Chapter 1: Overview of the Medicare Program

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Introduction

The Medicare program covers inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, hospice care, physician and supplier services, and outpatient services. Most persons 65 years of age or over, disabled persons entitled to Social Security cash benefits for at least 24 months, and most persons with end stage renal disease are eligible for these benefits. In calendar year 1990, total Medicare disbursements amounted to an estimated $111.0 billion (derived from Tables 1.4 and 1.5).

The Medicare program has two complementary but distinct parts: hospital insurance (HI, also called Part A) and supplementary medical insurance (SMI, also called Part B). Medicare benefits and administrative expenses are paid from the two separate trust funds. The HI trust fund is financed primarily through a tax on current earnings from employment covered by the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of persons enrolled in the program and from general revenues of the Federal Government.

Hospital insurance program

About 98 percent of the Nation's aged are enrolled in the HI program. On July 1, 1966, when Medicare became operational and eligibility was limited to persons age 65 or over, 19.1 million persons were enrolled. By July 1, 1990, the number of HI enrollees had increased to 33.7 million; this total included 3.3 million disabled enrollees. (Medicare coverage of the disabled began on July 1, 1973.) The HI program covers 90 days of medically necessary inpatient hospital care in a benefit period (spell of illness), which begins with the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 consecutive days. Although there is no limit to the number of benefit periods an enrollee may have, there are limits on the number of days covered.

The HI program covers up to 90 days of services in a participating hospital during a single benefit period. After an initial deductible for each benefit period ($592 in 1990), the patient is entitled to 60 days of hospitalization with no additional cost sharing. From the 61st through the 90th day in the benefit period, the amount of the coinsurance per day is always equal to one-fourth of the inpatient hospital deductible. In addition, HI enrollees have a non-renewable "lifetime reserve" of 60 additional hospital days, which can be used at their option when the enrollee exhausts the 90 days covered in a benefit period. For the 60 lifetime reserve days, the amount of the coinsurance per day is always equal to one-half of the inpatient hospital deductible.

The HI program also pays non-participating hospitals for emergency services. The hospital may bill the Medicare program annually for all emergency services rendered. If this arrangement is unacceptable to the provider, the patient must pay for services received and submit a claim for reimbursement. Medicare program reimbursements are subject to beneficiary deductible and coinsurance cost-sharing amounts.

Hospital services covered by HI include room and board in "semiprivate" accommodations containing from two to four beds. Private accommodations are covered if they are medically necessary; otherwise, the patient must pay a special charge to the hospital. Nursing services (except private-duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients are also covered. The HI program covers the services of interns and resident physicians in approved teaching programs. The SMI program covers the services of other hospital-based physician specialists, such as radiologists, anesthesiologists, and pathologists. Hospital benefits also include covered services provided in tuberculosis hospitals and psychiatric hospitals. There is a 190-day lifetime limit for covered services in psychiatric hospitals. Table 1.1 summarizes the specific settings and types of services covered by the HI program.

The HI program covers up to 100 post-hospital days in a Medicare-participating SNF if a physician certifies that the beneficiary requires such care. Furthermore, the condition must require daily nursing care or skilled rehabilitation services that can be provided only in an SNF. For the first 20 days, patients pay no coinsurance. For the remaining 80 days, the coinsurance per day is always equal to one-eighth of the inpatient deductible ($74 in 1990). A beneficiary is eligible for SNF benefits only after hospitalization for at least 3 consecutive days and only if the transfer to an SNF occurs within 30 days after a hospital discharge.

Medicare began to cover hospice care in November 1983. Hospice care is a comprehensive home-care program for the terminally ill. Covered hospice care includes both home and inpatient care, when needed, and a variety of services not otherwise covered by Medicare. To qualify for hospice benefits, a patient must have HI coverage, and his or her doctor and the hospice medical director must certify that the patient has a terminal illness and a prognosis of 6 months or less to live. In addition, the care must be provided by a Medicare-certified hospice. Patients who elect this benefit must waive the standard Medicare HI benefits for services relevant to the terminal illness.

Under the Medicare hospice benefit, Medicare pays for daily services and permits a hospice to provide appropriate custodial care, including homemaker services and counseling. There are no deductibles under the hospice program. The beneficiary does not pay for Medicare-covered services for the terminal illness except

Table 1.1

Types of Medicare Part A covered services, by place of service: Calendar year 1990

Type of covered service	Inpatient hospital	Skilled nursing facility	Home health agency	Hospice
Accommodations, semiprivate, including special diets	x	x	–	x
Blood transfusions	x	x	–	x
Counseling	–	–	–	x
Dental services requiring hospitalization	x	–	–	–
Doctors' services	–	–	–	x
Drugs and biologicals	x	x	–	x
Durable medical equipment	x	x	x	x
Emergency services	x	–	–	–
Home health aides	–	–	x	–
Homemakers' services	–	–	–	x
Intern and resident services, and teaching physicians in hospitals	x	x	x	–
Medical social services	x	x	x	x
Medical supplies and appliances	x	x	x	x
Nursing and related services, excluding private duty	x	x	–	x
Nursing, intermittent skilled nursing care	–	–	x	–
Occupational therapy	x	x	x	x
Other diagnostic services[1]	x	x	–	–
Outpatient services	–	x	x	–
Physical therapy	x	x	x	x
Respite care and procedures necessary for pain control	–	–	–	x
Speech pathology	x	x	x	x
White blood and packed red blood cells	x	x	–	–

[1]Includes blood tests, X-rays, psychologist and physical therapy services, rehabilitative care, respiratory therapy, independent clinical laboratory services, and mental health services.

NOTE: x is covered; – is not covered.

SOURCE: (Health Care Financing Administration, 1990).

for small coinsurance amounts for outpatient drugs and inpatient respite care, which is meant to provide relief to persons caring for the terminally ill. Special benefit periods apply to hospice care. The HI program pays for two 90-day periods followed by a 30-day period, and, when necessary, an extension period of indefinite duration.

Another type of benefit covered by HI is home health agency (HHA) services for persons under the care of a physician, confined to the home, and needing part-time or intermittent skilled nursing care, physical therapy, or speech therapy. Once these conditions are met, Medicare will pay for all medically necessary home health services. When the beneficiary no longer needs intermittent skilled nursing care, physical therapy, or speech therapy, Medicare will pay for HHA services if occupational therapy continues to be needed. Covered services also include the part-time or intermittent services of a home health aid, medical supplies (other than drugs and biologicals), the use of medical appliances, and, in certain cases, the services of an intern or resident physician. The services must be furnished by a Medicare-certified HHA. The Health Care Financing Administration (HCFA) imposes limits on payments for HHA visits at 112 percent of the mean labor-related and non-labor per-visit costs.

