55.9
1976	22,445,911	704,569	432,971	19	61.5
1978	23,530,893	1,005,467	648,249	28	64.5
1980	24,680,432	1,517,183	1,030,896	42	69.9
1982	25,706,792	2,402,462	1,645,064	64	68.5
1983	26,292,124	2,995,784	2,066,207	79	69.0
1984	26,764,150	4,122,859	2,679,571	100	65.0
1985	27,310,894	5,210,762	3,211,744	118	61.6
1986	27,862,737	6,529,273	3,809,992	137	58.4
1987	28,382,203	7,859,038	4,522,841	159	56.4
1988	28,780,154	9,790,273	5,098,546	177	52.1
1989	29,216,027	11,855,127	5,767,589	197	48.7
1990	29,691,180	15,384,510	6,563,454	221	42.7
1991	30,183,480	18,460,835	6,842,329	227	37.1
1992	30,722,080	22,253,657	7,741,774	252	34.8
1993	31,162,480	26,556,415	8,522,089	273	32.1
1994	31,443,800	29,768,892	9,116,610	290	30.6
1995 [2]	28,020,760	33,110,441	9,900,199	353	29.9
1996	27,849,640	36,099,678	10,542,937	379	29.2
1997	27,046,120	38,728,484	10,861,323	402	28.0
1998	26,243,140	41,945,972	10,681,369	407	26.0
Average annual rate of growth:					
1974–98	0.8	21.5	17.5	16.7	NA
1974–84	2.3	26.4	28.4	25.9	NA
1984–98	−0.1	18.0	10.4	10.5	NA
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

TABLE 2–22.—MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENTS BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED, SELECTED YEARS 1974–98—Continued

Type of enrollment and year of service	Number of SMI [1] enrollees (in thousands)	Charges for covered services (in thousands)	Program payments		
			Amount (in thousands)	Per enrollee	Percent of covered charges
1982	2,705,490	762,068	558,195	206	73.2
1983	2,682,411	817,335	595,187	222	72.8
1984	2,651,247	1,006,351	707,575	267	70.3
1985	2,677,869	1,270,015	870,560	325	68.5
1986	2,726,991	1,586,703	1,071,613	393	67.5
1987	2,787,757	1,773,664	1,167,945	417	65.8
1988	2,836,928	2,043,646	1,273,158	449	62.3
1989	2,882,743	2,340,124	1,392,897	483	59.5
1990	2,944,620	2,961,961	1,607,634	546	54.3
1991	3,056,360	3,555,838	1,769,991	579	49.8
1992	3,234,380	4,545,843	2,199,617	680	48.4
1993	3,480,020	5,470,161	2,416,456	694	44.2
1994	3,734,800	6,463,757	2,696,912	722	41.7
1995 [2]	3,785,980	7,465,739	3,033,158	801	40.6
1996	3,925,640	8,464,987	3,353,211	854	39.6
1997	3,975,920	9,159,645	3,521,238	886	38.4
1998	4,061,200	9,561,592	3,531,614	870	36.9
Average annual rate of growth:					
1974–98	3.6	19.2	15.9	11.9	NA
1974–84	4.6	27.4	26.4	20.9	NA
1984–98	3.1	17.4	12.2	8.8	NA

[1] 1974 is the first full year of coverage for disabled beneficiaries under Medicare.
[2] Beginning in 1995, Medicare enrollees in managed care plans are not included in the data.

NA—Not applicable.

Source: Health Care Financing Administration, Office of Strategic Planning.

Background

In the early years of the Medicare Program, Medicare paid for both inpatient and outpatient hospital care based on a hospital's reasonable costs attributable to caring for Medicare beneficiaries. These were retrospective payment systems, meaning payment for the costs incurred in providing care was determined and made after the service was rendered.

Payment systems for hospital inpatient care and outpatient services were separated in 1983 when a new prospective system was implemented for inpatient care. Under that arrangement, a hospital receives a fixed payment, known in advance of providing care, covering all care and services required by a patient during a hospital stay (exclusive of physician fees) and determined by the diagnosis-related group (DRG) into which the patient is classified at admission. However, outpatient services remained under the costs-or-charges retrospective payment arrangement.

Throughout the 1980s, Medicare payments for hospital outpatient services grew as the volume of services provided in that setting increased. Although growth in the Medicare population contributed to increased utilization of outpatient care, a substantial share of the growth in the volume of outpatient services is attributable to advances in medicine and technology that permit procedures formerly restricted to the inpatient hospital setting to be provided safely on an outpatient basis. Implementation in 1983 of the inpatient PPS, which included aggressive management of inpatient utilization, also led to a shift in care from hospital inpatient to outpatient departments. Currently, on average, outpatient services generate about half of all hospital revenues.

Since the early 1980s, Medicare's payments for OPD services have grown for reasons other than increased volume, and that growth is often attributed to the lack of incentives for efficiency or cost control inherent in the retrospective cost-based payment system. Congress sought to contain the rate of increase in Medicare payments for certain outpatient services by requiring implementation of "fee schedules" (a form of PPS) to pay for those services. For example, Congress required HCFA to establish fee schedules for many outpatient diagnostic procedures and tests; provision of orthotics, prosthetics, and other DME; dialysis for persons with end-stage renal disease (ESRD); and surgeries that might also take place in another outpatient setting such as ambulatory surgical centers (ASCs). These fee schedules save Medicare money because the amounts paid are generally less than payments under retrospective cost reimbursement systems.

In the Omnibus Budget Reconciliation Acts of 1986 and 1990, Congress directed the Secretary of the U.S. Department of Health and Human Services (DHHS) to develop a PPS for all hospital OPD care. In addition, to achieve more immediate savings, legislation required across-the-board reductions in Medicare payments for hospital operating costs and capital costs (including those associated with outpatient care) starting in 1990.

Although Medicare currently uses fee schedules for some OPD services, payment for other OPD services have remained under the retrospective costs-or-charges system, resulting in an extremely complex set of payment rules. For instance, payments for OPD services such as clinic and emergency room visits have been paid based on the lesser of hospital costs or charges. Certain surgeries carried out in OPDs, but which are also approved by Medicare to be provided in ASCs are paid the lower of costs, charges, or a blended payment that incorporates the ASC fee schedule amount (again, excluding physician charges). Payment for costs for certain radiology services and diagnostic procedures are based on a blended payment that includes, in part, the Medicare fee schedule for physician services. To add to the complexity, blended payment calculations may vary among different types of hospitals. Some OPD services are paid for exclusively according to a fee schedule (e.g., laboratory tests, physical therapy, prosthetics and orthotics, mammography screening, and some surgical dressings and supplies). Kidney dialysis services, which are often provided in specialized dialysis centers to which a PPS applies, are also paid under the dialysis PPS if provided in an OPD.

Beneficiary and hospital overpayment issues

The complex arrangements under which Medicare's payments for OPD care have been determined has meant that, often, the final Medicare approved payment amount is not known until a hospital's annual cost reports are settled with Medicare, which might be long after services to any individual beneficiary are rendered. However, the Social Security Act permits providers to charge Medicare beneficiaries 20 percent of the reasonable and customary charges for part B-covered services. In the case of OPD services for which payment is based on the blended rate formula, the amount Medicare eventually would approve for the service might be considerably less than the hospital's charge. Thus, hospital OPDs have often billed beneficiaries at the time of service for 20 percent of charges rather than 20 percent of the amount computed and approved under Medicare's formulas. As a result, beneficiaries are "overcharged," sometimes paying as much as 50 percent of the Medicare approved amount. The Medicare Payment Advisory Commission reported in 1999 that beneficiary coinsurance for OPD care represented about 47 percent of the total Medicare payment hospitals received for outpatient services. "Medigap" insurance policies, which Medicare beneficiaries may purchase to pay Medicare's deductibles, copayments and coinsurance, relieve policyholders from these high charges, but the insurance industry has noted that the prices of their policies reflect such overcharges.

When Medicare paid for hospital outpatient services under the blended rate formula, the program's share of the payment to the hospital was computed as if the beneficiary had paid only 20 percent of the Medicare approved amount, including the limited fee schedule payment, instead of 20 percent of the hospital's charges, which generally disregarded the limitations of a fee schedule. Thus, the Medicare formula that assumed the beneficiary had paid a lesser amount resulted in a larger Medicare payment, and, consequently, hospitals were "overpaid" by Medicare. This hospital overpayment situation was referred to as the "formula-driven overpayment."

The Balanced Budget Act (BBA) of 1997

Despite implementation of certain fee schedules and across-the-board reductions in payments, Medicare payments to hospital OPDs rose at an annual rate of over 12 percent from 1983 to 1997 and increased from 7 percent to 20 percent as a share of all Medicare payments to hospitals. Many saw the patchwork payment arrangements for OPD care as fraught with disincentives for hospitals to provide care efficiently. Congress responded to these cost issues in BBA 1997. In order to end the complex and inequitable retrospective cost and charge-based reimbursement system, the law directed the Secretary of DHHS to implement the OPD PPS in 1999. It eliminated the formula-driven overpayment, effective at the start of fiscal year 1998, a move that resulted in an almost immediate reduction in Medicare payments to hospitals for those OPD services for which Medicare payments duplicated beneficiary payments. BBA 1997 also extended the across-the-board reductions of 5.8 percent for operating costs and 10 percent for capital costs through 1999.

BBA 1997 established a procedure to bring beneficiary cost sharing for OPD services gradually into line at 20 percent of Medicare approved amounts by "freezing" the dollar amount hospitals may charge beneficiaries at 20 percent of the median of all hospital outpatient charges per procedure in 1996, updated to the time of implementation of the PPS. Thus, over time, as Medicare's payments under the new PPS rise according to an indexing formula, the "frozen" dollar amounts hospitals may charge beneficiaries will come to equal 20 percent of Medicare's PPS payments, and Medicare's payment will be 80 percent of the full amount approved under the new system. However, for those services for which the spread between the median charge and the PPS approved amount is large, it could take many years before the beneficiary copayment is 20 percent of the amount specified in the PPS. The law allows hospitals voluntarily to limit beneficiary copayments to 20 percent and to disseminate information regarding their reduced beneficiary charges.

On September 8, 1998, HCFA published proposed OPD PPS regulations for comment. Although the new PPS was then scheduled for implementation in 1999, HCFA delayed implementation until after the start of the year 2000 in order to accommodate resolution of "Y2K" data processing problems. HCFA extended the public comment period on the proposed regulations through July 30, 1999, and published final rules on April 7, 2000. Implementation began August 1, 2000.

Design and implementation of the outpatient department PPS

Under the hospital outpatient PPS included in final rules published by HCFA, individual OPD services that are similar clinically and also in terms of resource utilization are arranged into groups according to an ambulatory payment classification (APC) system. The system includes 451 payment groups. A payment amount is established for each group and is the same for each service in the group. The payments cover hospital facility and nonphysician personnel costs. The labor component of a payment is adjusted to reflect regional variations.

Services delivered in an OPD that are already covered by a PPS or fee schedule are excluded from the OPD PPS, but will continue to be paid under the existing applicable system. The OPD PPS does not apply for outpatient services provided to patients receiving services under part A in a skilled nursing facility (SNF) when the service is part of a patient's SNF plan of care and which is furnished by the hospital under an arrangement with the SNF.

Hospitals excluded from the outpatient PPS altogether include certain facilities in Maryland that are paid under a special State program and critical access hospitals that are paid under a reasonable cost-based system according to rules in the Social Security Act.

