Medicare

Overview

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons aged 65 older. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end stage renal disease (ESRD), and certain otherwise noncovered aged persons who elect to pay a premium for Medicare coverage.

Medicare has traditionally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. A new, third part of Medicare, sometimes known as Part C, is the Medicare+Choice program, which was established by the Balanced Budget Act of 1997 (Public Law 105-33 or "BBA") and which expanded beneficiaries' options for participation in private-sector health care plans. When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2000, about 40 million people are enrolled in one or both of Parts A and B of the Medicare program, and 6.4 million of them have chosen to participate in a Medicare+Choice plan.

Coverage

HI is generally provided automatically, and free of premiums, to persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in federal, state, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to HI benefits. HI coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 1999, the HI program provided protection against the costs of hospital and specific other medical care to about 39 million people (34 million aged and 5 million disabled enrollees). HI benefit payments totaled $129 billion in 1999.

The following health care services are covered under Medicare's HI program:

Inpatient hospital care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care (LTC) hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).

Skilled nursing facility (SNF) care is covered by HI only if it follows within 30 days (generally) of a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital care but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21-100. HI does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.

Home health agency (HHA) care, including care provided by a home health aide, may be furnished part time by a HHA in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment (DME) may also be provided. There must be a plan of treatment and periodical review by a physician. Home health care under HI has no duration limitations, no copayment, and no deductible. For DME, beneficiaries must pay a 20-percent coinsurance, as required under SMI of Medicare. Full-time nursing care, food, blood, and drugs are not provided as HHA services. The BBA transferred from HI to SMI those home health services furnished on or after January 1, 1998 that are unassociated with a hospital or skilled nursing facility stay. HI will continue to cover the first 100 visits following a 3-day hospital stay or a skilled nursing facility stay. The cost of the transferred services is being gradually shifted from HI to SMI over a 6-year period. A portion of the higher SMI costs is gradually included in the monthly SMI premium paid by beneficiaries over 7 years (1998-2003).

Hospice care is a service provided to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires

treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program, but does pay small coinsurance amounts for drugs and inpatient respite care.

An important HI component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by HI during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61-90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a nonrenewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

All citizens (and certain legal aliens) age 65 or older, and all disabled persons entitled to coverage under HI, are eligible to enroll in the SMI program on a voluntary basis by payment of a monthly premium. Almost all persons entitled to HI choose to enroll in SMI. In 1999, the SMI program provided protection against the costs of physician and other medical services to about 37 million people. SMI benefits totaled $80.7 billion in 1999.

The SMI program covers the following services and supplies:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists. Also covered are the services provided by these Medicare-approved practitioners who are not physicians: certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or skilled nursing facility), physician assistants, nurse practitioners and clinical nurse specialists in collaboration with a physician.
- Services in an emergency room or outpatient clinic, including same-day surgery, and ambulance services.
- Home health care not covered under HI.
- Laboratory tests, X-rays, and other diagnostic radiology services, as well as certain preventive care screening tests.
- Ambulatory surgical center services in a Medicare-approved facility.
- Most physical and occupational therapy and speech pathology services.
- Comprehensive outpatient rehabilitation facility services and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.
- Radiation therapy, renal (kidney) dialysis and transplants, and heart and liver transplants under certain limited conditions.
- Approved durable medical equipment for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, and casts.
- Drugs and biologicals that cannot be self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered).

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. SMI services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical or occupational therapy services performed after 2001 in settings other than hospitals), and higher cost-sharing requirements (such as those for outpatient treatments for mental illness).

It should be noted that some health care services are not covered by Medicare. Noncovered services include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, hearing aids, and most prescription drugs. These services are not a part of the Medicare program unless they are a part of a private health plan under the Medicare+Choice program.

Medicare+Choice (Part C) is an expanded set of options for the delivery of health care under Medicare. While all Medicare beneficiaries can receive their benefits through the original fee-for-service (FFS) program, most beneficiaries enrolled in both HI and SMI can choose to participate in a Medicare+Choice plan instead. Organizations that seek to contract as Medicare+Choice plans must meet specific organizational, financial, and other requirements. Following are the primary Medicare+Choice plans:

Coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law.

Private, unrestricted FFS plans, which allow beneficiaries to select certain private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization.

Medical savings account (MSA) plans, which provide benefits after a single high deductible is met. Medicare

makes an annual deposit to the MSA, and the beneficiary is expected to use the money in the MSA to pay for medical expenses below the annual deductible. MSAs are currently a test program for a limited number of eligible Medicare beneficiaries.

Except for MSA plans, all Medicare+Choice plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan. There are some restrictions as to who may elect an MSA plan, even when enrollment is no longer limited to a certain number of participants.

