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CRS Issue Brief

Catastrophic Health Insurance: Medicare

Updated May 4, 1990

by
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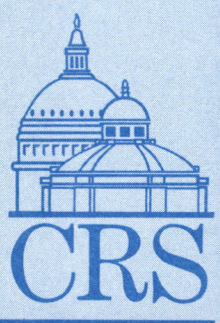

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Catastrophic Health Insurance: Medicare

SUMMARY

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. The absence of catastrophic health insurance protection for the elderly was the subject of concern for several years. During the 100th Congress, a number of proposals were considered to expand protection for the aged through the Medicare program. The Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360) was signed into law on July 1, 1988. This measure placed an upper limit on beneficiary liability in connection with covered Medicare services. It also established a new catastrophic prescription drug program. The measure did not include protection against long-term institutional care expenditures in the benefit package.

MCCA removed coinsurance and number-of-day limitations on hospital care; a beneficiary needing hospital care would pay only one inpatient deductible per year. The law modified the skilled nursing facility benefit and expanded benefits for home health and hospice care. The law established a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for cost-sharing charges in connection with physicians' and other Part B services. Beginning in 1991, the law authorized Medicare coverage for catastrophic outpatient prescription drug expenses. MCCA was to be financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium which was to be mandatory for all Part A enrollees with Federal tax liability (about 41% of the elderly in 1989). MCCA also contained several Medicaid provisions.

Many elderly complained about the supplemental premium; many also questioned the need for the new benefits. Further, concerns were raised regarding the rapid increase in estimated MCCA costs. During 1989, Congress considered ways to modify MCCA. Such modifications included developing a plan retaining a portion of the MCCA benefits, while reducing or eliminating the supplemental premium. However, a consensus could not be reached.

Thus, on Nov. 22, 1989, the House and Senate cleared the Medicare Catastrophic Coverage Repeal Act of 1989 (H.R. 3607), for the President's signature; it was signed into law Dec. 13 (P.L. 101-234). The Act repeals the Medicare catastrophic provisions included in MCCA; however, it retains the Medicaid provisions.

ISSUE DEFINITION

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. Further, these expenses must be the liability of the individual or family; that is, they are not covered by so-called third parties, either private insurance or public programs. Congress passed the Medicare Catastrophic Coverage Act of 1988 (MCCA), which provided protection against some catastrophic costs for the elderly. After enactment, a number of issues were raised about MCCA. Of particular concern was the financing mechanism. Critics also focused on the increases in MCCA estimated costs. On Nov. 22, 1989, the House and Senate cleared the Medicare Catastrophic Coverage Repeal Act of 1989 (H.R. 3607) for the President's signature; the measure was signed into law (P.L. 101-234) on Dec. 13, 1989.

BACKGROUND AND ANALYSIS

Insurance Coverage for the Aged

Medicare Coverage

Aged persons who face catastrophic health expenses do so because of gaps in their insurance coverage. Almost the entire aged population (between 95 and 96% or 30 million persons) are covered under Medicare; in addition,the program covers 3 million disabled persons. Medicare's benefits, which are the same throughout the country, are targeted toward meeting the acute health care needs of the elderly. Prior to 1989, limits were placed on the number of covered days of hospital care and continue to be placed on skilled nursing facility care. (The hospital limits will be restored in 1990.) Further, the program has placed no upper limit on cost sharing charges in connection with covered program services.

Overall, Medicare covers about half of the aged's health care costs. The program's benefit package excludes prescription drugs, routine eye examinations, eyeglasses, hearing aids, dental care, dentures, and most preventive care. The major gap in the Medicare benefit package is coverage of long-term-care services. Nursing home coverage is limited to short-term post-hospital stays in skilled nursing facilities (SNFs). As a result, Medicare covers less than 2% of the nursing home costs of the aged. Home health care is covered only when a beneficiary can be shown to need intermittent skilled nursing care or physical or speech therapy. Many chronically ill persons do not need skilled care to remain in their homes, but rather, need custodial care and assistance with daily routines; home health services for these persons are not covered by Medicare.