Balanced Budget Refinement Act (BBRA) of 1999

The proposed PPS regulations promulgated on September 8, 1998, raised concerns about the adequacy of the payments under that system for certain kinds of services, patients, and hospitals. As a result, in BBRA 1999 (Public Law 106–113, November 19, 1999), Congress legislated several major changes to Medicare pay-

ments under the hospital OPD PPS. The BBRA 1999: (1) requires the Secretary of DHHS to provide payments (within specified limits, and on a budget neutral basis) over and above PPS payments for certain high cost ("outlier") patients; (2) as a transition to the PPS, for 2–3 years, on a budget neutral basis, requires the Secretary of DHHS to provide "passthrough payments" to hospital OPDs above and beyond PPS payments for costs of certain "current innovative" and "new, high cost" devices, drugs, and biologicals; (3) limits the cost range of items or services that are included in any one PPS payment category so that the highest median (or mean) cost of an item or service in the group cannot be more than two times higher than the lowest median (or mean) cost for an item or service within the group; (4) requires the Secretary of DHHS to review the PPS groups and amounts annually and to update them as necessary; (5) as a transition to the PPS, through 2003, establishes "transitional corridors" which phase in reductions in aggregate Medicare payments individual hospitals experience due to the PPS; (6) provides special "hold harmless" payments until January 1, 2004, for small, rural hospitals to ensure that they receive no less under the outpatient PPS than they would have received in aggregate under the "pre-BBA" system and provides the same protection permanently for cancer hospitals; (7) caps beneficiary copayments for OPD care at the amount of the beneficiary deductible for inpatient care ($776 in 2000, and indexed for subsequent years); (8) requires that the pre-PPS payment base used as the budget neutrality benchmark for Medicare spending under the PPS include beneficiary coinsurance amounts as paid under the pre-PPS system (i.e., 20 percent of hospital charges); (9) requires coverage of the cost of implantable items; (10) allows the Secretary of DHHS to use either the mean or the median of hospital costs when establishing weights that determine payment amounts under the PPS; (11) extends across-the-board reductions to payments for hospital operating costs and capital costs until implementation of the PPS; (12) allows reclassification of certain hospitals as urban or rural.

The "budget neutral" requirement applicable to some of these changes means that the total cost of the Medicare Program is to be the same with the change as it would have been without the change. Thus, program cost increases would require payment adjustments elsewhere to offset those increases.

According to HCFA data, on average, hospitals would receive 4.6 percent more in payments under the new outpatient PPS, including the BBRA 1999 changes, than under the retrospective cost-based system.

On December 8, 1999, the Congressional Budget Office (CBO) estimated that the provisions of BBRA 1999 applicable to Medicare OPD payments would add $11.2 billion in payments to hospitals over the period fiscal years 2000–2009.

Medicare payments to outpatient departments

Table 2–22 summarizes the history of Medicare payments for hospital outpatient services from 1974 through 1998. (Starting in 1995, the data include only beneficiaries enrolled in traditional fee-for-service Medicare and exclude those who elected to enroll in a managed care plan.) The total number of beneficiaries enrolled in

part B grew by about 31 percent during this time period, at an average annual rate of about 1 percent, although disability caseload growth rates were higher than the rate of increase of elderly beneficiaries. The table documents the dramatic increase in hospital outpatient utilization and Medicare payments for OPD services since the early 1980s. Medicare payments increased 44-fold, from $323 million in 1974 to $14.2 billion in 1998, with annual rates of increase averaging as high as 26.5 percent from 1974 to 1984. The substantial rates of increase in OPD payments per part B enrollee (from $14 in 1974 to $469 in 1998) reflect the increase in the volume of services provided in OPDs as well as growth in payments for those services under the retrospective cost-based payment system.

Since 1983, hospital charges for OPD care for Medicare beneficiaries increased by 17.8 percent per year, on average. Medicare's payments for OPD services increased by 10.8 percent per year during that time period (table 2–22). The table shows that Medicare's payments as a percent of hospital charges for Medicare-covered OPD services has declined from nearly 70 percent in 1983 to 28.1 percent in 1998. This declining ratio reflects primarily the high rates of increase in hospital charges and, to a lesser extent, limits on the rate of increase in Medicare's payments for OPD services due to fee schedules and blended payment formulas. It also reflects the increasing share of charges billed to beneficiaries. Payment systems under Medicare have included incentives for hospitals to increase their OPD charges. For example, since implementation in 1983 of the PPS for hospital inpatient care, some hospitals have shifted costs and charges from inpatient accounts to OPD accounts because they receive higher payments from Medicare under the outpatient payment formulas. In addition, because hospitals have routinely billed Medicare beneficiaries (or their Medigap plan) for 20 percent of charges, higher charges generate greater revenues from beneficiaries.

AMBULATORY SURGICAL CENTER SERVICES

Services provided in an ambulatory surgical center (ASC) are paid under Medicare part B. An ASC is a facility where surgeries that do not require an inpatient hospital admission are performed. ASCs treat only patients who have already seen a health care provider and for whom surgery has been selected as an appropriate treatment. All ASCs must have at least one dedicated operating room and the equipment needed to perform surgery safely and to provide for recovery from anesthesia. Patients electing to have surgery in an ASC arrive for a scheduled appointment on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff before leaving for home.

Medicare began covering ASC services in 1982 as a way to reduce costs for surgeries generally carried out on a hospital inpatient basis but that could be performed safely in a less costly outpatient setting. ASCs must meet certain conditions specified by Medicare in order to participate in the program. Some ASCs limit services to one type of surgery, such as ophthalmology, and others provide a variety of procedures, including gastroenterological, orthopedic, pain block, urology, podiatry, and ear, nose, and throat

procedures. About half of all ASC procedures provided under Medicare in 1999 were related to cataracts or other types of eye surgery.

Currently, over 2,500 procedures are included on the Medicare-approved list of ASC procedures. HCFA determines which procedures will constitute the ASC list on the basis of certain criteria related to the safety, appropriateness, and effectiveness of performing the procedure in an ASC setting.

Table 2–23 shows the procedures most often carried out for Medicare beneficiaries in ASCs in 1999, the volume of those procedures for Medicare beneficiaries, and Medicare's total payments per procedure in that year.

TABLE 2–23.—AMBULATORY SURGICAL CENTER UTILIZATION BY MEDICARE BENEFICIARIES IN 1999: INCIDENCE OF HIGH VOLUME PROCEDURES AND MEDICARE PAYMENTS

Current procedural terminology code	Short descriptor	Volume of Medicare cases	Medicare payments (in thousands)
66984	Remove cataract, insert lens	688,700	$689,700
66821	After cataract laser surgery	208,342	208,342
43239	Upper GI endoscopy, biopsy	133,783	39,791
45378	Diagnostic colonoscopy	114,330	37,283
45385	Colonoscopy, lesion removal	74,883	24,210
45380	Colonoscopy and biopsy	58,143	18,321
45384	Colonoscopy	41,948	12,985
52000	Cystourethroscopy	35,359	8,348
43235	Upper GI endoscopy, diagnosis	33,685	7,057
43248	Upper GI endoscopy, guidewire	16,029	4,824

Note.—Data for calendar year 1999 are preliminary and are about 95 percent complete.

Source: Health Care Financing Administration.

Payment for ambulatory surgical centers

From the start of Medicare coverage of ASC services, Medicare-based payments on a prospective payment fee schedule. This system was one of the first applications of a fee schedule for outpatient, or ambulatory, care.

The two primary cost components of a surgical procedure are the physician's (or practitioner's) professional fees for performing the procedure and the costs associated with services furnished by the facility where the surgery is performed. Medicare pays ASCs for facility and nonphysician personnel costs incurred in connection with performing specific surgical procedures. Payments are based on "reasonable overhead allowances." For example, items included among those covered by the allowances are nursing and technician services; supplies; drugs and biologicals; surgical dressings; housekeeping services; and use of the facility. As with other Medicare services, physician and certain practitioner fees are paid under a separate system.

The Medicare-approved ASC procedures (about 2,500 procedures) are consolidated into 8 payment groupings, each of which has 1 payment amount; that amount is adjusted for different geographic

regions using the hospital wage index. After a beneficiary meets the part B annual deductible, Medicare pays ASCs 80 percent of the prospectively determined rate, and the beneficiary is responsible for 20 percent. In addition, Medicare and the beneficiary pay the physician or surgeon separately, with Medicare paying 80 percent of the approved amount under the physician fee schedule and the beneficiary being responsible for 20 percent.

Growth in services

At the end of 1983, 1 year after Medicare began coverage of ASC care, 239 ASCs were approved to provide services for beneficiaries. Use of ASCs grew rapidly, and, at the end of 1998, over 2,300 facilities participated in Medicare. From 1993 through 1998, the volume of Medicare-covered ASC services provided grew from 1.06 million to 1.9 million. Medicare payments to ASCs increased at an average of 12.8 percent per year, from $495 million in 1993 to $902 million in 1998. Table 2–24 shows the annual volume of ASC services and Medicare payments since 1993. Note that calendar year 1999 data do not include a full year of payments.

TABLE 2–24.—AMBULATORY SURGICAL CENTERS: UTILIZATION AND MEDICARE PAYMENTS, 1993–99

Year	Number of services	Medicare payments to ASCs
1993	1,059,644	$495,313,388
1994	1,298,740	572,001,981
1995	1,499,866	664,437,432
1996	1,655,538	743,098,264
1997	1,827,410	832,846,641
1998	2,012,271	902,920,576
1999	1,921,356	898,137,203
Average annual increase 1993–98		12.8 percent

Note.—Calendar year 1999 data are preliminary and are about 95 percent complete.

Source: Health Care Financing Administration.

Starting January 1, 1995, the Secretary of DHHS has been required to update ASC rates every 5 years based on a survey of the actual audited costs incurred by a representative sample of ASCs for a representative sample of procedures, and to increase annual payments in the intervening years by the Consumer Price Index for All Urban Consumers (CPI–U). However, for fiscal years 1998–2002, BBA 1997 reduced the annual update to the CPI–U increase minus 2 percentage points. Because the fiscal year 1999 adjustment would have been very small, HCFA made no adjustment for that year.

Effective October 1, 1999 (for fiscal year 2000), payments for the eight categories into which all ASC procedures are grouped were updated by the CPI–U increase minus 2 percentage points. The increase was 0.8 percent. As of October 1, 1999, the base rates (prior to geographic adjustments) are:

Group 1 ...	$317	Group 5 ...	683
Group 2 ...	425	Group 6 ...	644 + 150 for an intraocular lens
Group 3 ...	486	Group 7 ...	949
Group 4 ...	600	Group 8 ...	784 + 150 for an intraocular lens
Group 5 ...	683		

Proposed changes to ASC Medicare payments

On June 12, 1998, HCFA issued proposed rules which would make major changes in Medicare payments to ASCs. The major changes include replacing the eight payment groupings with an APC system comprised of 105 payment groups; updating underlying cost data using 1994 survey data updated to the present; and making additions to and deletions from the list of Medicare covered ASC procedures. Payments would range from $53 to $2,107 and would be updated by the CPI–U annually on a calendar year basis. As of this writing, HCFA had received extensive comments on the proposed new APC groups and payments and estimates that final rules will be published in November 2000 for implementation in April 2001.

Some surgical procedures approved for ASCs are also performed in hospital outpatient departments (OPDs). In designing the new OPD prospective payment system (PPS) and the new APC groups for ASC procedures, HCFA aimed to keep the grouping of surgical procedures comparable.

BBRA 1999 did not address ASC payment rates, the APC system, or update procedures. However, it requires that, if the Secretary implements new rates based on the 1994 data (or any rates based on pre-99 Medicare cost survey data), those new rates must be phased in by basing payments one-third on the new rates in the first year, two-thirds in the second year, and fully in the third year.

OTHER PART B SERVICES

Preventive services

Screening mammograms.—Medicare covers an annual screening mammography for all women over age 40. 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 2000 limit is $67.81.

Screening Pap smears; pelvic exams.—Medicare authorizes coverage for a screening Pap smear and a screening pelvic exam once every 3 years; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule (see above). BBRA 1999 requires a minimum payment of $14.60 for Pap tests furnished in 2000.

Prostate cancer screening tests.—BBA 1997 authorized coverage, beginning January 1, 2000, for an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) after 2002, such other proce-

dures as the Secretary finds appropriate for the purpose of early detection of prostate cancer.

Colorectal screening.—BBA 1997 authorized coverage of and established frequency limits for colorectal cancer screening tests, effective January 1, 1998. A covered test is any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than one every 4 years); (3) screening colonoscopy for high-risk individuals (limited to one every 2 years); and (4) such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer. Payment limits are established for the tests.

BBA 1997 required the Secretary, within 90 days of enactment, to publish a determination on the coverage of screening barium enema. The Secretary determined that barium enema tests, as an alternative to either a screening flexible sigmoidoscopy or a screening colonoscopy, are to be covered in accordance with the same screening parameters specified for those tests.

Diabetes screening tests.—Medicare's covered benefits include diabetes outpatient self-management training services. These services are defined as including educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting. They are covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of their own condition. Certified providers for these purposes are defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers must meet quality standards established by the Secretary. They are deemed to meet the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations that participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services.

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

Bone mass measurements.—Bone mass measurement is covered for the following high risk persons: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess osteoporosis drug therapy. The Secretary is required to establish frequency limits.