Program Financing, Beneficiary Liabilities, and Provider Payments

All financial operations for Medicare are handled through two trust funds, one for the HI program and one for the SMI program. These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The HI program is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by the HI program and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The HI tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Beginning in 1994, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The HI tax rate is specified in the Social Security Act and cannot be changed without legislation.

The HI Trust Fund also receives income from the following sources: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries; (2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily; (3) reimbursements from the general fund of the U.S. Treasury for the cost of providing HI coverage to certain aged persons who retired when the HI program began and thus were unable to earn sufficient quarters of coverage (and those federal retirees similarly unable to earn sufficient quarters of Medicare-qualified federal employment); (4) interest earnings on its invested assets; and (5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

The SMI program is financed through premium payments ($45.50 per beneficiary per month in 2000) and contributions from the general fund of the U.S. Treasury. Beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are the largest source of SMI income. The SMI Trust Fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. Beneficiary premiums and general fund payments are redetermined annually, to match estimated program costs for the following year.

Capitation payments to Medicare+Choice plans are financed from the HI and SMI Trust Funds in proportion to the relative weights of HI and SMI benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both HI and SMI. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private "Medigap" insurance; or (3) by Medicaid, if the person is eligible. The term "Medigap" is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by Blue Cross and Blue Shield (BC/BS) and various commercial health insurance companies.

For beneficiaries enrolled in Medicare+Choice plans, the beneficiary's payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries pay the monthly Part B premium and may, depending on the plan, pay an additional plan premium.

For hospital care covered under HI, a fee-for-service beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($776 in 2000). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($194 per day in 2000) are required through the 90th day of a benefit period. Each HI beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance

payments ($388 per day in 2000) are required.

For skilled nursing care covered under HI, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21-100, a copayment ($97 per day in 2000) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing. Home health care has no deductible or coinsurance payment by the beneficiary. In any HI service, the beneficiary is responsible for fees to cover the first 3 pints or units of nonreplaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by the HI program. Eligibility is generally earned through the work experience of the beneficiary or of his or her spouse. However, most aged people who are otherwise ineligible for premium-free HI coverage can enroll voluntarily by paying a monthly premium, if they also enroll in SMI. For people with fewer than 30 quarters of coverage as defined by SSA, the 2000 HI monthly premium rate is $301; for those with 30 to 39 quarters of coverage, the rate is reduced to $166. Voluntary coverage upon payment of the HI premium, with or without enrolling in SMI, is also available to disabled individuals for whom cash benefits have ceased due to earnings in excess of those allowed for receiving cash benefits.

For SMI, the beneficiary's payment share includes the following: one annual deductible (currently $100); the monthly premiums; the coinsurance payments for SMI services (usually 20 percent of the medically allowed charges); a deductible for blood; certain charges above the Medicare-allowed charge (for claims not on assignment); and payment for any services that are not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

Provider Payments

Before 1983, HI payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under PPS, a specific predetermined amount is paid for each inpatient hospital stay, based on each stay's diagnosis-related group (DRG) classification. In some cases the payment the hospital receives is less than the hospital's actual cost for providing the HI-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays. Payments for skilled nursing care are made under a separate prospective payment system. Payments for inpatient rehabilitation, psychiatric, and home health care are currently reimbursed on a reasonable cost basis, but prospective payment systems are expected to be implemented in the near future, as required by the BBA.

For SMI, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality. Beginning January 1992, allowed charges were defined as the lesser of (1) the submitted charges, or (2) the amount determined by a fee schedule based on a relative value scale (RVS). Payments for DME and clinical laboratory services are also based on a fee schedule. Hospital outpatient services and HHAs are currently reimbursed on a reasonable cost basis, but the BBA has provided for implementation of prospective payment systems for these services in the near future.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are "participating physicians" if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since Medicare beneficiaries may select their doctors, they have the option to choose those who participate.

Medicare payments to Medicare+Choice plans are based on a blend of local and national capitated rates, generally determined by the capitation payment methodology described in section 1853 of the Social Security Act. Actual payments to plans vary based on demographic characteristics of the enrolled population. New "risk adjusters" based on demographics and health status are currently being phased in to better match Medicare capitation payments to the expected costs of individual beneficiaries.

Claims Processing

Medicare's HI and SMI fee-for-service claims are processed by nongovernment organizations or agencies that contract to serve as the fiscal agent between providers and the federal government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process HI claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for SMI. Examples of intermediaries are BC/BS (which utilize their plans in various states) and other commercial insurance companies. Intermediaries' responsibilities include the following:

- Determining costs and reimbursement amounts.
- Maintaining records.