Other Insurance Protection

The majority of Medicare beneficiaries have had some insurance protection in addition to Medicare coverage. The largest group is that with **Medigap coverage**. Medigap is the term used to describe individually purchased policies designed to

supplement Medicare's coverage. Approximately 39% of the noninstitutionalized Medicare population purchased private health insurance policies in 1987, most of which could be classified as Medigap. The principal protection offered by the majority of these policies is coverage of Medicare's cost sharing charges; some policies may offer coverage of additional services. Few policies offer protection against the costs of long-term institutional care -- potentially the most costly service item.

Regulation of insurance, including health insurance, is generally a State responsibility. However, in the 1970s there were a series of reports on marketing and sales abuses with respect to health policies sold to the elderly. Congress therefore approved a voluntary certification program in 1980. Under the program, policies that wished to be certified as Medigap policies had to meet or exceed standards set forth in a model regulation approved by the National Association of Insurance Commissioners (NAIC). The voluntary program applies only in States that fail to establish equivalent or more stringent programs. Almost all States established their own programs. (See MCCA summary and summary of MCCA repeal for Medigap provisions.)

Approximately 29% of the noninstitutionalized Medicare population has **employer-based health insurance coverage** which may be paid in whole or part by their employers. Employer-sponsored plans are not covered by the NAIC rules. (See MCCA summary and summary of MCCA repeal for maintenance of effort provision.)

Some low-income aged and disabled Medicare beneficiaries are also covered by the Federal-State **Medicaid** program. However, many of the aged do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standard through their expenditures on health care. Medicaid beneficiaries are effectively protected against the costs associated with covered program services.

Prior to MCCA, an estimated 20% of the Medicare population had no other health insurance coverage. According to DHHS, this figure included over 2 million poor and 6 million near-poor elderly not covered by Medicaid.

Enactment of MCCA

President Reagan submitted the Administration proposal for catastrophic coverage for the Medicare population on Feb. 24, 1987. It was seen by many in Congress as defining the minimum parameters of a Medicare expansion bill. The final law differed considerably from the original Administration plan. The major benefit expansion included in the law was the new catastrophic prescription drug coverage.

Financing was a key issue during Congressional consideration of MCCA. Given the Federal budget deficit, it was decided that any program expansions could not rely on general revenue financing. Therefore another mechanism had to be developed. It was determined that, first, the legislation must provide the revenues for any benefit expansions. Second, expanded benefits had to be paid for by the beneficiaries

themselves. As the legislation was developed, there was concern that many beneficiaries would be unable to afford the cost of the improved benefits, if the cost were to be spread equally across all beneficiaries. The law therefore provided that those with a greater ability to pay (as evidenced by Federal tax liability) would shoulder a larger portion of the costs. On the other hand, State Medicaid programs would be required to phase in coverage of Part B premium payments (and other Medicare cost-sharing charges) for those with incomes below the poverty line.

Summary of MCCA

The Medicare Catastrophic Coverage Act of 1988 was given final approval by Congress June 8, 1988, and signed into law as P.L. 100-360 July 1, 1988. The following are highlights of the major provisions. (For a detailed summary see CRS Report 89-155 EPW, Medicare Catastrophic Coverage Act of 1988.) The hospital and SNF benefit expansions were effective Jan. 1, 1989; the remaining benefit provisions (except drugs) were to be effective Jan. 1, 1990. The catastrophic prescription drug benefit was to be effective Jan. 1, 1991.

Part A (Hospital Insurance) Benefits

Part A provides coverage for inpatient hospital services, skilled nursing facility (SNF) services, home health care, and hospice services. Prior to the enactment of MCCA, long-term hospital stays were subject to significant coinsurance charges. Further a beneficiary could potentially exhaust all benefits; however, a very small percentage actually did so. MCCA made the following Part A changes:

Inpatient Hospital Services. Specified a maximum of one hospital deductible per year ($560 in 1989) and eliminated the day limits, coinsurance charges, and spell of illness provisions.