Drugs/vaccines

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

—*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 (HHA). 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. Also covered are oral antinausea drugs used as part of an anticancer chemotherapeutic regimen, subject to specified conditions.

Medicare also covers immunosuppressive drugs (such as cyclosporin) for 36 months following a covered organ transplant. BBRA 1999 provides for a temporary extension of the 36-month limit on immunosuppressive drugs for persons otherwise exhausting their coverage in 2000–2004. In each calendar year, there will be an extension specified by the Secretary (as the number of months or partial months), applicable to persons who exhaust their benefits in that calendar year. The increase for persons exhausting their benefits in 2000 is 8 months. The minimum increase for persons exhausting their benefits in 2001 is 8 months.

By May 1, 2001, the Secretary may increase the number of months for the cohort exhausting their benefits in 2001. At the same time, the Secretary is also required to announce the additional months of benefits that will be available for the cohort exhausting their benefits in 2002. Similarly by May 1, 2002 and 2003, the Secretary is required to announce the number of months that will apply to the cohort exhausting their benefits in the following year. Total expenditures over the 5-year period are limited to $150 million.

Medicare payment for drugs (not made on a cost or prospective payment basis) equals 95 percent of the average wholesale price. The Secretary is authorized to pay a dispensing fee to pharmacies. A special payment limit ($10 per 1,000 units) applies for EPO.

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

Ambulance services

Medicare pays for ambulance services provided certain conditions are met. The services must be medically necessary and other methods of transportation must be contraindicated. Ambulance services are currently paid on the basis of reasonable costs when such services are provided by a hospital; otherwise the payment is based on reasonable charge screens developed by individual carriers based on local billings (which may take a variety of forms). Based on

these local billing methods, carriers develop screens for one or more of the following four main billing methods: (1) a single all inclusive charge reflecting all services, supplies, and mileage; (2) one charge reflecting all services and supplies, with separate charge for mileage; (3) one charge for all services and mileage, with separate charges for supplies; and (4) separate charges for services, mileage, and supplies. Within each broad payment method, additional distinctions are made based on whether the service is basic life support service or advanced life support, whether emergency or nonemergency transport was used, and whether specialized advanced life services were rendered.

The Balanced Budget Act (BBA) of 1997 specified that the reasonable cost and charge limits would apply through 1999, with annual increases equal to the Consumer Price Index (CPI) minus 1.0 percentage point. A fee schedule was to be implemented in 2000. The aggregate amount of payments in 2000 could not exceed what would be paid if the interim reductions remained in effect in that year. Annual increases in subsequent years would equal the CPI increase, except that in 2001 and 2002 there would be a 1.0-percentage point reduction. Implementation of the fee schedule has been delayed until at least 2001.

END-STAGE RENAL DISEASE SERVICES

COVERAGE

Medicare's End-Stage Renal Disease (ESRD) Program established in the Social Security Amendments of 1972, covers individuals who suffer from ESRD if they are: (1) fully insured for Old-Age and Survivors 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 ESRD and must file an application for benefits.

Benefits for qualified ESRD 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. Medicare+Choice (M+C) plans may provide ESRD benefits to the Medicare beneficiary who has been enrolled in an M+C organization and subsequently develops ESRD. However, beneficiaries with ESRD cannot enroll in an M+C plan.

Table 2–25 shows expenditures, number of beneficiaries, and the average expenditure per person for all persons with ESRD (including the aged and disabled) from 1974 through 2005. Total projected program expenditures for the Medicare ESRD Program for fiscal year 2000 are estimated at $10.7 billion. In fiscal year 2000, there are an estimated 320,005 beneficiaries, including successful transplant patients and persons entitled to Medicare on the basis of disability who also have ESRD.

TABLE 2–25.—END-STAGE RENAL DISEASE MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES, 1974–2005

Fiscal year	Expenditures (HI & SMI) in millions of dollars	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	54,725	22,750
1981	1,464	61,487	23,810
1982	1,640	69,267	23,676
1983	1,984	78,361	25,319
1984	2,325	87,609	26,538
1985	2,835	96,965	29,237
1986	3,165	106,568	29,699
1987	3,490	117,020	29,824
1988	3,998	128,075	31,216
1989	4,653	140,324	33,159
1990	5,251	154,575	33,971
1991	5,634	170,718	33,003
1992	6,115	182,826	33,445
1993	7,059	201,168	35,091
1994	7,902	220,972	35,758
1995	8,751	239,056	36,608
1996	9,634	256,096	37,620
1997	9,841	271,880	36,198
1998	9,943	287,589	34,573
1999	9,880	303,476	32,557
2000	10,748	320,005	33,585
2001	11,580	337,351	34,327
2002	12,316	355,488	34,645
2003	13,257	374,769	35,374
2004	14,242	395,953	35,969
2005	15,351	415,597	36,938

Note.—Estimates for 1982–2005 are subject to revision by the Office of the Actuary, Office of Medicare and Medicaid Cost Estimates; projections for 1998–2005 are under the fiscal year 1996 budget assumptions.

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

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

Table 2–26 shows that new enrollment for all Medicare beneficiaries receiving ESRD services grew at an average annual rate of 4.6 percent from 1992 to 1998. Most of the growth in program participation is attributable to growth in the numbers of elderly people receiving services and growth in the numbers of more seriously ill people entering treatment. Table 2–26 shows the greatest

TABLE 2–26.—MEDICARE END-STAGE RENAL DISEASE PROGRAM INCIDENCE BY AGE, SEX, RACE, AND PRIMARY DIAGNOSIS, 1992–98

Age, sex, race, and primary diagnosis	Number of new enrollees							Percent change 1997–98	Average annual percent change 1992–98
	1992	1993	1994	1995	1996	1997	1998		
Age:									
Under 15 years	410	428	444	465	428	373	342	−8.3	−3.0
15–24 years	1,359	1,301	1,298	1,351	1,288	1,099	1,093	−0.6	−3.6
25–34 years	3,545	3,562	3,638	3,497	3,342	3,120	3,030	−2.9	−2.6
35–44 years	5,892	5,738	6,068	6,438	6,342	5,951	5,891	−1.0	0.0
45–54 years	7,575	7,856	8,968	9,327	9,448	9,589	9,880	3.0	4.5
55–64 years	11,429	11,561	12,843	13,266	13,220	13,753	14,140	2.8	3.6
65–74 years	16,530	17,147	18,832	18,640	19,550	21,472	21,712	1.1	4.6
75 years or older	10,443	11,065	12,571	13,072	14,605	17,405	18,694	7.4	10.2
Sex:									
Male	30,401	31,430	34,434	35,221	36,878	39,021	40,100	2.8	4.7
Female	26,782	27,228	30,228	30,835	31,345	33,741	34,682	2.8	4.4
Race:									
Asian	1,317	1,441	1,684	1,509	1,570	1,415	1,531	8.2	2.5
African-American	16,621	17,115	18,675	19,162	19,790	20,451	21,145	3.4	4.1
White	37,606	38,080	41,597	41,251	42,359	46,611	47,806	2.6	4.1
Native American	774	660	749	1,001	1,109	771	1,133	47.0	6.6
Other/unknown	865	1,362	1,957	3,133	3,395	3,514	3,167	−9.9	4.1
Ethnicity:									
Non-Hispanic	1,302	1,400	1,980	45,103	59,796	64,188	66,085	3.0	92.4
Hispanic	133	142	186	5,379	7,281	7,327	7,816	6.7	97.2
Unknown	55,748	57,116	62,496	15,574	1,146	1,247	881	−29.4	−49.9
Primary diagnosis:									
Diabetes	21,292	21,751	25,289	27,679	29,486	31,962	33,359	4.4	7.8

Glomerulonephritis	6,535	6,565	7,161	7,267	7,361	7,078	6,933	−2.1	1.0
Hypertension	17,685	17,447	19,755	17,677	17,947	19,601	20,297	3.6	2.3
Cystic/hereditary disease	2,247	2,236	2,359	2,479	2,313	2,256	2,242	−0.6	0.0
Interstitial nephritis	2,532	2,314	2,646	2,918	2,870	2,784	2,925	5.1	2.4
Other	3,388	3,551	3,876	4,802	5,072	5,488	5,501	0.2	8.4
Unknown	2,623	2,393	2,459	2,446	2,645	2,787	2,991	7.3	2.2
Not reported	881	2,401	1,117	788	529	806	534	−33.8	−8.0
Total number of new enrollees	57,183	58,658	64,662	66,056	68,223	72,762	74,782	2.8	4.6

Source: Health Care Financing Administration, Office of Clinical Standards and Quality.

rate of growth in program participation is in people over age 75, at 10.2 percent, followed by people of ages 65–74 with a growth rate of 4.6 percent. The largest rate of growth in primary causes of people entering ESRD treatment was diabetes. People with diabetes frequently have multiple health problems, making treatment for renal failure more difficult.

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

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

Table 2–27 indicates that a total of 13,272 kidney transplants were performed in Medicare-certified U.S. hospitals in 1998. Despite the significant increases in the number and success of kidney transplants, transplantation is not the treatment of choice for all ESRD patients. A chronic, severe shortage of kidneys available for transplantation now limits the number of patients who can receive transplants. Even absent a shortage of organs, some patients are not suitable candidates for transplants because of their age, severity of illness, or other complicating conditions. Finally, some ESRD patients do not want an organ transplant.

For all of these reasons, dialysis is likely to remain the primary treatment for ESRD. Dialysis is an artificial method of performing the kidney's function of filtering blood to remove waste products. There are two types of dialysis: hemodialysis and peritoneal dialysis. In hemodialysis, still the most common form of dialysis, blood is removed from the body, filtered and cleansed through a dialyzer, sometimes called an artificial kidney machine, before being returned to the body. There are three types of peritoneal dialysis. Intermittent peritoneal dialysis and continuous cycling peritoneal dialysis (CCPD) requires the use of a machine while continuous ambulatory peritoneal dialysis does not require the use of a machine. Under peritoneal dialysis, filtering takes place inside the body by inserting dialysate fluid through a permanent surgical opening in the peritoneum (abdominal cavity). Toxins filter into the dialysate fluid and are then drained from the body through the surgical opening. Hemodialysis is usually performed three times a week, Intermittent peritoneal dialysis is performed once or twice a week, while continuous ambulatory peritoneal dialysis and CCPD require daily exchanges of dialysate fluid.

TABLE 2–27.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE-CERTIFIED U.S. HOSPITALS, 1979–98

Calendar year	Total transplants	Living donor		Cadaveric donor	
		Number	Percent	Number	Percent
1979	4,189	1,186	28	3,003	72
1980	4,697	1,275	27	3,422	73
1981	4,883	1,458	30	3,425	70
1982	5,358	1,677	31	3,681	69
1983	6,112	1,784	29	4,328	71
1984	6,968	1,704	24	5,364	76
1985	7,695	1,876	24	5,819	76
1986	8,976	1,887	21	7,089	79
1987	8,967	1,907	21	7,060	79
1988	8,932	1,816	20	7,116	80
1989	8,899	1,893	21	7,006	78
1990	9,796	2,091	21	7,705	79
1991	10,026	2,382	24	7,644	76
1992	10,115	2,536	25	7,579	75
1993	10,934	2,828	26	8,106	74
1994	11,312	3,000	26	8,312	73
1995	11,902	3,416	29	8,426	71
1996	12,198	3,084	25	8,495	70
1997	12,427	3,210	26	8,512	68
1998	13,272	3,453	26	8,752	70

Source: Health Care Financing Administration, Office of Clinical Standards and Quality.

REIMBURSEMENT

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

Beneficiaries electing home dialysis may choose either to receive dialysis equipment, supplies, and support services directly from the facility with which the beneficiary is associated (method I) or to make independent arrangements for equipment, supplies, and support services (method II). Under method I, the equipment, supplies, and support services are included in the facility's composite rate. Under method II, payments are made on the basis of reasonable charges and limited to 100 percent of the median hospital composite rate, except for patients on CCPD, in which case the limit is 130 percent of the median hospital composite rate.

Typically, neither the composite rate nor the reasonable charge payment for method II is routinely updated. To the extent that kidney transplantation services are inpatient hospital services, they are subject to the Medicare PPS. There is no specific update policy for reasonable costs of kidney acquisition, and 100 percent of rea-

sonable costs is reimbursed. However, the composite rate for renal dialysis was updated in the Medicare Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106–113). The act increased the composite rate by 1.2 percent above the revised composite rate that was in effect in 1999. In fiscal year 2000, the composite rate is $132 for hospitals and $128 for freestanding facilities, following an additional increase of 1.2 percent in the rates in effect in 1999.