Supplementary medical insurance program

The SMI program provides payments for physician services as well as related medical services and supplies ordered by physicians. SMI pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers. It also pays for outpatient rehabilitation, speech therapy, and physical therapy services. Medicare law specifies that payment will be made only for services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. Table 1.2 summarizes the specific types of services covered by the SMI program.

About 97 percent of the total Medicare population is voluntarily enrolled in the SMI program. On July 1, 1966, 17.7 million aged persons were enrolled in the SMI program. By July 1, 1990, the number of SMI enrollees had increased to 32.6 million; of this total, about 0.5 million aged enrollees had SMI coverage only.

Under SMI cost-sharing provisions, the beneficiary must pay: a monthly premium, an annual deductible, a 20-percent coinsurance for physician and physician-related services, and balance billing on unassigned claims for services rendered by physicians who have not agreed to accept the Medicare-allowed charge as full payment. For 1990, the monthly SMI premium was $28.60 and the annual deductible was $75.

During each calendar year, enrollees must exceed the SMI deductible to receive reimbursable services. After the deductible is met, SMI pays 80 percent of the allowed (reasonable) charges for covered physician services and most other medical services. Before the Medicare physician fee schedule began on January 1, 1992, Medicare paid for all physician services based entirely on the concept of the allowed charge. The

Table 1.2

Types of Medicare Part B physician and outpatient covered services: Calendar year 1990

Physician services	Outpatient services
Diagnostic tests and procedures	Ambulance transportation
Medical and surgical services, including anesthesia	Ambulatory surgical centers
Radiology and pathology services while a hospital inpatient or outpatient	Antigens and blood-clotting factors
Other services furnished in the doctor's office:	Blood transfusions, blood and other components
X-rays	Certified registered nurse anesthetist
Drugs and biologicals	Clinic services
Blood and blood components	Comprehensive outpatient rehabilitation facility
Medical supplies	Dialysis services
Physical therapy	Drugs and biologicals
Occupational therapy	Durable medical equipment
Speech therapy	Emergency room services
Chiropractic services (manual manipulation of the spine to correct subluxation)	Independent clinical laboratory
Dental services that involve surgery on the jaw or the setting of fractures	Laboratory tests billed by hospital
Optometrists, excluding routine eye examinations	Medical supplies
Podiatrist services, excluding routine foot care	Mental health services
Second opinions	Nurse-midwife
	Occupational therapy
	Physical therapy
	Physician assistant
	Portable diagnostic X-ray
	Prosthetic devices
	Psychologist services
	Rural health services
	Speech pathology
	Vaccines, hepatitis and pneumococcal
	X-rays and other radiology services billed by the hospital

SOURCE: (Health Care Financing Administration,1990).

allowed charge is determined for each specific service and is the lowest of: the physician's actual charge for the service; the physician's customary charge for the service (the physician's 50th percentile charge level for the specific type of service); or the prevailing charge, which is set at the 75th percentile of the customary charge for the service by physicians in an area defined by the carrier.

The beneficiary also is liable for physician charges resulting from balance billing, that is, the difference between the physician's submitted charge and the Medicare-allowed charge on unassigned claims.

Physicians who treat Medicare patients make an annual choice to be participating or non-participating physicians. Participating physicians agree to accept assignment on all claims and to accept 80 percent of the reasonable charge as payment in full. The patient is responsible for the deductible and the remaining 20 percent of the reasonable charge. The non-participating physician may accept or not accept assignment on a claim-by-claim basis. For unassigned claims submitted by non-participating physicians, the patient is responsible for the physician's total charge, i.e., the patient must pay the difference between the physician's submitted charge and the Medicare-allowed charge. The difference is referred to as balance billing. It should be noted that the Medicare-allowed charges are frequently lower than the physician's submitted charges. Thus, the Medicare beneficiary may save a substantial amount of money by choosing a physician who accepts Medicare assignment. Under Medicare's physician payment reform, a limit exists on the amount that physicians who do not accept assignment may charge Medicare beneficiaries on unassigned claims. This limit is to be phased in over a 3-year period that began January 1, 1991. By 1993, a physician will not be allowed to charge a Medicare beneficiary more than 115 percent of the amount listed in a Medicare fee schedule for non-participating physicians.

Under the law, Medicare covers only acute care that is "reasonable and necessary" for the treatment of an illness or injury. Medicare does not cover "custodial" care that is needed primarily for the purpose of meeting personal needs and which could be provided by persons without professional skills or training. In addition, some health care services that Medicare beneficiaries generally use, such as routine eye examinations and preventive services, are not covered by Medicare. Drugs and certain dental procedures are covered only if provided during an authorized hospital inpatient stay. A list of services that Medicare does not cover appears in Table 1.3.

State buy-in coverage

Under State buy-in agreements, most State Medicaid programs pay SMI premiums for persons who qualify for both Medicaid and Medicare benefits. Through these buy-in agreements, 3.2 million (about 10 percent) aged and disabled SMI Medicare enrollees were also covered by State Medicaid programs in calendar year 1990. States that pay the SMI premium for dually eligible persons are also responsible for Medicare cost sharing. These States generally supplement Medicare coverage by providing some additional health care services offered by the State Medicaid program. When persons are eligible under both programs, Medicare is the primary payer for Medicare services, and Medicaid pays the deductible and coinsurance. State payments for the deductible and coinsurance amounts on behalf of persons covered by the buy-in agreements are included in the total Medicaid expenditures for which Federal contributions are made. States receive Federal funds on premium payments only for approved Medicaid programs for the categorically needy.

If a State does not buy SMI coverage for Medicare-Medicaid eligibles, it cannot receive Federal payments for services that would have been covered by SMI. All but one State (Wyoming) and two other jurisdictions with a Medicaid program (Puerto Rico and the Northern Marianas) had a buy-in agreement as of calendar year 1987.