- Establishing controls.
- Safeguarding against fraud and abuse or excess use.
- Conducting reviews and audits.
- Making the payments to providers for services.
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle SMI claims for services by physicians and medical suppliers. Examples of carriers are the BS plans in a state, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare.
- Maintaining quality-of-performance records.
- Assisting in fraud and abuse investigations.
- Assisting both suppliers and beneficiaries as needed.
- Making payments to physicians and suppliers for services that are covered under SMI.

Peer review organizations (PROs) are groups of practicing health care professionals who are paid by the federal government to generally oversee the care provided to Medicare beneficiaries in each state and to improve the quality of services. PROs educate other health care professionals and assist in the effective, efficient, and economical delivery of health care services to the Medicare population. The ongoing effort to combat monetary fraud and abuse in the Medicare program was intensified after enactment of the Health Insurance Portability and Accountability Act of 1996, which created the Medicare Integrity Program. Prior to this 1996 legislation, HCFA was limited by law to contracting with its current carriers and fiscal intermediaries to perform payment safeguard activities. The Medicare Integrity Program provided HCFA with stable, increasing funding for payment safeguard activities, as well as new authorities to contract with entities to perform specific payment safeguard functions.

Administration

The Department of Health and Human Services (HHS) has the overall responsibility for administration of the Medicare program. Within HHS, responsibility for administering Medicare rests with HCFA. The Social Security Administration (SSA) assists, however, by initially determining an individual's Medicare entitlement by withholding Part B premiums from the Social Security benefit checks of beneficiaries, and by maintaining Medicare data on the Master Beneficiary Record, which is SSA's primary record of beneficiaries. The Internal Revenue Service in the Department of the Treasury collects the HI payroll taxes from workers and their employers.

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the federal government, oversees the financial operations of the HI and SMI Trust Funds. The Secretary of the Treasury is the managing trustee. The Board of Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds on or about the first day of April each year.

State agencies (usually State Health Departments under agreements with HCFA) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with HCFA, these agencies then certify the facilities that are qualified.

Data Summary

The Medicare program covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. In 1999, HI covered about 39 million enrollees with benefit payments of $128.8 billion, and SMI covered 37 million enrollees with benefit payments of $80.7 billion. Administrative costs were about 1 percent of HI and about 2 percent of SMI disbursements for 1999. Total disbursements for Medicare in 1999 were $213 billion.

Medicare: History of Provisions

Act [*]	Insured Status
	Entitlement to Hospital Insurance Benefits
1965	Any individual aged 65 or older entitled to monthly benefits under the Social Security or Railroad Retirement program, or aged 65 before 1968, or 3 quarters of coverage (QC) after 1965 and before attainment of age 65.
1967	Or 3 QC for each year after 1966 and before attainment of age 65.
1972	Any disabled individual, under age 65, entitled to monthly disability benefits for 24 consecutive months under the Social Security or Railroad Retirement program (excludes spouses and children of disabled individuals). Any individual under age 65 who has end stage renal disease and who is either fully or currently insured, or is entitled to monthly benefits under the Social Security or Railroad Retirement program or is the spouse or dependent child of such an insured individual or beneficiary. Entitlement begins on the first day of the third month following the initiation of a course of renal dialysis and ends with the 12th month following the month in which either the dialysis terminates or the individual has a renal transplant.
	Any individual aged 65 or older enrolled in the SMI program who is not otherwise entitled to HI benefits, upon voluntary participation with payment of hospital insurance premium.
1980	Any individual who would be entitled to monthly benefits under the Social Security or Railroad Retirement program if application were made.
	Any disabled individual under age 65 entitled to monthly disability benefits for a total of 24 months, not necessarily consecutive, under the Social Security or Railroad Retirement program.
	Medicare coverage extended for up to 36 months for disabled individuals whose disability continues, but whose monthly benefit ceased because they engaged in substantial gainful activity.
	Second waiting period eliminated if a former disabled-worker beneficiary becomes entitled again within 5 years (7 years for disabled widows and widowers and disabled children aged 18 or older).
1982	Federal employees covered under HI based on QC for earnings as federal employees and/or based on deemed QC for earnings as federal employees before 1983.
1983	Employees of nonprofit organizations, effective Jan. 1, 1984.
1985	Premium-paying individuals who do not purchase Part A coverage within a specific time after becoming eligible because of age are subject to a 10-percent penalty for each 12 months they are late in enrolling. There is a cutoff on the length of time these individuals will have to pay an enrollment penalty. The 10-percent premium penalty would be limited to twice the number of years enrollment was delayed. Therefore, if enrollment were delayed 1 year, the penalty would be assessed for 2 years. Individuals in this category and already enrolled will have the length of time the higher premium was paid credited to them.
1986	Mandatory coverage—Hospital Insurance (Part A) program only—provided to state and local government employees not covered under Social Security and hired after Mar. 31, 1986.
1987	Second waiting period eliminated if a former disabled beneficiary becomes entitled again (no time limit).