MEDICARE+CHOICE

Medicare has a longstanding history of offering its beneficiaries an alternative to the traditional fee-for-service program, beginning with private health plans contracts in the 1970s and the Medicare Risk Contract Program in the 1980s. Then, in 1997, Congress passed BBA 1997 (Public Law 105–33), replacing the Risk Contract Program with the new Medicare+Choice (M+C) Program. The M+C Program established new rules for beneficiary and plan participation, along with a new payment methodology. In addition to controlling costs, the M+C Program was also designed to expand health plans to markets where access to managed care plans was limited or nonexistent and to offer new types of health plans. Most recently, Congress enacted legislation in order to address some of the issues arising from the BBA changes. BBRA 1999 (Public Law 106–33) changed the M+C Program in an effort to make it easier for Medicare beneficiaries and plans to participate in the program.

By March 2000, M+C plans were available to about 72 percent of the 39 million Medicare beneficiaries, and about 16 percent of them chose to enroll in one of over 260 available M+C plans. The rapid growth rate of Medicare managed care enrollment in the 1990s has leveled off since the implementation of the M+C Program, and there was even a small decline in enrollment in 2000. Despite this recent trend, the Congressional Budget Office (CBO) projects that M+C enrollment will almost double by 2010, covering 31 percent of the Medicare population.

In order to increase enrollment in Medicare managed care and to allow beneficiaries to better meet their health care needs, the M+C Program offers a diverse assortment of managed care plans. However achieving the goals of the M+C Program has been difficult, in part because the goal to control Medicare spending may have dampened interest by managed care entities in developing new markets, adding plan options, and in maintaining their current markets (see appendix E for further information about the M+C Program).

SELECTED ISSUES

UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS

The Medicare Utilization and Quality Control Peer Review Organization (PRO) 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 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, 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 health maintenance organizations (HMOs).

There are currently 53 PRO areas, incorporating the 50 States and the territories. Organizations eligible to become PROs include physician-sponsored and physician-access organizations. In limited circumstances, Medicare fiscal intermediaries may also be eligible. Physician-sponsored organizations are composed of a substantial number of licensed physicians practicing in the PRO review area (for example, a medical society); physician access organizations are those which have available to them sufficient numbers of licensed physicians so that adequate review of medical services can be assured. Such organizations obtain PRO contracts from the Secretary of the U.S. Department of Health and Human Services (DHHS) through a competitive proposal process. Each organization's proposal is evaluated by HCFA for technical merit using specific criteria that are quantitatively valued. Priority is given to physician-sponsored organizations in the evaluation process. Effective October 1, 1999, all 53 PROs are operating under the sixth round of contracts (also referred to as the "sixth scope of work").

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

PROs are paid by Medicare on a cost basis for their work. Outlays for PROs in fiscal year 1998 and in fiscal year 1999 totaled $221.6 million and $213.4 million, respectively, with fiscal year 2000 outlays projected to be $484.9 million. Spending varies considerably from year to year depending on where the PROs are in their contract cycles. HCFA has indicated that actual outlays for fiscal year 2000 may be considerably lower than their current projection. Currently HCFA uses an allocation of 80 percent from the Medicare Hospital Insurance (HI) Trust Fund and 20 percent from the Supplementary Medical Insurance (SMI) Trust Fund to finance PRO activity.

The PRO review process combines both utilization and quality review. In conducting utilization review, the PRO determines whether the services provided to a Medicare patient were necessary, reasonable, and appropriate to the setting in which they were provided. Although some utilization review is done on a prospective

basis, the bulk of the reviews are done retrospectively. When a PRO determines that the services provided were unnecessary or inappropriate (or both), it issues a payment denial notice. The providers, the physicians, and the patient are given an opportunity to request reconsideration of the determination.

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

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

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

The sixth scope of work includes national and local quality improvement projects which address clinical priorities that are designed to improve the health status of Medicare beneficiaries. The intent is to increase the PRO's experience in collaborating with providers, practitioners, plans, purchasers, and beneficiaries to improve quality of care, test quality indicators and intervention strategies. One more controversial task has also been included in this most recent scope of work. PROs will implement a Payment Error Prevention Program to identify incorrect payments that result from billing errors. This is a cooperative program and does not include punitive actions. In the first year of the contract, PROs will implement review activities to identify unnecessary admissions and miscoded diagnosis-related group (DRG) assignments.

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 Program.

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

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

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

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

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

Table 2–28 shows savings attributable to these Medicare secondary payer provisions. In fiscal year 1998, combined Medicare part A and B savings are estimated at $3.4 billion.

TABLE 2–28.—MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS BY TYPE OF PROVISION, FISCAL YEARS 1988–98

[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

TABLE 2–28.—MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS BY TYPE OF PROVISION, FISCAL YEARS 1988–98—Continued

[In millions of dollars]

Year and Medicare part	Workers' compensation	Working aged	End-stage renal disease	Automobile	Disability	Total
1996:						
Part A	93.6	1,062.5	133.4	335.0	728.5	2,353.0
Part B	11.1	295.1	34.3	50.1	196.4	586.9
Total	104.7	1,357.6	167.6	385.0	924.9	2,939.9
1997:						
Part A	99.7	1,046.5	114.3	366.8	697.5	2,324.9
Part B	11.8	276.4	32.4	63.7	178.9	563.2
Total	111.5	1,322.9	146.7	430.6	876.3	2,888.0
1998:						
Part A	96.7	1,303.0	108.1	219.2	810.8	2,683.9
Part B	11.6	364.3	35.0	28.0	238.4	707.7
Total	108.3	1,667.3	143.1	247.1	1,049.3	3,391.6

Note.—Totals may not add due to rounding.

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

SUPPLEMENTING MEDICARE COVERAGE

Most beneficiaries depend on some form of private or public coverage to supplement their Medicare coverage. In 1996, only about 11.3 percent of beneficiaries relied solely on the traditional fee-for-service Medicare Program for protection against the costs of care; an additional 8.0 percent were enrolled in managed care organizations.

The majority of the Medicare population (62.5 percent in 1996) have private supplemental coverage. This private insurance protection may be obtained through a current or former employer (29.9 percent had such coverage in 1996). It may also be obtained through an individually-purchased policy, commonly referred to as a "Medigap" policy (28.4 percent had these plans in 1996). Some persons have both (4.2 percent in 1996). In addition, a smaller percentage (about 16.5 percent in 1996) have Medicaid coverage; a small group (1.7 percent in 1996) have supplemental coverage from one of a variety of other public sources (such as the military) (table 2–29).

TABLE 2–29.—SUPPLEMENTARY HEALTH INSURANCE FOR THE MEDICARE POPULATION, 1996

Type of coverage	Number of Persons	Persons (in percent)
Medicare only	7,609.0	19.3
Fee-for-service population	4,462.3	11.3
Managed care population	3,146.7	8.0
Medigap	11,180.4	28.4
Employer-sponsored coverage	11,768.3	29.9
Both private types	1,667.9	4.2
Medicaid, total	6,494.1	16.5
Full coverage	3,268.6	8.3
Qualified Medicare beneficiaries	2,925.7	7.4
Specified low-income Medicare beneficiaries	299.9	0.8
Other	665.4	1.7
Total	39,385.1	100.0

Source: Eppig, et al., 1997.

Medigap

Medigap policies offer coverage for Medicare's deductibles and coinsurance and for some services not covered by Medicare. Premiums vary widely by type of coverage, geographic location and whether premiums are community-rated or based on a beneficiary age. The Omnibus Budget Reconciliation Act of 1990 provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices and to prevent marketing abuses. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a State to no more than 10 standard benefit plans, known as "plan A" to "plan J." The standardized plan A covers a core benefits package. Each of the other nine includes the core package plus a different combination of additional benefits. Only plan H, plan I, and plan J offer some drug coverage. Beneficiaries who purchased policies prior to the standardization requirement may renew these policies; however, policies issued after July 1992 must be one of the 10 standard plans.

The law contains certain requirements which guarantee the ability of beneficiaries to enroll in Medigap plans under certain specified conditions. These guaranteed issue provisions, which are outlined below, were significantly expanded by the Balanced Budget Act of 1997.

Six-month open enrollment.—Federal law establishes an open enrollment period for the aged. All insurers offering Medigap policies are required to offer open enrollment for 6 months from the date a person first enrolls in part B (generally when the enrollee turns 65). During this time an insurer cannot deny the issuance, or discriminate in the pricing of a policy because of an individual's medical history, health status, or claims experience This requirement is known as guaranteed open enrollment.

There is no guaranteed open enrollment period for the nonaged disabled population. However, when a disabled person turns 65,

that individual has the same open enrollment guarantee as other aged persons.

Guaranteed issue.—The law guarantees issuance of specified Medigap policies (without an exclusion based on a preexisting condition) for certain persons whose previous supplementary coverage was terminated. Guaranteed issue also applies to certain persons who elect to try out an M+C plan but subsequently disenroll from such plan. In these cases, the insurer is prohibited from discriminating in the pricing of the Medigap policy on the basis of the individual's health status, claims experience, receipt of health care or medical condition. In general, this right must be exercised within 63 days of termination of other enrollment. In the case of terminating M+C plans, beneficiaries may elect to obtain the Medigap policy within 63 days of the notice of termination (rather than within 63 days of the actual termination date).

Certain requirements enable persons whose previous supplementary coverage was terminated to obtain Medigap coverage. These provisions may be particularly important to persons whose HMO terminates its participation in the M+C Program.

The following groups of persons whose coverage is involuntarily terminated are guaranteed issue of any Medigap plan A, B, C, or F that is sold to new enrollees by Medigap issuers in the State:

1. An individual enrolled under an employee benefits plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits;
2. A person enrolled with an M+C organization whose enrollment is discontinued because the plan's certification is terminated or the organization no longer provides the plan in the individual's service area; the individual moves outside of the entity's service area; or the individual elects termination due to cause; and
3. An individual enrolled under a Medigap policy if enrollment ceases because: (i) of the bankruptcy or insolvency of issuer and there is no provision under State law for continuation of such coverage; (ii) the issuer violates a material provision; or (iii) the issuer materially misrepresented the policy's provisions.

Guaranteed issue protections also extend to certain persons who elect to try out one of the options available under the M+C Program. An individual is guaranteed issuance of the Medigap policy in which he or she was previously enrolled if the individual terminated enrollment in a Medigap policy, enrolled in an M+C organization or similar entity, and terminated such enrollment within 12 months. (If the same policy is no longer sold by the insurer, the individual is guaranteed issuance of Medigap plans A, B, C, or F.) The guarantee only applies if the individual was never previously enrolled in an M+C or similar plan.

One group of persons are guaranteed issuance of any Medigap policy sold in the State. These are persons who, when they first become entitled to Medicare at age 65, enroll in an M+C plan and disenroll from such plan within 12 months.

Preexisting condition exclusions.—At the time insurers sell a Medigap policy, they are generally permitted to limit or exclude coverage for services related to a preexisting health condition; such preexisting condition exclusions cannot be imposed for more than

6 months. However, preexisting limitations may not be imposed in the following cases:

1. During the first 6-month open enrollment period, if on the date of application, the individual had health insurance coverage meeting the definition of "creditable coverage" under the Health Insurance Portability and Accountability Act.
2. An individual who has met the preexisting condition limitation in one Medigap policy. The individual does not have to meet the requirement under a new policy for previously covered benefits; however, an insurer could impose exclusions for newly covered benefits (for example, for prescription drugs if not covered under the previous policy).
3. Any individual who falls into one of the qualifying events categories discussed above under "Guaranteed Issue." These include persons whose previous coverage was involuntarily terminated or persons who elect to try out Medicare+Choice.

The prohibition applies to persons who had coverage under a prior policy for at least 6 months. If the individual has less than 6 months prior coverage, the policy must reduce the preexisting exclusion by the amount of the prior coverage.

The Balanced Budget Act (BBA) provides for high deductible Medigap plans. Specifically, it added 2 plan types to the list of 10 standard Medigap plans. These offer the benefit package of either plan F or plan J, except for the high deductible feature. The high deductible was set at $1,500 in 1998 and 1999. In subsequent years, it is increased by the Consumer Price Index (CPI). The beneficiary would be responsible for expenses up to this amount. The 2000 deductible is $1,530.