Beginning January 1, 1989, all States were required to provide Medicaid buy-in coverage of qualified Medicare beneficiaries. The qualified Medicare

Table 1.3

Services not covered by Medicare: Calendar year 1990

- Acupuncture
- Chiropractic services[1]
- Christian Science practitioners' services
- Cosmetic surgery[1]
- Custodial care
- Dental care[1]
- Drugs and medicines purchased by enrollee with or without a doctor's prescription[1]
- Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses[1]
- Foot care that is routine[1]
- Hearing aids and hearing examinations; fitting or changing hearing aids
- Homemaker services[1]
- Immunizations, except hepatitis and pneumococcal injections that can be self-administered, such as insulin
- Long-term care (nursing homes)
- Meals delivered to enrollee's home
- Naturopaths' services
- Nursing care on full-time basis in home of enrollee
- Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge
- Personal convenience items requested by enrollee (a phone or television in a hospital room or skilled nursing facility)
- Physical examinations that are routine (for example, yearly physical examinations) and tests directly related to such examinations
- Private duty nurses
- Private room[1]
- Services performed by immediate relatives and members of enrollee's household
- Services provided outside the United States[1]
- Services that are not reasonable and necessary under Medicare program standards
- Services payable by another government program

[1]Items can be covered by Medicare under certain conditions.

NOTE: This alphabetical list shows most of the major services and supplies not usually paid for by Medicare.

SOURCE: (Health Care Financing Administration, 1990).

beneficiary program helps beneficiaries who have very limited assets and whose income is below the Federal poverty level but not quite low enough for Medicaid eligibility. Each State Medicaid program pays the Medicare premium and cost-sharing amounts for the qualified Medicare beneficiary. Such coverage is optional for commonwealths and territories.

State Medicaid programs provide many services for the aged and disabled that are not provided by Medicare, including SNF care beyond the 100-day post-hospital benefit provided by Medicare, long-term care in intermediate care facilities (ICFs), prescription drugs, eyeglasses, and hearing aids. In terms of the range of benefits that a State can provide, Medicaid is more comprehensive than Medicare. However, States have broad flexibility in defining limits on the amount, duration, and scope of the services they cover.

Financing

HI is financed primarily through a tax on a portion of current employment earnings covered by the Social Security Act. Other sources of income for the HI program (Table 1.4) include proceeds from the railroad retirement system, income to the trust fund appropriated from general revenues to reimburse the program for costs of transitionally insured persons, and interest earned by the fund. These monies are earmarked for the HI trust fund to pay benefits and administrative expenses. In 1990, payroll taxes accounted for about 90 percent of the HI trust fund's total income; benefit payments accounted for almost 99 percent of total HI disbursements (derived from table).

The Federal SMI trust fund comes from premiums paid by or on behalf of SMI enrollees, contributions of the Federal Government from the general funds of the U.S. Department of the Treasury, and interest from investments of the fund (Table 1.5). As of January 1, 1990, the monthly SMI premium was $28.60. Until 1973, premiums were set to finance one-half of the benefit and administrative costs of the SMI program plus a contingency amount. General revenues financed the other half. The 1972 Amendments to the Social Security Act (Public Law 92-603) altered that arrangement. Beginning July 1973, monthly premiums can be increased only if the monthly Social Security cash benefits are increased. Furthermore, premiums are permitted to rise no more than the percentage increase in cash benefits.

Since the 1972 Amendments to the Social Security Act, the major source of income for the SMI trust fund has been Federal contributions from general revenues, which made up about 72 percent of total income in calendar year 1990. Enrollees' premiums made up about 25 percent, and the remainder was interest on investments (derived from Table 1.5).

Administration

Fiscal intermediaries

HCFA has the primary responsibility for administering the Medicare program, including policy and guidelines; contract oversight and operation; maintenance and review of utilization records; and general financing of the program. The Social Security Administration (SSA) makes the initial determination of an individual's eligibility and maintains the master beneficiary record system. The U.S. Department of the Treasury manages the HI and SMI trust funds and transfers funds to pay Medicare bills.

Groups or associations of providers may nominate a national, State, or other public or private agency or organization to be their fiscal intermediary for inpatient hospital, SNF, and HHA services covered by the HI program. Under an agreement with the Secretary of Health and Human Services, the fiscal intermediary determines reasonable costs for covered items and services, makes payment, and guards against unnecessary use of covered services. The intermediary may also furnish consulting services to help providers establish and maintain the fiscal records needed to qualify as providers of service, to serve as a center for communicating with providers, or to audit provider records. In addition, HI fiscal intermediaries make payments for outpatient hospital services and home health services covered by SMI.

Table 1.4

Operations of the Medicare hospital insurance trust fund for calendar years 1970-91 and estimates for 1992-94

Year	Income							Disbursements			Interfund borrowing transfers[4]	Trust fund	
	Total income	Payroll taxes	Transfers from railroad retirement account	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other income[1]	Total disbursements	Benefit payments[2]	Administrative expenses[3]		Net change	Yearend balance
	Amount in millions												
Historical													
1970	$5,979	$4,881	$66	$863	—	$11	$158	$5,281	$5,124	$157	—	$698	$3,202
1975	12,980	11,502	138	621	$7	48	664	11,581	11,315	266	—	1,399	10,517
1980	26,097	23,848	244	697	18	141	1,149	25,577	25,064	512	—	521	13,749
1981	35,725	32,959	276	659	22	207	1,603	30,726	30,342	384	—	4,999	18,748
1982	37,998	34,586	351	808	24	207	2,022	36,144	35,361	513	−$12,437	−10,583	8,164
1983	44,570	37,259	358	878	27	[5]3,456	2,593	39,877	39,337	540	—	4,693	12,858
1984	46,720	42,288	351	752	33	250	3,046	43,887	43,257	629	—	2,834	15,691
1985	51,397	47,576	371	766	41	[6]−719	3,362	48,414	47,580	834	1,824	4,808	20,499
1986	59,267	54,583	364	566	43	91	3,619	50,422	49,758	664	10,613	19,458	39,957
1987	64,064	58,648	368	447	38	94	4,469	50,289	49,496	793	—	13,775	53,732
1988	69,239	62,449	364	475	41	80	5,830	53,331	52,517	815	—	15,908	69,640
1989	76,721	68,369	379	515	55	86	7,317	60,803	60,011	792	—	15,918	85,558
1990	80,372	72,013	367	413	122	[7]−993	8,451	66,997	66,239	758	—	13,375	98,933
1991	88,839	77,851	352	605	432	89	9,510	72,570	71,549	1,021	—	16,269	115,202
Estimates[8]													
1992	92,737	80,606	370	621	514	85	10,541	79,405	78,344	1,061	—	13,332	128,534
1993	98,513	85,914	384	367	558	80	11,210	86,367	85,239	1,128	—	12,146	140,680
1994	104,367	91,329	382	293	624	75	11,664	95,477	94,271	1,206	—	8,890	149,570