[*] Act refers to legislation enacted in the year shown.

Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1989 Disabled individuals under age 65 who are no longer entitled to Social Security disability benefits because their earnings exceeded the substantial gainful activity level have the option to purchase Medicare coverage by paying the HI and SMI premiums.

Entitlement to Supplementary Medical Insurance Benefits

1965 Any U.S. resident (citizen or lawfully admitted alien with 5 years continuous residence) aged 65 or older or any individual entitled to HI benefits upon voluntary participation with payment of SMI premium.

1972 Any individual under age 65 entitled to HI benefits, upon voluntary participation with payment of SMI premium.

1984 For calculating the amount of premium surcharge for individuals from age 65 up to age 70 not previously enrolled in Medicare, the number of years of an individual's employer group health insurance will not be taken into account.

1987 Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

Medicare Benefits

HI and SMI

Requires that Medicare be secondary payer to benefits provided by liability insurance policies or under no-fault insurance.

1981 Requires that Medicare be secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely due to end-stage renal disease (ESRD) for up to 12 months.

1982 For workers and their spouses aged 65-69, Medicare is the secondary payer when benefits are provided under an employer-based group health plan (applicable to employers with 20 or more employees who sponsor or contribute to the group plan).

Health maintenance organizations (HMOs) will be covered as providers of benefits. The Secretary of HHS must certify the prospective payment mechanism for HMOs before implementation.

1984 Medicare secondary payer provisions are extended to spouses aged 65-69 of workers under age 65 whose employer-based group health plan covers such spouses.

For health maintenance organizations (HMOs), includes medical and other health services furnished by clinical psychologists.

1985 Provides payment for liver transplant services.

1986 Extends the working age secondary payer provision to cover workers and their spouses beyond the age of 69.

For HMOs that offered organ transplants as a basic health service on Apr. 15, 1985, such services may be offered from Oct. 1, 1985, through Apr. 1, 1988.

For disabled individuals who are covered by employer-based health plans (with at least 100 employees), Medicare is the secondary payer, effective for 1987-91.

1987 Requires health maintenance organizations/competitive medical plans that cease to contract with Medicare to provide or arrange supplemental coverage of benefits related to preexisting conditions for the lesser of 6 months or the duration of an exclusion period.

Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

Clarifies that the secondary payer provision for disabled individuals covered under employer-based health plans for employers with at least 500 employees applies to employers that are government entities.

1990 Requires that Medicare be the secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely due to ESRD for up to 18 months (extended from 12 months), effective Feb. 1, 1991, to Jan. 1, 1996.

The secondary payer provision for disabled beneficiaries covered under large employer plans (see 1986.); effective through Sept. 30, 1995.

1993 The secondary payer provision for disabled beneficiaries covered under large employer plans is effective through Sept. 30, 1998.

The secondary payer provision for beneficiaries with ESRD applies for all beneficiaries with end stage renal disease, not only those entitled to Medicare solely on the basis of it. The extension to include the first 18 months of an individual's entitlement on the basis of ESRD is effective through Sept. 30, 1998.

1997 An expanded set of options for the delivery of health care under Medicare, referred to as Medicare+Choice, is established. All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service program. In addition, most beneficiaries can choose instead to receive their Medicare benefits through one of the following Medicare+Choice plans: (1) coordinated care plans (such as health maintenance organizations, provider-sponsored organizations, and preferred provider organizations); (2) Medical Savings Account (MSA)/High Deductible plans (through a demonstration available for up to 390,000 beneficiaries); or (3) private fee-for-service plans. Except for MSA plans, all Medicare+Choice plans are required to provide the current Medicare benefit package (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. MSA plans provide Medicare benefits after a single high deductible is met, and enrollees receive an annual deposit in their Medical Savings Account. Transition rules for current Medicare HMO program also provided.

The provision making Medicare the secondary payer for disabled beneficiaries in large group health plans, previously scheduled to expire Sept. 30, 1998, made permanent.

The provision making Medicare secondary payer for the first 12 months of entitlement due to ESRD, which had been extended on a temporary basis (through Sept. 30, 1998) to include the first 18 months of entitlement, has been extended, permanently, to include the first 30 months of entitlement on the basis of ESRD.