Skilled Nursing Facility Services. Required daily coinsurance payments for the first 8 days equal to 20% of the national average Medicare reasonable cost for SNF care ($25.50/day in 1989); eliminated coinsurance charges for 21st-100th days; provided coverage for up to 150 days and eliminated prior hospitalization requirement.

Home Health Services. Expanded the "intermittent" skilled nursing care definition so that "daily" care was defined as 7 days a week for up to 38 days (instead of 5 days a week for up to 2 or 3 weeks).

Hospice Services. Provided that the 210 day lifetime limit could be extended.

Part B (Supplementary Medical Insurance) Benefits

Beneficiaries enrolled in Part B pay a monthly premium ($31.90 a month in 1989). They are also liable for certain charges in connection with their use of physicians and other services covered under the program. All beneficiaries are liable for the $75 deductible and 20% coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., agree to accept Medicare's

determination of the "reasonable charge" amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. (This is sometimes referred to as the "balance billed" amount.) The following are the Part B changes which were made by MCCA.

Limitation on Out-of-Pocket Expenses. Established a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for Part B cost-sharing charges after which Medicare would pay 100% of the approved amount. (Balance billing charges would not count toward the cap; nor would Medicare pay these charges once the beneficiary hit the cap.) The limit was set at $1,370 for 1990; it was to be indexed so that a constant 7% of beneficiaries would be eligible for this catastrophic benefit each year.

Mammography Screening. Established a new Medicare benefit. Screenings for women over 65 would be covered every other year, subject to a maximum payment per screening of $50 in 1990 (indexed in future years).

Respite Care. Provided coverage for in-home care for a chronically dependent individual for up to 80 hours per year. The benefit was to be available only for persons who met either the catastrophic cap or the outpatient prescription drug cap.

Catastrophic Prescription Drug Benefits

MCCA established, effective Jan. 1, 1990, a limited prescription drug benefit for home intravenous (IV) drugs and immunosuppressive drugs furnished after the first year following a transplant (they are already covered in the first year). The deductible was to be $550 in 1990; the coinsurance was to be 20% for home IV drugs and 50% for immunosuppressives. Beginning Jan. 1, 1991, catastrophic prescription drug coverage was to be available for all outpatient prescription drugs, subject to a $600 deductible and 50% coinsurance charges. The deductible was slated to go to $652 in 1992 and be indexed in future years so that 16.8% of beneficiaries would reach the deductible each year. The coinsurance was slated to be lowered to 40% in 1992 and 20% in 1993.

Financing

The new benefits were to be financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium which was to be mandatory for all those entitled to Part A who had Federal tax liability of $150 or more.

Part B Premium. The additional monthly Part B premium was set in the statute through 1993. The additional monthly amount was set at $4 in 1989, $4.90 in 1990, $7.40 in 1991, $9.20 in 1992, and $10.20 in 1993.

Supplemental Premium. The supplemental premium (to be collected in conjunction with the Federal income tax) was to be based on Federal tax liability (i.e., amount of taxes owed). The supplemental premium was in effect a surtax. The surtax rate was to be 15% in 1989, 25% in 1990, 26% in 1991, 27% in 1992, and 28% in 1993. The maximum annual premium per enrollee was $800 in 1989, rising to

$1,050 in 1993. It was estimated that the approximate income levels at which the maximum premium amounts would be reached were $40,000 for a single return and $80,000 for a couple.

Other Provisions

Medigap Policies. MCCA amended procedures for Federal certification of Medigap policies. It provided that if the National Association of Insurance Commissioners (NAIC) revised its standards prior to Oct. 1, 1988, such revised standards would apply as the standard for certification. The NAIC met this deadline. Policies sold before enactment, but still in effect on Jan. 1, 1989, were deemed not to duplicate Medicare's new benefits if they complied with the NAIC model transition rule; this rule required insurers to notify beneficiaries of policy and premium changes and to make appropriate premium adjustments in their policies.