[1]Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous income.
[2]Includes costs of peer review organizations (beginning with the implementation of the prospective payment system on October 1, 1983).
[3]Includes costs of experiments and demonstration projects.
[4]A negative amount is a loan to the Old Age and Survivors Insurance trust fund; a positive amount is a repayment of loan principal to the hospital insurance trust fund.
[5]The lump sum general revenue transfer, as provided for by section 151 of Public Law 98-21.
[6]Includes the lump sum general revenue adjustment of −$805 million, as provided for by section 151 of Public Law 98-21.
[7]Includes the lump sum general revenue adjustment of −$1,100 million, as provided for by section 151 of Public Law 98-21.
[8]Under Alternative II. Alternative II is the "intermediate" set of assumptions, with "best estimates" of future economic and demographic conditions.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund: *1992 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.* Washington. U.S. Government Printing Office, Apr. 2,1992.

Table 1.5

Operations of the Medicare supplementary medical insurance trust fund (cash basis) for calendar years 1966-91 and estimates for 1992-94

Year	Income				Disbursements			
	Total income	Premiums from enrollees	Government contributions[1]	Interest and other income[2]	Total disbursements	Benefit payments	Administrative expenses	Yearend balance[3]
Historical				Amount in millions				
1966	$324	$322	$0	$2	$203	$128	$75	$122
1967	1,597	640	933	24	1,307	1,197	110	412
1968	1,711	832	858	21	1,702	1,518	184	421
1969	1,839	914	907	18	2,061	1,865	196	199
1970	2,201	1,096	1,093	12	2,212	1,975	237	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	450
1972	2,808	1,382	1,389	37	2,614	2,325	289	643
1973	3,312	1,550	1,705	57	2,844	2,526	318	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	1,506
1975	4,673	1,918	2,648	107	4,735	4,273	462	1,444
1976	5,977	2,060	3,810	107	5,622	5,080	542	1,799
1977	7,805	2,247	5,386	172	6,505	6,038	467	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	4,902
1980	10,874	3,011	7,455	408	11,245	10,635	610	4,530
1981	15,374	[4]3,722	[4]11,291	361	14,028	13,113	915	5,877
1982	16,580	[4]3,697	[4]12,284	599	16,227	15,455	772	6,230
1983	19,824	4,236	14,861	727	18,984	18,106	878	7,070
1984	23,180	5,167	17,054	959	20,552	19,661	891	9,698
1985	25,106	5,613	18,250	1,243	23,880	22,947	933	10,924
1986	24,665	5,722	17,802	1,141	27,299	26,239	1,060	8,291
1987	31,844	[5]7,409	[5]23,560	875	31,740	30,820	920	8,394
1988	35,825	[5]8,761	[5]26,203	861	35,230	33,970	1,260	8,990
1989	[6]44,349	[6]12,263	30,852	[6]1,234	[6]39,783	38,294	[6]1,489	[6]13,556
1990	45,913	11,320	33,035	1,558	43,987	42,468	1,519	15,482
1991	51,224	11,934	37,602	1,688	48,770	47,229	1,541	17,935
Estimates								
1992	51,882	12,864	37,889	1,129	56,243	54,603	1,640	13,574
1993	63,429	15,076	47,482	871	63,585	61,873	1,712	13,418
1994	71,734	17,213	53,652	869	71,827	70,033	1,794	13,325

[1]The payments shown as being from the general fund of the U.S. Department of the Treasury include certain interest-adjustment items.
[2]Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.
[3]The financial status of the program depends on both the total net assets and the liabilities of the program.
[4]Section 708 of title VII of the Social Security Act modified the provisions for the delivery of Social Security benefit checks when the regularly designated delivery day falls on Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January 1, 1982, occurred on December 31, 1981. Consequently, the supplementary medical insurance (SMI) premiums withheld from the checks ($264 million) and the general revenue contributions ($883 million) were added to the SMI trust fund on December 31, 1981. These amounts are excluded from the premium income and general revenue income for calendar year 1982.
[5]Delivery of benefit checks normally due January 1, 1988, occurred on December 31, 1987. Consequently, the SMI premiums withheld from the checks ($692 million) and the general revenue contributions ($2,178 million) were added to the SMI trust fund on December 31, 1987. These amounts are excluded from the premium income and general revenue income for calendar year 1988 (refer to footnote 4)
[6]Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).
SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1992 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, Apr. 2, 1992.

Until the beginning of Medicare's prospective payment system (PPS) in fiscal year (FY) 1984, Medicare hospitals were reimbursed by a retrospective, cost-based system. HCFA continues to make retrospective, cost-based reimbursements to SNFs and HHAs. In addition, four classes of specialty hospitals (children's, psychiatric, rehabilitation, and long-term) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are excluded from PPS. HCFA reimburses these excluded facilities under a system of limits based on reasonable and allowable costs as defined by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248).

Under PPS, most hospitals providing inpatient services to Medicare beneficiaries are paid on a per discharge basis as defined by the diagnosis related groups (DRGs) patient classification scheme. The intermediary assigns the appropriate DRG code to each patient bill record and then pays the hospitals the predetermined DRG rate for each discharge.

In general, the PPS payment for a given case is considered full payment for the care received except for beneficiary deductible and coinsurance amounts. The PPS rates are calculated separately for urban and rural hospitals. The rates are then adjusted for differences in wage levels in various geographic areas, indirect costs of patient care associated with hospitals that have teaching programs, and costs related to treating a disproportionately large share of low-income patients. Also, additional payments are made for cases that involve extremely long hospital stays or those that are extremely expensive.

Supplementary medical insurance carriers

The Secretary of Health and Human Services contracts with carriers to perform certain administrative duties under SMI. Carriers determine reasonable charges, make payments, determine whether claims are for covered services, and deny claims for non-covered services and unnecessary use of services. Carriers handle claims for services provided by physicians and other suppliers covered by the SMI program.

When an SMI claim is submitted to a carrier, the physician is paid on the basis of the "reasonable or allowed charge." This was defined as the lowest of the physician's actual, customary, or prevailing charge. Beginning in January 1992, the reasonable charges are defined as the lesser of the submitted charges or defined by a new schedule based on a resource-based relative value scale. The fiscal intermediaries pay for SMI outpatient services and HHA services on a reasonable-cost basis.