Hospital Insurance

1965 In each benefit period, inpatient hospital services, 90 days. Includes semiprivate accommodations, operating room, hospital equipment (including renal dialysis), laboratory tests and X-ray, drugs, dressings, general nursing services, and services of interns and residents in medical osteopathic or dentistry training. Inpatient psychiatric hospital care limited to 190-day lifetime maximum. Outpatient hospital diagnostic services. Post-hospital extended-care services, 100 days (including physical, occupational, and speech therapy). Post-hospital home health services, 100 visits. Deductible and coinsurance provisions (see table 2.C1).

1967 Lifetime reserve of 60 additional days of inpatient hospital services. Outpatient hospital diagnostic services transferred to SMI.

1972 Services of interns and residents in podiatry training.

1980 Unlimited home health visits in a year. Requirement for prior hospitalization eliminated. Home health services provided for up to 4 days a week and up to 21 consecutive days.

	Alcohol detoxification facility services.
1981	Part A coinsurance is based on the deductible for the calendar year in which services are received rather than the deductible in effect at the time the beneficiary's spell of illness began, starting in 1982.
	Alcohol detoxification facility services eliminated.
1982	Beneficiaries expected to live 6 months or less may elect to receive hospice care benefits instead of other Medicare benefits. May elect maximum of two 90-day and one 30-day hospice care periods, effective Nov. 1, 1983, to Oct. 1, 1986.
1984	For durable medical equipment provided by home health agencies, the payment amount is reduced from 100 percent of costs to 80 percent of reasonable charges.
1986	Set the Part A deductible for 1987 at $520 with resulting increases in cost sharing. Increased the Part A deductible annually by the applicable percentage increase in the hospital prospective payment rates.
	Hospice care benefit (enacted in 1982) made permanent.
1987	Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).
1988	Enrollee pays annual hospital deductible (set at $560 for 1989) and Medicare pays balance of covered charges, regardless of the number of days of hospitalization (except for psychiatric hospital care, which is still limited by 190-day lifetime maximum).
	The number of days in a skilled nursing facility changed to 150 per year. Deletes the requirement for a prior hospital stay of 3 or more consecutive days.
	Expands home health care to provide care for less than 7 days per week and up to 38 consecutive days.
	Hospice care extended beyond 210 days when enrollee is certified as terminally ill.
	All 1988 provisions became effective Jan. 1, 1989.
1989	The spell of illness and benefit period coverage of laws prior to 1988 return to the determination of inpatient hospital benefits in 1990 and later. After the deductible is paid in benefit period, Medicare pays 100 percent of covered costs for the first 60 days of inpatient hospital care. Coinsurance applies for the next 30 days in a benefit period.
	The requirement for a prior hospital stay of 3 or more consecutive days is reinstated for skilled nursing facility services. Coverage returns to 100 days post-hospital care per spell of illness with a daily coinsurance rate in effect for days 21 through 100.
	Home health services return to a limit of 21 consecutive days of care. Provision providing for home health care for fewer than 7 days per week continued due to a court decision.
	Hospice care is returned to a lifetime limit of 210 days.
1990	Hospice care is extended beyond 210 days when enrollee is certified as terminally ill.
1997	Home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled nursing facility stay. The cost to the SMI Trust Fund of the transferred services will phase in over a 6-year period (that is, the HI Trust Fund will transfer funds to the SMI Trust Fund during that period).
	Limits on the number of hours and days that home health care can be provided have been clarified. "Part-time" now defined as skilled nursing and home health aide services (combined) furnished any number of days per week, for less than 8 hours per day and 28 or

fewer hours per week. "Intermittent" now defined as skilled nursing care provided for fewer than 7 days each week, or less than 8 hours each day (combined) for 21 days or less.

Hospice benefit periods are restructured to include two 90-day periods, followed by an unlimited number of 60-day periods.

Medicare coverage provided for a number of prevention initiatives, most of which covered under SMI program. HI program affected mainly by two of the initiatives:

Annual prostate cancer screening for male beneficiaries aged 50 or older, effective Jan. 1, 2000; and (2) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries age 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances.

Supplementary Medical Insurance

1965 Physician and surgeon services. In-hospital services of anesthesiologists, pathologists, radiologists, and psychiatrists. Limited dental services. Home health services, 100 visits in calendar year. Other medical services including various diagnostic tests, limited ambulance services, prosthetic devices, rental of durable medical equipment used at home (including equipment for dialysis), and supplies used for fractures. For deductible and coinsurance provisions, see table 2.C1.

Beginning in 1966, the beneficiary pays a $50 deductible, with a 3-month carryover provision.

1967 Outpatient hospital diagnostic services transferred from HI. Includes physical therapy services in a facility. Purchase of durable medical equipment.

1972 Physical therapy services furnished by a therapist in his or her office or individual's home (calendar year limit of $100). Chiropractor services (limited to manual manipulation of the spine). Outpatient services include speech pathology services furnished in, or under arrangements with, a facility or agency. Services of a doctor of optometry in furnishing prosthetic lenses.