Employer-based policies

In 1996, employer-based policies covered 34 percent of Medicare beneficiaries. Employer-based plans are typically more comprehensive than Medigap plans. Generally they are defined benefit plans which may overlap significantly with Medicare benefits. As a result, employers use a variety of approaches to coordinate their plans with Medicare (which is the primary payer for retirees). The costs of coverage are generally shared by the employer and retiree.

In recent years, the percentage of employers offering retiree health coverage for their Medicare retirees has dropped. Between 1993 and 1999, the number of large firms (with 500 or more employees) offering such coverage dropped from 40 percent to 28 percent (Foster Higgins, 1999).

In addition, many other employers are pursuing strategies to lower their liabilities for retiree health costs. Some employers are moving toward a defined contribution model for retiree health benefits. Others are using Medicare risk plans and other managed care organizations to deliver services to their retirees.

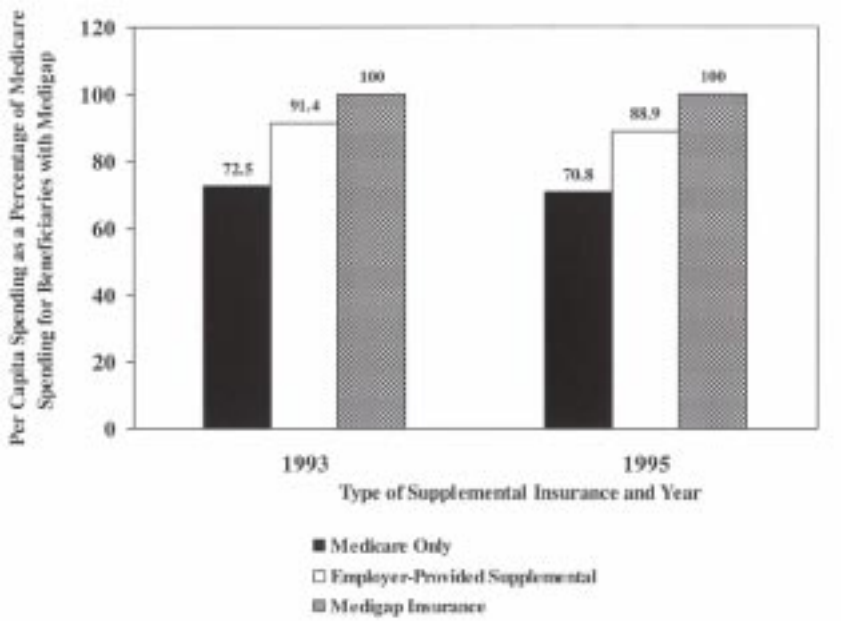
Impact of supplemental insurance on Medicare spending

Medicare cost-sharing requirements are intended, in part, to encourage cost-conscious utilization. Insurance that supplements Medicare by covering deductibles and coinsurance removes these incentives. Many analyses have addressed how supplemental insurance affects beneficiaries' use of Medicare-covered services and the

cost of those services to Medicare. Typically, these studies have estimated that Medicare spending for beneficiaries with supplemental coverage are one-quarter to one-third higher, on average, than expenditures for beneficiaries without such coverage.

A Physician Payment Review Commission analysis (Physician Payment Review Commission, 1997) of the Medicare Current Beneficiary Survey found a similar effect: Medicare expenditures for beneficiaries covered by supplemental insurance were about 30-percent higher than they were for those without such coverage. Subsequent analysis showed that the effect of secondary coverage on Medicare expenditures differs, depending on the source of coverage. Expenditures for beneficiaries having Medicare only are less than 75 percent of those for beneficiaries with Medigap. Spending for beneficiaries with employer-provided benefits average only about 10 percent less (chart 2–1).

CHART 2–1. COMPARISON OF PROJECTED PER CAPITA SPENDING FOR AVERAGE BENEFICIARIES, BY TYPE OF SUPPLEMENTAL INSURANCE AND YEAR



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

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

Higher utilization among beneficiaries with supplemental insurance translates into increased Medicare costs because Medicare is the primary payer for those services. The Medicare Current Beneficiary Survey analysis found that per capita expenditures for Medicare beneficiaries with Medigap insurance were from $1,000 to

$1,400 higher than those for beneficiaries with Medicare only. Per capita spending for beneficiaries with employer-provided supplements were from $700 to $900 higher than those for beneficiaries with no supplemental coverage.

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

Medicaid

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles" Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare. Of particular importance for this population is coverage for prescription drugs and long-term care services.

Several population groups are entitled to more limited Medicaid protection. These include qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and certain qualified 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.

Qualified Medicare beneficiaries.—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 ($8,592 for a single, $11,496 for a couple in 2000, including the $20 per month disregard); and (2) resources below 200 percent of the resources limit set for the Supplemental Security Income (SSI) Program (the QMB resource limits are $4,000 for an individual and $6,000 for a couple). Certain items, such as an individual's home and household goods, are excluded from the calculation.

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

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 parts A and B coinsurance; and (4) coinsurance and deductibles that M+C plans charge their enrollees.

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 law permits 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.

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

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

Specified low-income Medicare beneficiaries.—States are also required to pay Medicare part B premiums for SLMBs. These are persons meeting the QMB criteria except that their income is slightly over the QMB limit. The SLMB income limit is 120 percent of the Federal poverty line. In 2000 this is $10,260 for a single and $13,740 for a couple (including the $20 per month disregard). Medicaid protection is limited to payment of the Medicare part B premiums, unless the beneficiary is otherwise eligible for Medicaid.

Qualifying individuals.—BBA 1997 required State Medicaid Programs, effective January 1, 1998 through December 31, 2002, to pay part B premiums for beneficiaries with incomes up to 135 percent of poverty. These persons are referred to as QI–1s. For Medicare beneficiaries with incomes between 135 and 175 percent of poverty, State Medicaid Programs are required to cover that portion of the Medicare part B premium attributable to the transfer of home health visits from part A to part B. These persons are referred to as QI–2s.

The Federal Government will pay 100 percent of the costs associated with expanding Medicare part B premium assistance from 120 to 135 percent of poverty, as well as the extra premium cost attributable to the home health transfer for persons with incomes between 135 and 175 percent of poverty. To cover these costs, the Secretary is required to provide for allocations to States based on the sum of: (1) a State's number of Medicare beneficiaries with incomes between 135 and 175 percent of poverty, and (2) twice the number of Medicare beneficiaries with incomes between 120 and 135 percent of poverty, relative to the sum for all eligible States. Total amounts available for allocations are $200 million for fiscal

year 1998, $250 million for fiscal year 1999, $300 million for fiscal year 2000, $350 million for fiscal year 2001, and $400 million for fiscal year 2002. The Federal matching rate for each participating State will be 100 percent up to the State's allocation. If a State exceeds its allocation, the matching rate on the excess is zero. Payments are to be made from Medicare part B for the costs of this program.

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

Data

As of July 1998, Medicare reported that there were 331,924 Medicare part A beneficiaries for whom QMB payments for part A premiums were being made. As of the same date, States reported a total of 5,109,228 part B buy-ins of which 2,421,298 were separately identified as QMBs and 272,565 were separately identified as SLMBs (table 2–30). However, these numbers are low due to reporting problems. The QMB and SLMB numbers include persons who were eligible for the full Medicaid benefit package. No QMB-only or SLMB-only number is available. Nationwide there were 18 QDWIs in May 1997; this information is not broken down by State.

TABLE 2–30.—NUMBER OF QUALIFIED MEDICARE BENEFICIARIES, SPECIFIED LOW-INCOME MEDICARE BENFICIARIES, AND STATE BUY-INS BY JURISDICTION, 1998

State	Part A QMBs	Part B buy-ins	Part B QMBs	Part B SLMBs
Alabama	3,315	121,990	30,575	8,649
Alaska	584	7,093	0	16
Arizona	451	51,141	32,763	1,944
Arkansas	3,708	78,514	20,966	4,792
California	94,202	776,832	377,822	10,774
Colorado	512	52,175	11,930	0
Connecticut	2,465	51,335	40,737	3,961
Delaware	462	8,900	1,938	514
District of Columbia	1,152	14,582	390	1,599
Florida	41,860	313,744	199,721	16,584
Georgia	6,181	171,047	47,531	10,631
Hawaii	4,783	19,226	4,434	147
Idaho	250	14,909	8,473	864
Illinois	3,401	145,976	111,933	13,928
Indiana	1,739	81,184	52,626	11,585
Iowa	1,176	49,844	34,802	7,033
Kansas	635	39,008	15,064	1,675
Kentucky	3,242	106,537	29,826	8,029

TABLE 2–30.—NUMBER OF QUALIFIED MEDICARE BENEFICIARIES, SPECIFIED LOW-INCOME MEDICARE BENFICIARIES, AND STATE BUY-INS BY JURISDICTION, 1998—Continued

State	Part A QMBs	Part B buy-ins	Part B QMBs	Part B SLMBs
Louisiana	5,132	115,031	26,461	4,519
Maine	14	33,006	14,128	2,715
Maryland	6,387	61,669	43,784	2,154
Massachusetts	14,885	138,796	116,511	11,465
Michigan	6,387	135,769	40,969	15,115
Minnesota	3,766	57,559	14,871	3,354
Mississippi	6,814	106,336	68,307	5,169
Missouri	666	81,841	60,047	7,615
Montana	426	11,882	9,188	1,472
Nebraska	1	18,029	7,727	785
Nevada	1,047	17,191	12,590	1,839
New Hampshire	25	6,295	1,411	0
New Jersey	7,420	137,598	88,668	15,065
New Mexico	496	34,411	7,914	2,427
New York	253	363,331	169,511	1,187
North Carolina	11,254	210,388	45,553	10,195
North Dakota	6	5,612	1,394	388
Ohio	6,389	180,172	72,377	7,333
Oklahoma	4,373	63,142	55,936	6,858
Oregon	40	51,392	27,329	3,697
Pennsylvania	15,903	179,295	113,357	10,595
Rhode Island	744	17,729	1,540	8
South Carolina	1,793	104,111	85,020	5,729
South Dakota	759	12,791	4,508	1,388
Tennessee	7,642	171,653	73,825	2,219
Texas	42,979	339,648	96,543	18,763
Utah	140	14,900	10,147	1,474
Vermont	218	13,197	3,330	1,829
Virginia	2,939	108,427	42,957	6,450
Washington	5,144	89,419	26,461	6,478
West Virginia	3,560	43,019	38,503	3,911
Wisconsin	4,021	74,429	16,880	6,896
Wyoming	196	5,963	2,020	747
Outlying areas	0	1,160	1	0
Total	331,924	5,109,228	2,421,298	272,565

Note.—Total part B buy-ins include part B QMBs, part B SLMBs, and QI–1s (not separately broken out).

Source: Health Care Financing Administration, Office of Information Services.

LEGISLATIVE HISTORY, 1980–99

This section summarizes major Medicare legislation enacted into law since 1996. Previous editions of the *Green Book* review legislation enacted before 1996.

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. 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.

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

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

BALANCED BUDGET ACT (BBA) OF 1997, PUBLIC LAW 105–33

Hospitals

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

Skilled nursing facilities

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

Home health

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

Hospice

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

Physicians

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

Hospital outpatient departments

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

Other providers

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

Beneficiary payments

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

Prevention initiatives

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

Supplementary coverage

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

Competitive bidding

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

Commissions

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

Medicare+Choice

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

plans) offered in conjunction with medical savings accounts (effective on enactment).

BALANCED BUDGET REFINEMENT ACT (BBRA) OF 1999 (INCORPORATED IN CONSOLIDATED APPROPRIATIONS ACT OF 1999, PUBLIC LAW 106–113)

Prospective payment system hospitals

Froze the indirect medical education adjustment at 6.5 percent through fiscal year 2000, reduced the adjustment to 6.25 percent in fiscal year 2001 and to 5.5 percent in fiscal year 2002 and subsequent years. Froze the reduction in the DSH adjustment to 3 percent in fiscal year 2001; changed the reduction to 4 percent in fiscal year 2002. Changed the methodology for Medicare's direct graduate medical education payments to teaching hospitals to incorporate a national average amount calculated using fiscal year 1997 hospital-specific per-resident amounts. Increased the number of years that would count as an initial period for child neurology residency training programs. Provided for the reclassification of certain counties and areas for the purposes of Medicare reimbursement.