Before October 1, 1990, either the patient or the provider could submit claims for SMI benefits. Patients who submitted claims (itemized bills) directly to the carrier received direct payment for covered services but remained responsible for the physician's (or supplier's) bill. Beginning October 1, 1990, physicians are required to submit the claims for payment. Physicians no longer have the option of requiring the beneficiary to file the claim.

Private health plan option

TEFRA allowed HCFA to contract with health maintenance organizations (HMOs) and competitive medical plans (CMPs) on a prospective capitation payment basis in order to provide health care services to Medicare beneficiaries. Regulations to implement TEFRA were published in January 1985. HCFA signed the first such "risk" contract in April 1985. As of December 1990, there were 100 risk plans with about 1.3 million enrollees. Including these risk plans, there were 166 group practice pre-payment plans with a total Medicare population of 2.0 million enrollees.

TEFRA made three major changes in the previous HMO legislation. First, it established that HCFA would pay the contracting plans 95 percent of the adjusted average per capita cost (AAPCC) of providing health care services for each class of enrolled beneficiary in the geographic area served by the plan. The AAPCC is HCFA's actuarial estimate of the amount that would be paid for Medicare-covered services if they were furnished locally under fee-for-service payments. The AAPCC payment rates are adjusted for demographic factors such as age, sex, institutional status, and welfare status and are published each September for use in the following calendar year. If the actual cost of services are higher than the AAPCC payment rate, the risk plan suffers a loss. If the actual cost of services are lower than the AAPCC payment rate, the risk plan realizes a "savings." HCFA requires that plans distribute any savings accrued to enrollees in the form of reduced premium rates or other charges, or additional health benefits, or both. However, the plan may elect to forgo its savings by accepting lower program payments or it may withhold part of the savings in a stabilization fund to apply against future losses.

Second, TEFRA legislated the "lock-in" provision. This means that Medicare enrollees agree to obtain all health care services from or under arrangement through the HMO. If enrollees do not obtain authorization for care from the HMO or CMP (other than for emergency or urgently needed services), neither the plans nor the Medicare program are obligated to pay for these services.

Third, TEFRA allowed HCFA to contract with CMPs as well as federally qualified HMOs. HCFA determines CMPs to be eligible through a process similar to that used for Federal HMO qualification. However, some organizations may find it easier to qualify as a CMP. For example, CMPs may use experience rating to set their commercial premiums, whereas HMOs must use community rating to set their commercial premiums.

There are advantages to enrollees, the Federal Government, and the health services industry as a result of the TEFRA risk-contract option. Enrollees usually receive additional benefits not covered by Medicare. They pay predictable monthly premiums and specified copayments. The Federal Government is able to provide access to health care that is rendered in an effective and efficient manner while promoting competition between prepaid plans and fee-for-service providers. The sponsors of health care plans participating under the risk-contract option receive fixed monthly payments, can contract with HCFA in the same way as their commercial clients, and can offer services to the large market of Medicare beneficiaries.

Life expectancy and Medicare benefits

Most Medicare enrollees can expect to receive benefits over their life expectancy that will exceed their payroll tax and premium contributions (Table 1.6). For HI enrollees 65 years of age or over, HCFA's Office of the Actuary (OACT) has developed various estimates of the value of Medicare hospital insurance contributions compared with expected benefits for 1990 and 2010 (Table 1.7). Whether the enrollee's earnings on which HI taxes were paid were low, average, or maximum, Medicare enrollees are getting a good bargain under Medicare.

For 1990, the ratio of the average expected HI lifetime benefits to accumulated lifetime HI taxes (based on average earnings on which HI taxes were paid) is 5 to 1 for males and 6 to 1 for females (Figure 1.8). Therefore, a male Medicare HI enrollee received $5 of HI benefits for every $1 of HI taxes paid over a lifetime. A female Medicare HI enrollee received $6 of HI benefits for every $1 of HI taxes paid over a lifetime. For a married couple the ratio was estimated to be about 11 to 1.

Table 1.6

Years of life expectancy at age 65 and average age at death: 1965 and 1980-90

Year	Males		Females	
	Years	Age	Years	Age
1965	12.92	77.92	16.34	81.34
1980	14.04	79.04	18.35	83.35
1981	14.24	79.24	18.58	83.58
1982	14.45	79.45	18.80	83.80
1983	14.31	79.31	18.63	83.63
1984	14.41	79.41	18.66	83.66
1985	14.39	79.37	18.62	83.62
1986	14.52	79.52	18.66	83.66
1987	14.64	79.64	18.73	83.73
1988	14.56	79.56	18.66	83.66
1989	14.84	79.84	18.87	83.87
1990	14.78	79.78	18.81	83.81

SOURCE: Social Security Administration, Office of Program Components: Data from the Office of the Actuary.

In the year 2010, Medicare enrollees will still receive a good bargain under Medicare, but not as good a bargain as in 1990. For HI enrollees 65 years of age in the year 2010, HCFA's actuarial estimates show that, as of July 2010, the ratio of the average expected HI lifetime benefits to accumulated lifetime HI taxes will be about 3 to 1 (based on average earnings on which HI taxes are to be paid). The ratio of HI benefits to HI taxes (based on average earnings on which HI taxes are to be paid) is the same (3 to 1) for both males and females; for a couple, the ratio is estimated at 5 to 1. Table 1.7 shows these ratios for Medicare beneficiaries with "low" and "maximum" earnings as well.

For Medicare SMI, the premium amounts contributed by all Medicare enrollees cover only a small part of the total cost of SMI benefits (Table 1.9). For example, the monthly SMI premium covers only about 25 percent of SMI enrollee costs. The remaining 75 percent of the SMI costs are paid out of general revenue funds. Expressed as a ratio, for FY 1990, $3.60 was paid out in SMI benefits for all beneficiaries for every $1 of SMI premium paid in by, or on behalf of, all Medicare enrollees (Figure 1.10). For disabled SMI enrollees, an estimated $4.70 was paid out in SMI benefits for every $1 of SMI premium; this ratio is nearly one-third higher than that for aged SMI enrollees ($3.60).

The decline in the ratio from FY 1987 (4.6 to 1.0) to FY 1989 (3.2 to 1.0) reflects, to a large degree, the implementation of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (Public Law 100-360). MCCA increased the SMI monthly premium amounts in 1988 without a corresponding increase in benefits during 1988. For example, a substantial portion of the SMI catastrophic benefits, such as prescription drugs, were not scheduled to go into effect until the early 1990s.