Beginning in 1973, the beneficiary pays a $60 deductible.

1977 Services in rural health clinics.

1980 Home health services. Deductible applicable to home health services is eliminated, effective July 1, 1981.

Facility costs of certain surgical procedures performed in freestanding ambulatory surgical centers.

Increase in annual limit for outpatient therapy from $100 to $500.

Recognizes comprehensive outpatient rehabilitation facilities as Medicare providers.

1981 Beginning in 1982, the beneficiary pays a $75 deductible, with the carryover provision eliminated.

1984 Hepatitis B and pneumococcal vaccines and blood clotting factors and necessary supplies are included as Part B benefits. Debridement of mycotic toenails is limited.

For outpatient physical therapy services, includes services of a podiatrist. For outpatient ambulatory surgery, includes services of a dentist and podiatrist furnished in his or her office.

1986 Includes vision care services furnished by an optometrist.

For occupational therapy services, includes services furnished in a skilled nursing facility (when Part A coverage has been exhausted), in a clinic, rehabilitation agency, public health agency, or by an independently practicing therapist.

Includes outpatient immunosuppressive drugs for 1 year after transplant and occupational therapy services providers in certain delivery settings.

For ambulatory surgical procedures performed in ambulatory surgical centers, hospital outpatient departments, and certain physician offices, the Part B coinsurance and deductible are no longer waived.

1987 Increases the maximum payment for mental health services and includes outpatient mental health services provided by ambulatory hospital-based or hospital-affiliated programs under the supervision of a physician.

Services provided by clinical social workers when furnished by risk-sharing health maintenance organizations/competitive medical plans, physician assistants in rural health manpower shortage areas, clinical psychologists in rural health clinics and community mental health centers, and certified nurse-midwives.

Prescription drugs used in outpatient immunosuppressive therapy.

Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1988 Beginning Jan. 1, 1990, the beneficiary pays a $75 deductible and 20-percent coinsurance, but once out-of-pocket expenses for the deductible and coinsurance exceeds $1,370, Medicare pays 100 percent of allowable charges for remainder of year.

Beginning in 1991, Medicare pays 50 percent of the cost of outpatient prescription drugs above $600. When fully implemented in 1993, Medicare will pay 80 percent of prescription drug costs above a deductible which assumes that 16.8 percent of Part B enrollees will exceed the deductible.

Certain prescription drugs-immunosuppressive therapy and intravenous (IV) drugs that can be administered in a home setting will be covered in 1990 under the new prescription drug provision.

1989 Provisions enacted in 1988 and to begin in 1990 and 1991 are repeated and benefits are restored to levels in effect prior to Jan. 1, 1989.

Limits on mental health benefits eliminated in 1990. Coverage extended to services of clinical psychologists and social workers.

The annual payment limits of $500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to $750, for 1990 and later. (See 1980.)

1990 Beginning in 1991, routine mammography screenings are covered.

The Part B deductible is set at $100 in 1991 and subsequent years.

Beginning in 1992, physicians' services are reimbursed on a fee-schedule basis.

1993 Includes coverage of oral, self-administered anticancer drugs.

Lengthens the coverage period for immunosuppressive drugs after a transplant to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter.

The annual payment limits of $760 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to $900 for 1994 and later. (See 1989.)

1997 Home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled nursing facility stay. The cost to the SMI Trust Fund of the transferred services will phase in over a 6-year period, while the cost of the home health services will phase into the SMI premium over 7 years.

Coverage provided for a number of prevention initiatives, including (1) annual screening mammograms for female beneficiaries age 40 or older, with SMI deductive waived; (2)

screening pap smear and pelvic exam (including clinical breast exam) every 3 years or annually for beneficiaries at higher risk, with SMI deductible waived; (3) annual prostate cancer screening for male beneficiaries aged 50 or older, effective Jan. 1, 2000; (4) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances; (5) diabetes outpatient self-management training in nonhospital-based programs (previously covered in hospital-based programs only) and blood glucose monitors and testing strips for all diabetics (previously provided for insulin-dependent diabetics only), effective July 1, 1998; (6) procedures to identify bone mass, detect bone loss, or determine bone quality for certain qualified beneficiaries, at frequencies determined by the Secretary of HHS, effective July 1, 1998.

Beginning January 1999, an annual beneficiary limit of $1,500 will apply to all outpatient physical therapy services, except for services furnished by a hospital outpatient department. A separate $1,500 limit will also apply to outpatient occupational therapy services, except for services furnished by hospital outpatient departments. Beginning with 2002, these caps will be increased by the percentage increase in the Medical Economic Index. (See 1993.)