Maintenance of Effort. Any employer who provides health benefits to an employee or retired former employee (including State and local employees) that duplicate at least 50% of the new or improved Part A or Part B benefits would have to provide additional benefits or refunds that totalled at least the actuarial value of the duplicative benefits. The provision was to be effective with respect to Part A benefits in 1989 and Part B benefits in 1990 except that an extension was provided to cover current collective bargaining agreements.

Federal Employees. MCCA required the Director of the Office of Personnel Management (OPM) to reduce, effective Jan. 1, 1989, the rates charged to Medicare-eligible individuals participating in the Federal Employee Health Benefits Program (FEHBP) to reflect the amounts that would have been paid by those plans except for the enactment of this bill. The reduction was $3.10 per month in 1989. OPM was also required to conduct a study of changes to FEHBP that might required to incorporate plans designed specifically for Medicare-eligible individuals.

Medicaid. MCCA mandated States, on a phased-in basis, to pay Medicare premiums, deductibles and coinsurance for elderly and disabled individuals with incomes below the poverty line. Also, in the case of a couple where one member is institutionalized, the bill provided protection of a portion of the couple's income and resources for maintenance needs of the community spouse (the so-called spousal impoverishment provision).

Estimated Impact of MCCA

All beneficiaries had increased insurance protection as a result of the new law. The Congressional Budget Office (CBO) estimated that when the legislation was fully implemented, approximately 22% of Medicare beneficiaries each year would have been entitled to higher benefit payments as a result of the program expansions.

At the time of enactment, total new benefit and administrative costs were estimated at $30.8 billion over the FY89-FY93 period. This figure increased to $48.2 billion in September 1989. These costs were to be financed through the additional Part B premium and the new supplemental premium. It was estimated that 41.2%

of enrollees would pay the supplemental premium in 1989. Close to two-thirds of those paying the premium would pay less than $300. An estimated 5.6% of enrollees would pay the maximum supplemental premium in 1989.

It was estimated that approximately 30% of enrollees would pay more in new premiums (supplemental plus the new Part B) than they would receive in new benefits. However, all persons (including those paying the maximum supplemental premium) would still receive more in total Medicare benefits than they would pay in total. This was true even when you included the hospital insurance payroll tax which was paid by these individuals (and their employers) during their working years.

MCCA Issues

Following passage of MCCA, a number of issues were raised about the scope of the new legislation and its financing. Critics of the measure focused mainly on the financing aspects. Some persons who would be liable for the new supplemental premium (also known as the surtax) objected to the amount they would have been required to pay for the expanded coverage. Most persons liable for the supplemental premium would have averaged more in total new premium charges (supplemental plus Part B) than the per capita value of the new benefits. Critics further objected to the mandatory nature of the program; they felt that beneficiaries should be allowed to make their own choices about insurance coverage.

Proponents of the measure noted that, given the Federal budget deficit, it was decided that any program expansions could not rely on general revenue financing. Therefore another mechanism had been chosen. All beneficiaries, except those with incomes below the poverty line, would pay a portion of the additional costs. Higher-income individuals would assume a higher percentage of the costs. Proponents note that even though higher-income individuals would be paying more than the value of the new benefits, they would still be receiving a subsidy on the overall Medicare benefits package. Further, financing Medicare through an income-related charge was not new to Medicare. The Part A program has always been financed by an income-related hospital insurance tax levied on current workers and their employers.

Proponents noted that the program was mandatory rather than voluntary to help maintain a sound financial base. The mandatory base was intended to prevent those beneficiaries who were younger, healthier, and had higher incomes from dropping out of the program until they were older, sicker and more likely to need the protection.

Critics noted that over three-quarters of Medicare beneficiaries already had private and or public health insurance coverage in addition to Medicare. They suggested that these individuals did not need, nor in many cases want, expanded Medicare coverage. Some individuals who had their additional coverage paid for in whole or in part by their current or former employer would have been subject to the supplemental premium and therefore have been subject to higher total charges after enactment of MCCA.