Three major legislative initiatives

There have been numerous legislative and regulatory changes to the Medicare program since its inception in 1966. The following three initiatives stand apart from other reforms with respect to the magnitude of changes in the incentives to providers, as in the instances of the hospital prospective payment system and the physician fee schedule, and with respect to benefit structure, as in the case of catastrophic coverage. The data that appear in this statistical issue of the *Health Care Financing Review* must be interpreted with an understanding of the nature and timing of each of these three Medicare program reforms.

Table 1.7

Present or estimated value of Medicare hospital insurance (HI) contributions and benefits: July 1, 1990 and 2010

Earnings on which HI taxes were paid	Present value of accumulated HI contributions with interest from 1966[1]	Present value of expected HI benefits to be paid on behalf of persons age 65 or over in 1988[2]			Ratio of present value of expected HI benefits to present value of accumulated HI contributions[3]		
		Male	Female	Couple	Male	Female	Couple
Year 1990							
Low	$3,380	$37,600	$41,340	$78,940	11:1	12:1	23:1
Average	7,510	37,600	41,340	78,940	5:1	6:1	11:1
Maximum	14,460	37,600	41,340	78,940	3:1	3:1	5:1
Year 2010 (estimated)							
Low	21,100	150,060	156,220	306,280	7:1	7:1	15:1
Average	46,890	150,060	156,220	306,280	3:1	3:1	5:1
Maximum	99,090	150,060	156,220	306,280	2:1	2:1	3:1

[1]Interest rates used for each year (to accumulate the contributions to July 1, 1990) were the June rate for the HI trust fund for that year. (For 1990 and beyond June rates were used from the *1991 Annual Report of the Board of Trustees of the Medicare Hospital Insurance Trust Fund*, Alternative II-B.)

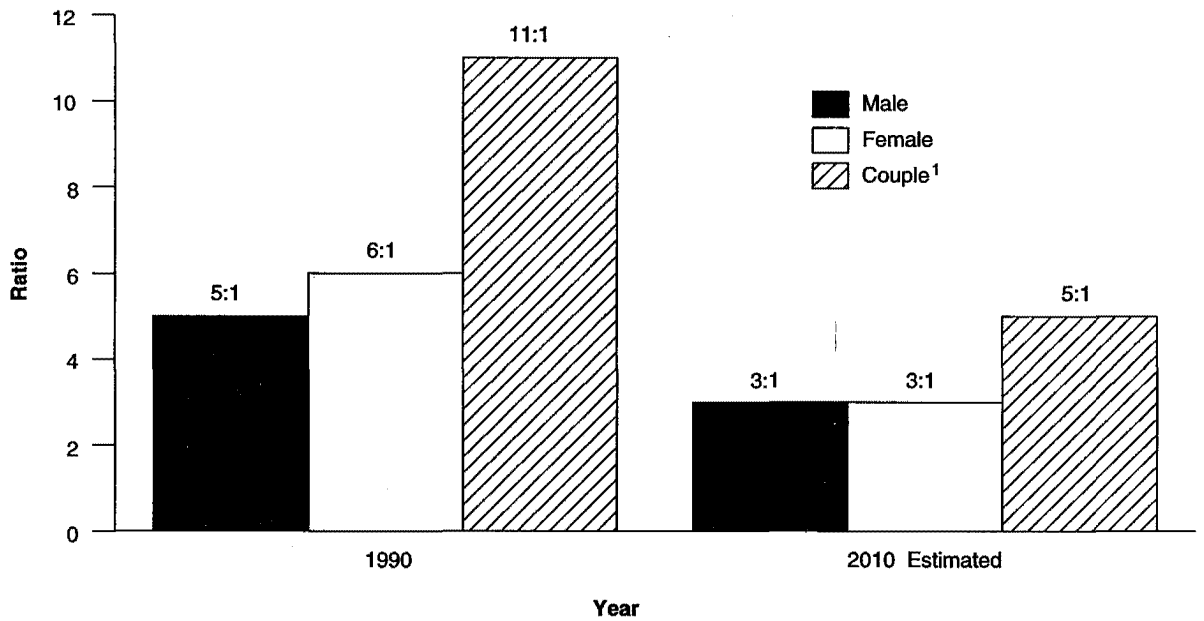
[2]Present value July 1, 1990, and 2010 of expected future benefits, discounted for both interest and mortality effects. Mortality is based on life tables for appropriate cohort group. June interest rates were used, including the assumed ultimate interest rate of 6.125 percent, from the *1991 Annual Report of the Board of Trustees of the Medicare Hospital Insurance Trust Fund*, Alternative II-B.

[3]Assumes (for a couple) that only one spouse has covered earnings since 1986 and the other has no covered earnings at all. For couples where both spouses have covered earnings (assuming, as it is assumed throughout, that at least one of them has earned enough quarters of coverage to entitle them to HI), the ratio would be somewhere between the single person ratio and the couple ratio for the spouse with the higher covered earnings.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates, Division of Hospital Insurance.

Figure 1.8

Ratio of present value of expected Medicare hospital insurance benefits to present value of hospital insurance contributions: Calendar years 1990 and 2010



[1]Assumes (for a couple) that only one spouse has covered earnings since 1986 and the other has no covered earnings at all. For couples where both spouses have covered earnings, the ratio would be somewhere between the single person ratio and the couple ratio for the spouse with the higher covered earnings.

NOTE: Based on average earnings on which hospital insurance contributions were paid.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates, Division of Hospital Insurance.

Prospective payment

When Congress passed the Social Security Amendments of 1983 (Public Law 98-21), it represented the most significant change in Medicare's hospital payment methodology since the beginning of the program. The amendments established Medicare's PPS, which became effective in FY 1984. As previously noted, PPS removed the cost-based reimbursement methodology for most participating hospitals and replaced it with payments that vary by type of case. The prospective, price-based system gave hospitals new incentives for cost containment and has produced major changes in the hospital industry and in the way hospital services are used by physicians and their patients.

Catastrophic coverage

The MCCA marked the most significant expansion of Medicare program benefits since its inception. Portions of the MCCA, primarily those affecting HI benefits, were in effect during 1989. However, Congress repealed the MCCA in 1989 (effective January 1, 1990), and most of the act's major provisions were never implemented.

The basic features of the MCCA were an expansion of certain HI benefits, reductions in the amounts beneficiaries had to pay for Medicare benefits under HI and SMI, and coverage for outpatient prescription drugs. The new law did not provide coverage for long-term stays in nursing homes.