PPS-exempt hospitals

Adjusted the labor-related portion of the 75-percent cap to reflect the wage differences in the hospitals' area relative to the national average. Increased the amount of continuous bonus payments to eligible long-term care and psychiatric providers from 1 percent to 1.5 percent for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002. Required the Secretary to report on a discharge-based PPS for long-term care hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002. Required the Secretary to report on a per-diem-based PPS for psychiatric hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002. Required the Secretary base the PPS for inpatient rehabilitation hospitals on discharges and incorporate functional related groups as the basis for payment adjustments.

Rural providers

Permitted reclassification of certain urban hospitals as rural hospitals. Updated existing criteria used to designate outlying rural counties as part of metropolitan statistical areas for the purposes of Medicare's hospital PPS. Changed certain requirements pertaining to Medicare's Critical Access Hospital Program. Extended the Medicare dependent hospital classification through fiscal year 2006. Permitted certain sole community hospitals to receive Medicare payments based on their hospital specific fiscal year 1996 costs. Increased the target amount for SCHs by the full market basket amount for discharges occurring in fiscal year 2001.

Skilled nursing facilities

Increased, from April 1, 2000, until October 1, 2000, per-diem payments by 20 percent for 15 resource utilization groups (RUGs) under the PPS. Permitted payment under the Federal PPS rate for agencies for which it is more advantageous than under the transition rates. Provided for payment beyond the designated PPS rate for ambulance services for dialysis patients and for specific chemotherapy items and services, radioisotope services, and prosthetic devices. Until October 1, 2001, fixed PPS per-diem rates at 50 percent of the facility-specific rate and 50 percent of the Federal rate for facilities in which 60 percent of the patients are immunocompromised.

Home health agencies

Delayed the 15-percent reduction in home health payments until 12 months after implementation of the PPS but, within 6 months of implementation, required the Secretary to assess the need for any reductions. Increased per-beneficiary limits by 2 percent for older agencies; excluded DME from consolidated billing, and provided $10 per beneficiary to offset HHA costs for collecting outcome and assessment information set (OASIS) data.

Hospice

Increased payment rates otherwise in effect under the hospice PPS for fiscal year 2001 by 0.5 percent and for fiscal year 2002 by 0.75 percent, provided that these increases are not to be included in the base on which subsequent increases will be computed.

Physicians

Made technical changes to limit oscillations in the annual update to the conversion factor beginning in 2001 and provided that the sustainable growth rate is calculated on a calendar year basis. Required the Secretary, in determining practice expense relative values, to establish by regulation a process under which the Secretary would accept for use and would use, to the maximum extent practicable and consistent with sound data practices, data collected by outside organizations and entities.

Hospital outpatient departments

Made seven major changes to Medicare payments under the hospital OPD PPS: (1) required the Secretary of the U.S. Department of Health and Human Services (DHHS) to provide payments (within specified limits, and on a budget neutral basis) over and above PPS payments for certain high cost ("outlier") patients; (2) as a transition to the PPS, for 2–3 years, on a budget neutral basis, required the Secretary of DHHS to provide "passthrough payments" to hospital OPDs above and beyond PPS payments for costs of certain "current innovative" and "new, high cost" devices, drugs, and biologicals; (3) limited the cost range of items or services that are included in any one PPS category and required the Secretary to review the PPS groups and amounts annually and to update them as necessary; (4) as a transition to the PPS, through 2003, limited the reduction in Medicare payments individual hospitals experience due to the PPS; (5) provided special payments until 2004 for small,

rural hospitals to ensure that they receive no less under the outpatient PPS than they would have received under the prior system and provided the same protection permanently for cancer hospitals; (6) limited beneficiary copayments for outpatient care to no more than the amount of the beneficiary deductible for inpatient care; and (7) required that the pre-PPS payment base used as the budget neutrality benchmark for the PPS include beneficiary coinsurance amounts as paid under the pre-PPS system (i.e., 20 percent of hospital charges).

Therapy services

Suspended for 2 years (2001 and 2002) application of the caps on physical therapy and occupational therapy services.

Pap smears

Set the minimum payment for the test component of a Pap smear at $14.60.

Immunosuppressive drugs

Extended the 36-month limit on coverage of immunosuppressive drugs for persons exhausting their coverage in 2000–2004. Set the increase for persons exhausting benefits in 2000 at 8 months, and limited total expenditures to $150 million over the 5 years.

Studies

Required a number of studies including a Medicare Payment Advisory Commission comprehensive study of the regulatory burdens placed on all classes of providers under fee-for-service Medicare and the associated costs. Required GAO to conduct a study of Medigap policies.

Medicare+Choice

Contained several provisions designed to facilitate the implementation of M+C. Changed the phase in of the new risk adjustment payment methodology based on health status to a blend of 10 percent new health status method/90 percent old demographic method in 2000 and 2001, and not more than 20 percent health status in 2002. Provided for payment of a new entry bonus of 5 percent of the monthly M+C payment rate in the first 12 months and 3 percent in the subsequent 12 months to organizations that offer a plan in a payment area without an M+C plan since 1997, or in an area where all organizations announced withdrawal as of January 1, 2000. Reduced the exclusion period from 5 years to 2 years for organizations seeking to reenter the M+C Program after withdrawing. Allowed organizations to vary premiums, benefits, and cost sharing across individuals enrolled in the plan so long as these are uniform within segments comprising one or more M+C payment areas. Provided for submission of adjusted community rates by July 1 instead of May 1. Provided that the aggregate amount of user fees collected would be based on the number of M+C beneficiaries in plans compared to the total number of beneficiaries.

Delayed implementation of the Medicare+Choice Competitive Bidding Demonstration Project.

CBO SAVINGS AND REVENUE ESTIMATES FOR BUDGET RECONCILIATION AND RELATED ACTS, 1981–99

Table 2–31 shows estimates of savings and revenue increases for budget reconciliation legislation enacted from 1981 to 1997 and spending increases enacted in 1999. 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.

MEDICARE HISTORICAL DATA

Tables 2–32 through 2–41 present detailed historical data on the Medicare Program. Tables 2–32, 2–33, and 2–34 present detailed enrollment data. Table 2–35 describes the percentage of enrollees participating in a State buy-in agreement. Tables 2–36 and 2–37 show the distribution of Medicare payments by type of coverage and by type of service. Tables 2–38 and 2–39 show the number of persons served and the average reimbursement per person served and per enrollee. Table 2–40 shows the utilization of short stay hospital services. Table 2–41 shows the number of participating institutions and organizations.

TABLE 2–31.—MEDICARE SAVINGS ESTIMATES, 1981–99

[In billions of dollars]

Legislative act	Savings
Omnibus Budget Reconciliation Act of 1981:	
Spending reductions for fiscal years 1982–84	$4.3
Tax Equity and Fiscal Responsibility Act of 1982:	
Spending reductions for fiscal years 1983–87	23.1
Social Security Amendments of 1983:	
Spending reductions for fiscal years 1983–88	0.2
Revenue increases for fiscal years 1983–88	11.5
Deficit Reduction Act of 1984:	
Spending reductions for fiscal years 1984–87	6.1
Consolidated Omnibus Budget Reconciliation Act of 1985:	
Spending reductions for fiscal years 1986–81	12.6
Omnibus Budget Reconciliation Act of 1986:	
Spending reductions for fiscal years 1987–89	1.0
Omnibus Budget Reconciliation Act of 1987:	
Spending reductions for fiscal years 1988–90	9.8
Omnibus Budget Reconciliation Act of 1989:	
Spending reductions for fiscal years 1990–94	10.9
Omnibus Budget Reconciliation Act of 1990:	
Spending reductions for fiscal years 1991–95	43.1
Revenue increases for fiscal years 1991–95	26.9
Omnibus Budget Reconciliation Act of 1993:	
Spending reductions for fiscal years 1994–98	55.8
Revenue increases for fiscal years 1994–98	53.8
Health Insurance Portability and Accountability Act of 1996:	
Spending reductions for fiscal years 1996–2002	3.0
Balanced Budget Act of 1997:	
Spending reductions for fiscal years 1998–2002	116.4
Spending reductions for fiscal years 1998–2007	393.8
Balanced Budget Refinement Act of 1999:	
Spending increases for fiscal years 2000–2004	−15.0
Spending increases for fiscal years 2004–9	−25.1

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

Source: Committee on Ways and Means, (1998); Congressional Budget Office.

TABLE 2–32.—NUMBER OF MEDICARE ENROLLEES BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, SELECTED YEARS 1968–98

[In thousands]

Type of entitlement and coverage	Year												Average annual rate of growth (percent)		
	1968	1975	1980	1982	1984	1986	1988	1990	1995	1996	1997	1998	1968–75	1975–85	1985–98
Total:															
HI[1] and/or SMI[2]	19,821	24,959	28,478	29,494	30,456	31,750	32,980	34,203	37,535	38,064	38,445	38,825	3.3	2.2	1.9
Total HI:	19,770	24,640	28,067	29,069	29,996	31,216	32,413	33,719	37,135	37,662	38,052	38,432	3.2	2.2	1.9
HI only	1,016	1,054	1,079	1,082	1,040	1,160	1,363	1,574	1,850	1,925	1,985	2,044	0.5	0.4	5.3
Total SMI	18,805	23,905	27,400	28,412	29,416	30,590	31,617	32,629	35,685	36,140	36,460	36,781	3.5	2.3	1.7
SMI only	51	318	411	425	460	534	567	484	400	402	393	393	29.9	4.5	−1.9
Aged:															
HI and/or SMI	19,821	22,790	25,515	26,540	27,571	28,791	29,879	30,948	33,142	33,424	33,630	33,802	2.0	2.1	1.5
Total HI	19,770	22,472	25,104	26,115	27,112	28,257	29,312	30,464	32,742	33,022	33,237	33,410	1.8	2.1	1.6
HI only	1,016	845	835	833	807	928	1,098	1,263	1,000	1,440	1,466	1,494	−2.6	0.2	4.7
Total SMI	18,805	21,945	24,680	25,707	26,765	27,863	28,780	29,686	31,742	31,984	32,164	32,308	2.2	2.2	1.4
SMI only	51	318	411	425	459	534	567	484	400	402	393	392	29.9	4.5	−1.9
All disabled:															
HI and/or SMI	(4)	2,168	2,963	2,954	2,884	2,959	3,102	3,255	4,393	4,640	4,815	5,023	NA	3.0	4.7
Total HI	(4)	2,168	2,963	2,954	2,884	2,959	3,101	3,255	4,393	4,640	4,815	5,023	NA	3.0	4.7
HI only	(4)	209	244	249	233	232	265	311	451	485	519	551	NA	0.9	7.6
Total SMI	(4)	1,959	2,719	2,759	2,682	2,727	2,837	2,943	3,942	4,155	4,296	4,472	NA	3.2	4.4
SMI only[3]	(4)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

TABLE 2–32.—NUMBER OF MEDICARE ENROLLEES BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, SELECTED YEARS 1968–98—Continued

[In thousands]

Type of entitlement and coverage	Year												Average annual rate of growth (percent)		
	1968	1975	1980	1982	1984	1986	1988	1990	1995	1996	1997	1998	1968–75	1975–85	1985–98
End-stage renal disease only:															
HI and/or SMI	(4)	13	28	27	30	39	53	65	71	73	75	77	NA	9.1	7.9
Total HI	(4)	13	28	27	30	39	53	65	71	73	75	77	NA	9.1	7.9
HI only	(4)	1	1	2	2	3	4	6	8	8	9	10	NA	7.2	14.4
Total SMI	(4)	12	27	26	28	36	49	59	63	65	66	67	NA	9.2	7.2
SMI only[3]	(4)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

[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.

NA—Not available.

Source: Health Care Financing Administration.