1999 The coverage period for immunosuppressive drugs after a transplant is lengthened to 44 months, for individuals who exhaust their 36 months of coverage in 2000. For those exhausting their 36 months of coverage in 2001, at least 8 more months will be covered. (The Secretary of HHS will specify the increase, if any, beyond 8 months.) For those exhausting their 36 months of coverage in 2002, 2003, or 2004, the number of additional months may be more or less than 8. (The Secretary will specify the increase for each of these years.) (See 1993.)

The annual payment limits of $1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services furnished by independent practitioners (that is, not by hospital outpatient department), are suspended for 2000 and 2001. (See 1997.)

Medicare Financing

Hospital Insurance Taxes

See table 2.A3.

Appropriations from General Revenues

1965 For HI costs attributable to transitionally insured beneficiaries.

For HI costs attributable to noncontributory wage credits granted for military service prior to 1957 (see table 2.A2).

For the SMI program, an amount equal to participant premiums.

1972 For cost of SMI not met by enrollee premiums.

1982 For HI costs attributable to beneficiaries having transitional entitlement based on Medicare-qualified federal employment.

1983 For HI taxes on noncontributory wage credits granted for military service (a) from the inception of HI program through 1983 and (b) on a current basis, annually, beginning in 1984 (see table 2.A2).

Participant Premiums

See also table 2.C1.

1965 SMI enrollee premium rate (originally $3 per month) to be established annually such as to pay one-half of program costs.

1972	SMI enrollee premium rate increase limited to rate of increase in OASDI cash benefits.
	HI premium (originally $33 per month) to be established annually. Only individuals not otherwise entitled to HI but desiring voluntary participation need to pay the HI premium.
1983	SMI enrollee premiums for July 1983, to Dec. 31, 1983, frozen at premium level of June 30, 1983. Premiums for Jan. 1, 1984, to Dec. 31, 1985, set to cover 25 percent of aged program costs.
1984	SMI enrollee premiums for Jan. 1, 1986, to Dec. 31, 1987, will be set to cover 25 percent of aged program costs. Increases in the SMI premium may not exceed the dollar amount of the Social Security cost-of-living adjustment.
1985	Extends through calendar year 1988 the requirement that SMI premiums be set to cover 25 percent of aged program costs and that increases in the SMI premium may not exceed the dollar amount of the Social Security cost-of-living adjustment.
1987	Extends through calendar year 1989 the provisions requiring that the SMI premium be set to cover 25 percent of aged program costs, prohibiting any increase in the premium if there is no Social Security cost-of-living adjustment, and continuing to hold beneficiaries harmless from Social Security check reductions as a result of a premium increase.
1988	Increases in the SMI premium may not exceed the dollar amount of the Social Security cost-of-living adjustments for 1989 and beyond.
1989	Extends through calendar year 1990 the requirement that SMI premiums be set to cover 25 percent of aged program costs.
1990	The SMI premium amounts are $29.90 in 1991; $31.80 in 1992; $36.60 in 1993; $41.10 in 1994; and $46.10 in 1995.
1993	SMI enrollee premiums for Jan. 1, 1996, to Dec. 31, 1998, will be set to cover 25 percent of aged program costs.
1997	The SMI premium is permanently set a 25 percent of program costs.
	Income from Taxation of OASDI Benefits
1993	The additional income tax revenues resulting from the increase in the taxable percentage applicable to OASDI benefits (an increase from 50 percent to 85 percent, see table 2.A31) are transferred to the HI Trust Fund.
	Interfund Borrowing
1981	See table 2.A6.
1983	See table 2.A6.

Medicaid

Overview

Note: The following narrative is intended for informational purposes only. This description of the Medicaid program is not an official statement of policy that can be relied upon in lieu of the appropriate law, regulations, and rulings. This narrative is not intended to render legal or other professional advice; therefore, it should not be relied upon for making specific legal decisions. Instead the law, regulations, and rulings should be consulted for purposes of making such decisions.

Title XIX of the Social Security Act is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

Basis of Eligibility and Maintenance Assistance Status

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each state within federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have additional "state-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for state-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program which was in effect in their state on July 16, 1996, or-at state option-more liberal criteria.
- Children under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL).
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).
- Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under title IV of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL (this process phases in coverage, so that by the year 2002 all such poor children under age 19 will be covered).
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each state).
- Children under age 21 who meet the AFDC income and resources requirements that were in effect in their state on July 16, 1996.

- Institutionalized individuals eligible under a "special income level" (the amount is set by each state up to 300 percent of the SSI federal benefit rate).
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Recipients of state supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).
- "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act of 1997 (BBA).
- "Medically needy" persons (described below).