For calendar year 1989, the MCCA eliminated many of the HI program's cost-sharing requirements and time limitations. The "spell of illness" concept was eliminated and, instead, Medicare covered an unlimited number of inpatient hospital days per year. Medicare covered 150 SNF days per year, and the prior hospitalization requirement was eliminated. An additional period of unspecified duration was added to the three periods of hospice care (210 days) otherwise provided. In addition, beginning in 1990, the number of days of coverage for home health care services provided on an intermittent basis was to have been increased from the 21-day maximum limit to 38 consecutive days. However, this did not go into effect in 1990 because of the repeal of the MCCA.

The MCCA added four new benefits to the SMI program: outpatient prescription drugs, home intravenous drug therapy, mammography screening, and respite care. These benefits were to have begun on January 1, 1990, but they never became effective. The new law set an upper limit on the amount of out-of-

Table 1.9

Medicare supplementary medical insurance benefit payments, percent change, and ratio of payments to premium income: Fiscal years 1967 and 1970-91

Fiscal year	Benefit payments			Ratio of benefit payments to premium income		
	Total	Aged	Disabled	Total	Aged	Disabled
	Amount in millions					
1967	$664	$664	NA	1:0	1:0	NA
1970	1,979	1,979	NA	2:1	2:1	NA
1971	2,035	2,035	NA	1:6	1:6	NA
1972	2,255	2,255	NA	1:7	1:7	NA
1973	2,391	2,391	NA	1:7	1:7	NA
1974	2,874	2,555	$319	1:7	1:6	2:6
1975	3,765	3,312	453	2:0	1:9	3:0
1976	4,672	4,064	608	2:4	2:3	3:6
Transitional quarter	1,269	1,083	186	2:4	2:2	4:0
1977	5,867	5,035	832	2:7	2:5	4:0
1978	6,852	5,821	1,031	2:8	2:7	4:2
1979	8,259	6,964	1,295	3:1	2:9	4:9
1980	10,144	8,512	1,632	3:5	3:2	5:6
1981	12,345	10,382	1,963	3:7	3:5	5:9
1982	14,806	12,404	2,402	3:9	3:6	6:5
1983	17,487	14,783	2,704	4:1	3:9	6:9
1984	19,473	16,845	2,628	4:0	3:8	5:9
1985	22,180	19,075	2,733	3:9	3:8	5:7
1986	25,169	22,180	2,989	4:4	4:3	6:0
1987	29,937	26,350	3,587	4:6	4:5	6:2
1988	33,682	29,797	3,885	3:8	3:7	4:9
1989	36,867	32,748	4,119	3:2	3:5	4:4
1990	41,498	36,838	4,660	3:6	3:6	4:7
1991	45,514	40,200	5,314	3:9	3:7	5:0
	Percent change					
1967-91	6,755	5,954	NA	—	—	—
1974-91	1,484	1,473	1,566	—	—	—
1989-90	13	12	13	—	—	—
1990-91	10	9	14	—	—	—

NOTES: For more detail on fund transactions, see the *1992 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund.* NA is not applicable.

SOURCE: Health Care Financing Administration: Office of the Actuary: Data from the Office of Medicare Cost Estimates, Division of Hospital Insurance.

pocket expenses a beneficiary would have had to pay in cost sharing per year under SMI, beginning in 1990. The upper limit was set at $1,370 in 1990 and would have been indexed to inflation in future years.

Physician payment reform

The new Medicare physician payment system is the most significant change in the way Medicare pays doctors, practitioners, and suppliers since the program began. In passing the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), Congress created a three-part physician payment reform package. One reform sets a goal for the rate of increase in Medicare expenditures by establishing volume performance standards. A second reform establishes limits on the amounts that non-participating physicians can charge beneficiaries. The third reform established a physician fee schedule, which is based on the resource-based relative value scale mandated by the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).

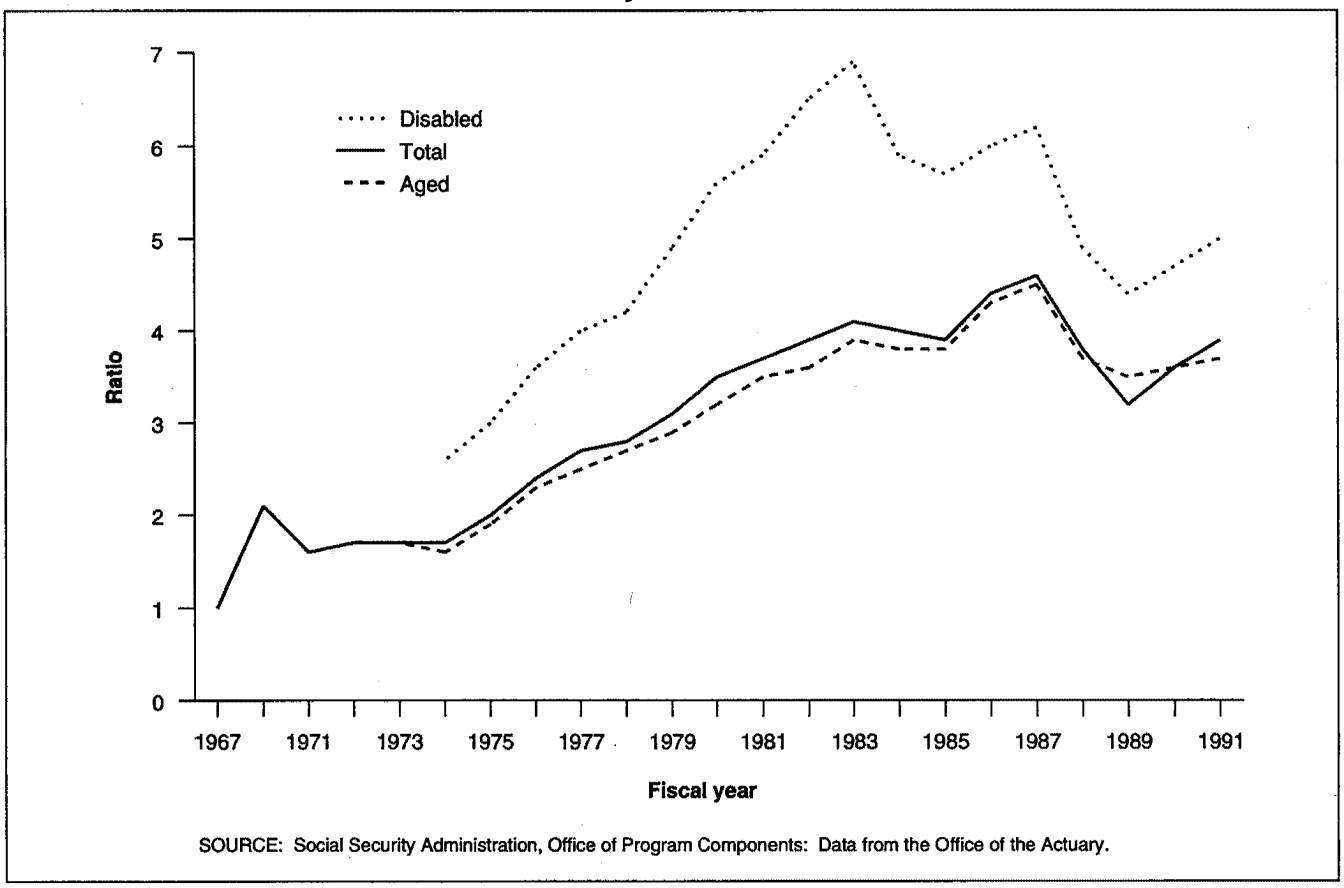
The Medicare fee schedule began January 1, 1992, and will be phased in over 5 years. Essentially, the fee schedule amounts are based on the relative resources used to render a service. Variation in practice costs between areas are accounted for by applying geographic practice cost indexes. There are no payment differentials for a service based on the specialty of the rendering physician. Under the fee schedule, Medicare continues to pay 80 percent of the allowed charge. The allowed charge is the actual charge or the fee schedule amount, whichever is lower.