TABLE 2–33.—GROWTH IN NUMBER OF AGED MEDICARE ENROLLEES BY SEX AND AGE, SELECTED YEARS 1968–98

Sex and age	Year								Average annual growth rate (percent)			Total aged population 1998 [1]	Enrollees as percent of total aged population 1998
	1968	1975	1980	1990	1995	1996	1997	1998	1968–75	1975–84	1986–98		
All persons	19,496	22,548	25,515	30,948	33,142	33,424	33,630	33,802	2.1	2.3	1.3	34,401	98.3
65–69	6,551	7,642	8,459	9,695	9,517	9,445	9,317	9,184	2.2	1.6	0.0	9,593	95.7
70–74	5,458	5,950	6,756	7,951	8,756	8,745	8,737	8,725	1.2	2.3	1.2	8,802	99.1
75–79	3,935	4,313	4,809	6,058	6,563	6,749	6,932	7,055	1.3	2.4	2.08	7,218	97.7
80–84	2,249	2,793	3,081	3,957	4,470	4,554	4,619	4,707	3.1	2.2	2.4	4,734	99.4
85 and older	1,303	1,850	2,410	3,286	3,837	3,930	4,025	4,130	5.1	4.6	2.9	4,054	101.9
Males	8,177	9,201	10,268	12,416	13,434	13,583	13,701	13,806	1.7	2.0	1.5	14,199	97.2
65–69	2,944	3,420	3,788	4,352	4,348	4,332	4,284	4,234	2.2	1.6	0.3	4,393	96.4
70–74	2,322	2,504	2,841	3,406	3,791	3,796	3,808	3,819	1.1	2.4	1.4	3,857	99.0
75–79	1,596	1,669	1,854	2,382	2,642	2,730	2,816	2,876	0.6	2.4	2.4	2,997	96.0
80–84	864	1,005	1,062	1,369	1,593	1,636	1,670	1,717	2.2	1.6	2.9	1,764	97.3
85 and older	450	604	722	906	1,060	1,090	1,122	1,159	4.3	3.1	2.9	1,188	97.6
Females	11,319	13,347	15,247	18,532	19,708	19,841	19,929	19,996	2.4	2.4	1.2	20,203	99.0
65–69	3,606	4,222	4,671	5,343	5,169	5,113	5,032	4,950	2.3	1.5	0.2	5,201	95.2
70–74	3,136	3,446	3,914	4,545	4,964	4,949	4,928	4,906	1.4	2.3	1.0	4,945	99.2
75–79	2,338	2,644	2,954	3,676	3,921	4,019	4,116	4,179	1.8	2.4	1.7	4,221	99.0
75–84	1,386	1,788	2,019	2,588	2,877	2,919	2,949	2,989	3.7	2.4	2.1	2,970	100.6
85 and older	853	1,246	1,689	2,380	2,777	2,840	2,903	2,972	5.6	5.3	2.9	2,866	103.7

[1] U.S. residents only.

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

TABLE 2–34.—GROWTH IN NUMBER OF DISABLED MEDICARE ENROLLEES WITH HOSPITAL INSURANCE COVERAGE BY TYPE OF ENTITLEMENT AND AGE, SELECTED YEARS 1975–98

Type of entitlement and age	Year							Average annual percent growth rate		
	1975	1980	1990	1995	1996	1997	1998	1975–84	1984–94	1984–98
All disabled persons	2,058,424	2,425,231	3,254,983	4,393,287	4,640,180	4,814,782	5,022,811	3.8	3.7	4.0
Under age 35	238,070	193,392	483,262	587,709	587,160	570,264	558,417	5.6	4.0	2.6
35–44	251,142	258,374	654,953	973,328	1,030,456	1,057,583	1,093,962	5.9	8.0	7.0
45–54	508,345	572,823	741,193	1,187,993	1,291,453	1,373,326	1,453,356	1.6	6.4	6.7
55–64	1,060,967	1,400,642	1,375,575	1,644,257	1,731,111	1,813,609	1,917,076	3.8	0.5	1.8
All disabled workers	1,638,662	2,396,897	2,579,097	3,602,559	3,828,220	3,987,130	4,180,635	3.9	3.8	4.3
Under age 35	100,439	184,619	257,760	357,794	357,442	343,052	333,963	7.5	6.0	4.0
35–44	164,439	253,186	482,071	769,071	819,512	840,790	872,918	6.5	9.4	8.2
45–54	426,451	565,846	612,692	1,023,616	1,120,184	1,195,960	1,269,628	1.4	6.7	7.1
55–64	947,333	1,393,246	1,226,574	1,452,078	1,531,082	1,607,328	1,704,126	3.9	0.3	1.7
Adults disabled as children	324,864	409,072	542,416	609,081	621,620	632,300	642,579	3.9	2.6	2.4
Under age 35	151,708	173,684	208,901	213,973	213,456	210,936	208,220	2.1	1.4	0.8
35–44	84,508	105,092	158,725	189,108	195,185	200,758	204,694	4.6	3.8	3.5
45–54	71,484	80,381	107,092	132,484	137,704	142,839	148,336	2.3	3.9	3.9
55–64	45,164	49,910	67,698	73,516	75,275	77,766	81,329	3.2	1.9	2.2
Widows and widowers	83,771	110,785	68,793	111,121	117,028	120,137	122,203	0.2	1.9	2.6
Under 55	7,446	7,577	5,615	12,420	13,014	13,198	13,162	−5.2	9.5	7.8
55–64	76,325	103,208	63,178	98,701	104,014	106,939	109,041	0.6	1.3	2.2
End-stage renal disease only	11,127	28,334	64,677	70,526	73,312	75,215	77,394	11.5	8.7	7.1
Under age 35	3,729	8,773	16,601	15,942	16,262	16,276	16,234	10.5	5.6	4.2
35–44	2,187	5,188	14,157	15,149	15,759	16,034	16,350	10.9	10.3	8.0
45–54	2,966	6,977	15,794	19,473	20,551	21,328	22,230	9.7	10.4	8.8
55–64	2,245	7,396	18,125	19,962	20,740	21,576	22,580	15.4	9.1	7.6

Source: Health Care Financing Administration.

TABLE 2–35.—NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OR 1998 AREA OF RESIDENCE, SELECTED YEARS 1968–98

Year or area of residence [1]	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
Year:						
1968	1,648	8.8	1,648	8.8	NA	NA
1975	2,846	12.0	2,483	11.4	363	18.7
1980	2,954	10.9	2,449	10.0	504	18.9
1985	2,670	9.0	2,164	8.0	505	19.2
1990	3,604	11.0	2,714	9.1	890	30.2
1995	4,895	13.7	3,369	10.6	1,526	38.7
1996	5,001	13.1	3,404	10.6	1,597	38.4
1997	5,089	13.2	3,445	10.7	1,644	38.3
1998	5,109	13.2	3,492	10.8	1,775	39.7
Area of residence: [1]						
Alabama	122	18.2	86	16.4	34	41.5
Alaska	7	18.4	4	14.8	2	50.0
Arizona	51	7.8	31	6.0	15	30.0
Arkansas	79	18.2	58	16.7	22	41.5
California	777	20.5	561	17.9	204	63.6
Colorado	52	11.5	32	9.0	17	42.5
Connecticut	51	10.0	31	7.1	19	51.4
Delaware	9	8.3	4	4.6	3	33.3
District of Columbia	15	19.7	11	17.5	4	57.1
Florida	314	11.4	211	9.0	77	42.3
Georgia	171	19.3	119	17.5	48	45.3
Guam and Virgin Islands [2]	1	5.3	1	9.1	0	6.3
Hawaii	19	11.9	14	10.8	4	44.4
Idaho	15	9.4	8	6.2	5	41.7
Illinois	146	9.0	89	6.4	54	37.8
Indiana	81	9.6	53	7.5	29	34.9
Iowa	50	10.5	33	7.8	18	48.6
Kansas	39	10.0	24	7.1	12	41.4
Kentucky	107	17.5	67	14.3	35	42.2
Louisiana	115	19.3	80	17.1	35	44.9
Maine	33	15.6	18	10.6	12	57.1
Maryland	62	9.9	44	8.5	19	38.8
Massachusetts	139	14.6	83	10.6	49	59.0
Michigan	136	9.9	75	6.5	53	37.6
Minnesota	58	9.0	35	6.3	26	53.1
Mississippi	106	25.8	77	24.4	30	51.7
Missouri	82	9.6	48	6.7	28	34.1
Montana	12	9.0	7	6.3	5	38.5
Nebraska	18	7.1	9	4.1	8	44.4
Nevada	17	7.6	10	6.1	5	33.3
New Hampshire	6	3.6	3	2.2	3	23.1
New Jersey	138	11.6	92	9.0	39	42.4

TABLE 2–35.—NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE UNDER STATE BUY-IN AGREEMENTS BY TYPE OF BENEFICIARY AND BY YEAR OR 1998 AREA OF RESIDENCE, SELECTED YEARS 1968–98—Continued

Year or area of residence [1]	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
New Mexico	34	15.1	22	12.6	9	40.9
New York	363	13.6	232	10.5	105	42.7
North Carolina	210	19.2	138	16.1	56	47.9
North Dakota	6	5.8	4	4.3	2	25.0
Ohio	180	10.7	119	8.3	54	32.5
Oklahoma	63	12.6	45	10.8	17	38.6
Oregon	51	10.6	29	7.1	16	42.1
Pennsylvania	179	8.6	105	5.8	64	38.8
Puerto Rico	0	0.0	0	0.0	0	0.0
Rhode Island	18	10.6	10	7.0	6	40.0
South Carolina	104	19.0	69	16.6	31	48.4
South Dakota	13	11.0	9	8.8	4	44.4
Tennessee	172	21.3	104	16.4	52	55.3
Texas	340	15.5	252	14.1	75	41.4
Utah	15	7.6	8	5.0	6	40.0
Vermont	13	14.9	8	11.4	5	62.5
Virginia	108	12.5	74	10.8	34	40.5
Washington	89	12.4	46	7.8	29	49.2
West Virginia	43	12.9	26	9.7	16	34.0
Wisconsin	74	9.5	45	6.8	31	45.6
Wyoming	6	9.4	3	5.8	2	40.0
United States	4,892	12.9	3,367	10.7	1,525	41.7
All areas	5,109	13.2	3,369	10.6	1,526	41.0

[1] State of residence is not necessarily State that bought coverage.
[2] Data for these areas combined to prevent disclosure of confidential information.

NA—Not available.

Source: Health Care Financing Administration, Office of Strategic Planning.

TABLE 2–36.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE AND TYPE OF SERVICE, CALENDAR YEARS 1995–98

[In millions of dollars]

Type of coverage and type of service	Amount and distribution of payments for enrollees							
	1995		1996		1997		1998	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Hospital insurance	$116,176	100.0	$128,457	100.0	$137,592	100.0	$133,244	100.0
Inpatient	81,984	70.6	85,756	66.8	88,498	64.3	87,029	65.3
Skilled nursing facility	9,236	8.0	11,101	8.6	12,995	9.4	13,487	10.1
Home health agency	16,373	14.1	17,825	13.9	17,680	12.8	11,789	8.8
Hospice	1,883	1.6	1,997	1.6	2,082	1.5	2,180	1.6
Managed care	6,701	5.8	11,777	9.2	16,338	11.9	18,759	14.1
Supplementary medical insurance	64,972	35.9	68,598	37.9	72,757	40.2	76,673	42.3
Physicians fee schedule [1]	31,660	17.5	31,631	17.5	31,901	17.6	32,456	17.9
Durable medical equipment	3,689	2.0	3,826	2.1	4,237	2.3	4,033	2.2
Carrier laboratory	2,807	1.5	2,550	1.4	2,386	1.3	2,088	1.2
Other carrier	4,530	2.5	5,059	2.8	5,582	3.1	5,937	3.3
Outpatient hospital	8,663	4.8	8,691	4.8	9,455	5.2	8,844	4.9
Home health agency	236	0.1	262	0.1	261	0.1	166	0.1
Intermediary laboratory	1,448	0.8	1,311	0.7	1,447	0.8	1,476	0.8
Other intermediary	5,329	2.9	5,711	3.2	6,527	3.6	6,334	3.5
Managed care	6,610	3.6	9,558	5.3	10,962	6.1	15,338	8.5
Total payments	181,148	100.0	197,055	100.0	210,349	100.0	209,917	100.0

[1] Includes other services.

Note.—See table 2–3 for historical fiscal year data.