The medically needy (MN) option allows states to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their state. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their state's MN income level.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a state elects to have a MN program, there are federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A state may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. Currently, 38 states have elected to have a MN program and are providing at least some MN services to at least some MN recipients. All remaining states utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)- known as the "welfare reform" bill made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are state options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstituted by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides states with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits states to impose a wide range of other requirements as well, in particular, those related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a new program initiated by the BBA. In addition to allowing states to craft or expand an existing state insurance program, SCHIP provides more federal funds for states to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which states may select to provide health care coverage for more children, as prescribed within the BBA's title XXI program.

Medicaid coverage may begin as early as the third month prior to application-if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows states to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

Scope of Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive federal matching funds to provide certain optional services. Following are the most common of the 34 currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Home and community-based care to certain persons with chronic impairments.

The BBA included a state option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

Amount and Duration of Services

Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that state's plan; and (2) states may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, states have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, states may not provide room and board for the recipients). With certain exceptions, a state's Medicaid program must allow recipients to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Payment for Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to

the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. During 1988-91, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing federal expenditures for Medicaid. However, under legislation passed in 1991, 1993, and again within the BBA of 1997, the federal share of payments to DSH hospitals has become increasingly limited.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. The following Medicaid recipients, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid recipients must be exempt from copayments for emergency services and family planning services.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In 2000, the FMAPs varied from 50 percent in ten states to 76.80 percent in Mississippi, and averaged 57 percent overall. The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent and raised the FMAP for Alaska from 50 percent to 59.8 percent only through 2000. For the children added to Medicaid through the SCHIP program, the FMAP average for all states is about 70 percent, compared to the general Medicaid average of 57 percent.

The federal government also reimburses states for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the 12 states that furnish the highest number of emergency services to undocumented aliens, and shares in each state's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program and the Qualifying Individuals (QI) program (described later), federal payments to states for medical assistance have no set limit (cap). Rather, the federal government matches (at FMAP rates) state expenditures for the mandatory services, as well as for the optional services that the individual state decides to cover for eligible recipients, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

Summary and Trends

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures, although the rate of increase has subsided somewhat recently. This rapid growth in Medicaid expenditures has been due primarily to the following factors:

The increase in size of the Medicaid-covered populations as a result of federal mandates, population growth, and the earlier economic recession. In recent years Medicaid enrollment has declined somewhat.

- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase federal payments to states.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid recipients require relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. The data for 1998, for example, indicate that Medicaid payments for services for 20.6 million children, who constitute 51 percent of all Medicaid recipients, average about $1,150 per child (a relatively small average expenditure per person). Similarly, for 8.6 million adults, who comprise 21 percent of recipients, payments average about $1,775 per person. However, certain

other specific groups have much larger per-person expenditures. Medicaid payments for services for 4 million aged, constituting 11 percent of all Medicaid recipients, average about $9,700 per person; for 7.2 million disabled, who comprise 18 percent of recipients, payments average about $8,600 per person. When expenditures for these high- and lower-cost recipients are combined, the 1998 payments to health care vendors for 40.6 million Medicaid recipients average $3,500 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program has paid for almost 45 percent of the total cost of care for persons using nursing facility or home health services in recent years. However, for those persons who use more than 4 months of this long-term care, Medicaid pays for a much larger percentage. The data for 1998 show that Medicaid payments for nursing facility services (excluding ICFs/MR) and home health care totaled $41.3 billion for more than 3.3 million recipients of these services-an average 1998 expenditure of $12,375 per long-term care recipient. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow states to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided states a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 54 percent in 1998.

Medicaid data as reported by the states indicate that more than 41.0 million persons received health care services through the Medicaid program in 1999. Total outlays for the Medicaid program in 1999 included direct payment to providers of $133.8 billion, payments for various premiums (for HMOs, Medicare, etc.) of $31.2 billion, payments to the disproportionate share hospitals of $15.5 billion, and administrative costs of $9.5 billion.

The total expenditure for the nation's Medicaid program in 1999, excluding administrative costs, was $180.9 billion ($102.5 billion in federal and $78.4 billion in state funds). With anticipated impacts from the BBA, projections now are that total Medicaid outlays may be $285 billion in fiscal year 2005, with an additional $6 billion expected to be spent for the new SCHIP.

Medicaid-Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort."

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their state Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) premiums and the Medicare coinsurance and deductibles, subject to limits that states may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the SMI premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals (QDWIs). According to HCFA estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the above three categories.

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes a capped allocation to states, for each of the 5 years beginning January 1998, for payment of all or

some of the Medicare SMI premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a state plan. The payment of this QI benefit is 100 percent federally funded, up to the state's allocation.

CONTACT: Earl Dirk Hoffman, Jr. (410) 786-7913 for further information.