HCFA estimates that about one-third of physician services will be paid on the basis of the new Medicare fee schedule in 1992; the other two-thirds will be paid on the basis of a transitional fee schedule while moving to the full fee schedule amount over the next 5 years. By 1996, all physician services will be paid under the Medicare fee schedule.

By replacing the traditional "customary, prevailing, and reasonable" charge system with the new fee schedule, HCFA will address widespread concern that the charge system led to imbalances in relative payment levels between procedural services, such as surgery, and primary care services, such as visits and consultations. The new fee schedule will also mitigate the wide variations in payment levels that historically have been observed for the same service provided in different geographic locations.

Figure 1.10

Ratio of Medicare supplementary medical insurance benefit payments to premium income: Fiscal years 1967-91



SOURCE: Social Security Administration, Office of Program Components: Data from the Office of the Actuary.

Medicare data collection process

The information contained in the various Medicare data systems comes from several sources: the beneficiary eligibility determination process performed for HCFA by SSA; the claims data generated through HCFA's common working file (CWF); data collected through the medical care provider application and certification processes; data obtained by surveys sponsored or supported by HCFA and other Federal agencies; and through fiscal cost reports submitted by participating institutional providers. Each of these sources of data is discussed in further detail.

Eligibility for Medicare is tied to entitlement for Social Security benefits. Thus, SSA maintains entitlement and demographic information on all Medicare enrollees. Many of HCFA's centralized computer operations related to entitlement and eligibility are still performed by SSA. This enrollee information is transmitted daily to HCFA.

In January 1991, HCFA began using the CWF concept for processing Medicare claims. The CWF represents a major reorganization of certain fiscal intermediary and carrier claims procedures. It simplifies and improves the processing of Medicare claims by providing a single file containing merged HI and SMI eligibility and utilization data for each beneficiary. The CWF established a prepayment review and payment authorization process designed to reduce claims payment error, reduce provider overpayment, and provide the most current and accurate data on Medicare beneficiaries.

The CWF merges HI and SMI beneficiary-specific data into one of nine regionally based sectors. Each Medicare contractor within the sector is linked to a regional site and each CWF site has linked HI and SMI data. Each host site maintains beneficiary data containing complete entitlement, eligibility, and claims payment data on every Medicare beneficiary assigned to the CWF sector. Medicare fiscal intermediaries and carriers submit their claims to the CWF host where the claim is reviewed and, if no errors exist, an authorization is given to the intermediary or carrier to pay the claim. Furthermore, fiscal intermediaries, carriers, and hospitals have online inquiry capability to the CWF for claims processing, problem resolution, and answering beneficiary inquiries. The CWF hosts then forward the data to the HCFA central office.

The bulk of the statistical data collected by HCFA is a by-product of the CWF and is maintained in the Medicare Decision Support System (MDSS). The MDSS statistical files are generated by combining information from SSA on beneficiary eligibility with claims information from the CWF. The primary objective of the MDSS is to provide data to measure and evaluate the operation and effectiveness of the

Medicare program and to provide data for legislative, policy, and research initiatives.

HCFA collects data on participating institutional providers and suppliers of service through the formal application and certification process that examines the provider qualifications for furnishing health care. The certification procedure is performed according to HCFA guidelines and regulations by an agency of the State where the institution is located. Certification information is transmitted to the HCFA regional office for review and then forwarded to the HCFA central office to be posted to the provider of services master file. The final approval for participation comes from HCFA. After the initial certification, the qualifications of an institution are reviewed periodically, culminating in a decision to recertify or terminate provider participation.

HCFA also collects financial data obtained from cost reports submitted by all participating Medicare institutional providers (e.g., hospitals, SNFs, HHAs, and hospices) for the primary purpose of reimbursing the providers for services furnished to Medicare beneficiaries. These data are also frequently used to analyze the differences between Medicare payments and costs; to more accurately determine the passthrough costs (e.g., capital and medical education) per bill record for hospitals under PPS; and for a wide variety of policy, statistical, and financial reconciliation initiatives.

Finally, HCFA periodically collects data through the sponsorship or technical support of a number of surveys designed to gather information to supplement data obtained through the administration of the Medicare program. Data collected in surveys generally focus on services not covered by Medicare—e.g., drugs, eyeglasses, dental care, and long-term care—and on socioeconomic information and related health care characteristics that are not part of the Medicare administrative data system.

The Medicare data system contains a wealth of utilization, payment, and epidemiological information on the Medicare population. The disaggregated nature of the data and the relatively detailed diagnostic, procedure, and cost information allow for great flexibility regarding the types of reports and studies that can be produced. HCFA makes program data available through publication of a variety of analytical and statistical reports on the Medicare program, some of which are available in the form of public use computer tapes.

Reference

Health Care Financing Administration: *The Medicare Handbook, 1990.* HCFA Pub. No. 10050. Health Care Financing Administration. Washington. U.S. Government Printing Office, 1990.