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

TABLE 2–37.—DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS BY TYPE OF COVERAGE, TYPE OF SERVICE, AND TYPE OF ENROLLEE, CALENDAR YEAR 1998

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
Hospital insurance	$133,244	100.0	$117,066	100.0	$16,178	100.0
Inpatient	87,029	65.3	73,945	63.2	13,084	80.9
Skilled nursing facility	13,487	10.1	12,825	11.0	662	4.1
Home health agency	11,789	8.8	10,659	9.1	1,130	7.0
Hospice	2,180	1.6	2,071	1.8	109	0.7
Managed care	18,759	14.1	17,566	15.0	1,193	7.4
Supplementary medical insurance	76,673	100.0	65,882	100.0	10,791	100.0
Physicians fee schedule	32,456	42.3	28,491	43.2	3,966	36.8
Durable medical equipment	4,033	5.3	3,299	5.0	734	6.8
Carrier laboratory	2,088	2.7	1,794	2.7	294	2.7
Other carrier	5,937	7.7	5,136	7.8	801	7.4
Outpatient hospital	8,844	11.5	7,501	11.4	1,343	12.4
Home health agency	166	0.2	166	0.3	0	0.0
Intermediary laboratory	1,476	1.9	1,181	1.8	296	2.7
Other intermediary	6,334	8.3	3,989	6.1	2,346	21.7
Managed care	15,338	20.0	14,326	21.7	1,012	9.4
Total payments	209,917	100.0	182,948	100.0	26,969	100.0

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

TABLE 2–38.—PERSONS ENROLLED AND PERSONS SERVED UNDER MEDICARE, AND PROGRAM PAYMENTS, BY TYPE OF COVERAGE AND SERVICE, SELECTED CALENDAR YEARS 1967–97

Type of coverage and service	Year						Average annual rate of change		
	1967	1980	1990	1994	1996	1997	1967–83	1983–97	1967–97
	Number of enrollees (in thousands)								
Hospital insurance and/or supplementary medical insurance	19,521	28,478	34,213	36,950	38,093	38,465	2.7	1.9	2.4
Hospital insurance	19,494	28,067	33,731	36,542	37,677	38,059	2.6	2.0	2.3
Supplementary medical insurance	17,893	27,400	32,636	35,179	36,165	36,479	3.1	1.8	2.5
	Number of persons served (in thousands) [1]								
Hospital insurance	3,960	6,752	7,036	7,886	8,175	8,118	4.0	0.7	2.5
Inpatient hospital services	3,601	6,672	6,543	6,938	6,941	6,887	4.4	−0.3	2.3
Skilled nursing facility services	354	257	638	1,063	1,373	1,503	−1.8	14.3	5.1
Home health agency services	126	726	1,936	3,152	3,493	3,458	15.8	7.7	12.1
Supplementary medical insurance	6,523	17,822	26,951	29,912	29,981	29,620	7.1	3.3	5.4
Physician and other medical services	6,415	17,258	26,350	29,222	29,332	28,961	7.0	3.3	5.3
Outpatient services [2]	1,511	7,538	15,511	18,945	20,305	20,543	11.9	6.5	9.4
Home health agency services	118	327	38	37	44	48	−10.5	7.0	−3.1
Total	7,154	18,031	27,099	30,087	30,195	29,847	6.5	3.2	5.0
	Rate per thousand enrollees [3]								
Hospital insurance	203	241	209	234	243	241	1.3	−0.3	0.6
Inpatient hospital services	185	238	194	206	206	205	1.7	−1.3	0.4

TABLE 2–38.—PERSONS ENROLLED AND PERSONS SERVED UNDER MEDICARE, AND PROGRAM PAYMENTS, BY TYPE OF COVERAGE AND SERVICE, SELECTED CALENDAR YEARS 1967–97—Continued

Type of coverage and service	Year						Average annual rate of change		
	1967	1980	1990	1994	1996	1997	1967–83	1983–97	1967–97
Skilled nursing facility services	18	9	19	32	41	45	−4.3	13.2	3.2
Home health agency services	6	26	57	94	104	103	12.8	6.6	10.0
Supplementary medical insurance	365	650	826	926	931	920	3.9	2.4	3.2
Physician and other medical services	359	630	807	905	911	899	3.8	2.5	3.2
Outpatient services [2]	84	275	475	586	630	638	8.5	5.6	7.2
Home health agency services	7	12	1	1	1	1	−13.2	6.1	−5.0
Total	366	633	792	883	886	876	3.7	2.2	3.1
	Program payments (in millions of dollars)								
Hospital insurance	$2,967	$23,119	$62,347	$94,205	$107,949	[4] $114,327	16.9	9.2	13.4
Inpatient hospital services	2,667	22,297	56,716	75,715	79,911	84,563	17.4	7.1	12.7
Skilled nursing facility services	274	344	1,971	5,954	9,486	11,237	2.8	28.6	13.7
Home health agency services	26	478	3,660	12,537	16,546	16,487	28.1	21.1	25.9
Supplementary medical insurance	1,272	10,494	39,072	52,343	59,114	61,096	17.6	10.3	14.3
Physician and other medical services	1,217	8,358	30,222	38,490	42,510	43,621	16.3	9.3	13.1
Outpatient services [2]	38	1,962	8,773	13,696	16,387	17,256	32.5	13.2	24.2
Home health agency services	17	175	78	157	216	219	3.4	16.8	9.2
Total	4,239	33,613	101,419	146,549	167,062	175,423	17.2	9.6	13.7

	Program payments per person served								
Hospital insurance	749	3,424	8,861	11,945	13,205	14,082	12.4	8.5	10.6
Inpatient hospital services	741	3,342	8,688	10,913	11,513	12,279	12.4	7.5	10.2
Skilled nursing facility services	774	1,339	3,089	5,603	6,909	7,476	4.7	12.5	8.1
Home health agency services	206	658	1,690	3,977	4,737	4,768	10.6	12.5	11.4
Supplementary medical insurance	195	589	1,450	1,750	1,972	2,063	9.9	6.8	8.5
Physician and other medical services	190	484	1,147	1,317	1,449	1,506	8.7	5.8	7.4
Outpatient services [2]	25	260	566	723	807	840	18.5	6.3	12.9
Home health agency services	144	535	2,053	4,267	4,909	4,588	15.5	9.3	12.7
Total	593	1,864	3,743	4,871	5,533	5,877	10.0	6.1	8.2

[1] Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the year. Detail does not add to totals by type of service because one person may have used several types of services.

[2] Prior to April 1, 1968, outpatient hospital services were covered by health insurance and supplementary medical insurance. All outpatient hospital services for 1967 are shown as supplementary medical insurance services for purposes of comparison.

[3] Beginning with 1994, the utilization rates per 1,000 enrollees do not reflect managed care enrollment; that is, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

[4] Includes $2.0 billion for hospice services, not shown separately.

Note.—Medicare Program represents fee-for-service payments only. Numbers may not add to totals because of rounding.

Source: Health Care Financing Administration.

TABLE 2–39.—PERSONS SERVED AND PROGRAM PAYMENTS FOR MEDICARE BENEFICIARIES, BY DEMOGRAPHIC CHARACTERISTICS, CALENDAR YEAR 1997

Demographic characteristic	Persons served [1]		Program payments			
	Number in thousands	Percent	Amount in millions	Percent	Average amount per person served	Per enrollee [2]
Sex:						
Male	12,113	40.6	$75,357	43.0	$6,221	$5,326
Female	17,734	59.4	100,066	57.0	5,643	5,306
Age:						
Under 65 years	4,129	13.8	25,798	14.7	6,247	5,735
65–74 years	12,771	42.8	59,687	34.0	4,674	3,953
75–84 years	9,428	31.6	61,708	35.2	6,545	6,267
85 years or older	3,519	11.8	28,231	16.1	8,023	7,919
Race: [3]						
White	25,801	86.4	145,050	82.7	5,622	5,165
Nonwhite	2,550	8.5	21,447	12.2	8,409	4,509
Type of entitlement:						
Aged	26,130	87.5	151,655	86.5	5,804	5,319
Disabled	3,717	12.5	23,768	13.5	6,395	5,284
MSA type [4]						
Urban	21,549	72.2	134,200	76.5	6,228	5,694
Rural	7,956	26.7	40,142	22.9	5,048	4,648
Total	29,847	100.0	175,423	100.0	5,877	5,314

[1] Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the year.

[2] Beginning with 1994, the utilization rates per 1,000 enrollees do not reflect managed care enrollment; that is, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

[3] Excludes unknown race.

[4] Excludes outlying areas.

Note.—MSA is metropolitan statistical area. Numbers may not add to totals because of rounding.

Source: Health Care Financing Administration.

TABLE 2–40.—USE OF SHORT-STAY HOSPITAL SERVICES BY MEDICARE EMPLOYEES BY YEAR AND 1997 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1975–97

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	36,543	11,471	314	85,734	7.5	2,346	70,623	6,157	824	1,933
1995	37,135	11,681	315	81,282	7.0	2,189	74,836	6,407	921	2,015
1996 [1]	33,301	11,796	354	77,193	6.5	2,318	78,546	6,953	1,018	2,359
1997 [1]	32,614	11,919	365	74,901	6.3	2,297	80,751	7,118	1,078	2,476
Annual percentage change in period:										
1975–85	2.2	4.8	2.4	1.0	−2.8	−1.5	18.7	14.2	17.6	15.8
1985–95	2.0	−1.3	−3.1	−1.2	−1.7	−3.1	6.3	5.7	7.5	4.2
1975–97 [1]	1.3	1.8	0.5	−0.8	−2.6	−2.1	10.1	8.4	11.0	8.7

TABLE 2–40.—USE OF SHORT-STAY HOSPITAL SERVICES BY MEDICARE EMPLOYEES BY YEAR AND 1997 DEMOGRAPHIC CHARACTERISTICS, SELECTED YEARS 1975–97—Continued

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
Age:										
Less than 65 years	4,829	1,637	364	10,686	6.5	2,213	10,856	7,064	1,016	2,248
65–69 years	9,217	1,765	230	10,442	5.9	1,133	12,886	7,816	1,234	1,398
70–74 years	8,641	2,193	303	13,197	6.0	1,527	15,807	7,613	1,198	1,829
75–79 years	6,830	2,269	393	14,294	6.3	2,093	16,005	7,389	1,120	2,343
80–84 years	4,581	1,914	487	12,352	6.5	2,696	12,503	6,790	1,012	2,729
85 years or older	3,960	2,141	610	13,930	6.5	3,518	12,694	6,118	911	3,206
Sex:										
Male	16,383	5,208	371	32,652	6.3	1,993	37,436	7,619	1,147	2,285
Female	21,676	6,712	361	42,249	6.3	1,949	43,315	6,736	1,025	1,998
Race: [2]										
White	32,526	10,078	361	62,058	6.2	1,908	67,239	7,010	1,083	2,067
All other	5,349	1,766	388	12,347	7.0	2,308	12,993	7,739	1,052	2,429
Area of residence:										
Northeast	6,807	2,496	367	21,858	8.8	3,211	19,812	7,938	906	2,911
Midwest	8,456	3,018	357	19,414	6.4	2,296	19,937	6,606	1,027	2,358
South	12,080	4,533	375	29,657	6.5	2,455	28,884	6,372	974	2,391
West	4,862	1,730	356	9,477	5.5	1,949	11,718	6,773	1,236	2,410

[1] Prior to 1996, data were obtained from the Annual Person Summary Record. Beginning in 1996, utilization rates are based on persons receiving fee-for-service care and total persons not enrolled in prepaid health plans.

[2] Excludes unknown race.

Source: Health Care Financing Administration, Office of Strategic Planning.

TABLE 2–41.—MEDICARE PARTICIPATING INSTITUTIONS AND ORGANIZATIONS, 1984, 1996, AND 1998

Institution or organization	Year	
	1984	1998
Hospitals	6,675	6,116
Short stay	6,038	5,038
Long stay	637	1,078
Skilled nursing facilities	5,952	15,032
Home health agencies	4,684	9,330
Laboratories registered under the Clinical Laboratory Improvement Act	NA	166,817
Outpatient physical therapy providers	791	2,890
Portable x-ray suppliers	269	659
Rural health clinics	420	3,551
Comprehensive outpatient rehabilitation facilities	48	590
Ambulatory surgical centers	155	2,649
Hospices	108	2,317
Facilities providing services to renal disease benefit	1,335	3,581
Hospital certified as both renal transplant and renal dialysis center	147	148
Hospital certified as renal transplant centers	16	87
Hospital dialysis facilities	117	27
Nonhospital renal dialysis facilities	645	NA
Dialysis centers only	359	319
Inpatient care	51	44
Hospital and skilled nursing facility beds:		
Hospitals	1,144,000	1,012,000
Short stay	1,023,000	891,000
Long stay	120,700	122,000
Skilled nursing facilities	530,400	723,000

NA—Not available.

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

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