Proponents of the measure stated that it represented the most significant expansion in benefits since the enactment of Medicare in 1965. They noted that the law was designed to fill very significant program gaps. While many enrollees had other health insurance protection, approximately 20% of the aged had no additional coverage. These individuals tended to be older, sicker and poorer than those who purchased additional coverage.

Proponents noted that Medicare is more efficient to administer than private insurance. They also noted that it may be difficult for those elderly with preexisting conditions to obtain affordable private coverage.

Some persons suggested that persons will be paying for coverage that they will not actually use. Proponents noted that the new legislation provided catastrophic insurance protection. As with car insurance or homeowners insurance, not everyone expects to avail themselves of the benefits each year. However, if the program had been fully implemented, an estimated 22% of beneficiaries would have been entitled to higher Medicare payments as a result of the legislation.

Some critics of the catastrophic measure questioned its focus. They suggested that enactment of the catastrophic proposal would, in effect, delay enactment of a long-term-care bill. They noted that the major gap in Medicare was and continued to be coverage of long-term-care services. Very few private insurers offer protection against these costs. As a result, Medicaid remains the primary source of third party financing for these expenses. Many elderly at risk of needing long-term-care services face the prospect of impoverishing themselves to welfare levels in order to gain Medicaid eligibility.

Congressional Action in the 101st Congress

During the 1st Session of the 101st Congress, both the House and Senate considered a number of alternative approaches to modifying MCCA. This interest was spurred in large part by the considerable opposition that was voiced by many senior citizens to imposition of the supplemental premium. It was also spurred in part by the considerable increase in estimated program costs of catastrophic benefits. Two services accounted for most of the estimated increase -- the expanded skilled nursing facility benefit and the prescription drug benefit.

On Oct. 4, 1989, the House during its consideration of the FY90 budget reconciliation bill approved the amendment offered by Congressmen Donnelly and Archer by a vote of 360 to 66. This replaced the catastrophic provision approved earlier by the Committee on Ways and Means. The House rejected the substitute amendment offered by Congressmen Stark, Gradison, and Waxman. The Donnelly/Archer amendment basically repealed the Medicare provisions and the financing provisions of MCCA while retaining the Medicaid provisions.

On Oct. 6, 1989, the Senate by a vote of 99 - 0 approved S. 1726, as amended. This legislation was introduced by Senator McCain as a free-standing measure. (Earlier efforts by the Finance Committee to report a catastrophic agreement as part of reconciliation were unsuccessful.) The Senate's action came after a series of

amendments (including a repeal amendment) were disapproved. The Senate bill retained the Part A benefit with the exception of the SNF benefit. It also retained coverage for immunosuppressives and home IV drugs, mammography services, and respite care. The Senate bill eliminated the supplemental premium and provided beginning in 1990 for a recalculation of the Part B premium to fund the remaining benefits.

On Nov. 8, 1989, the House passed H.R. 3607, the Medicare Catastrophic Coverage Act of 1989. The provisions of this bill were identical to the catastrophic provisions approved by the House as part of the reconciliation bill. Also on Nov. 8, 1989, the Senate passed its version of H.R. 3607. The Senate version was a revised McCain bill which corrected technical errors incorporated in S. 1726. The Conferees reported the measure on Nov. 19, 1989. The Conferees essentially reported the House repeal measure with a few modifications. The Senate rejected the measure twice returning the measure to the House; the latter body insisted on the conference agreement. Both Houses approved the conference report with technical correction on Nov. 22, 1989. The bill was signed into law (P.L. 101-234) on Dec. 13, 1989.

MCCA Repeal Provisions

The following summarizes the provisions of H.R. 3607 as approved by Congress.

Part A Provisions

Hospital and SNF Benefits. The expanded hospital and SNF benefits authorized by MCCA were effective Jan. 1, 1989. P.L. 101-234 restores the prior law provisions effective Jan. 1, 1990.

Beginning Jan. 1, 1990, hospital and SNF benefits will again be tied to the beneficiary's "spell of illness." A spell of illness begins when a beneficiary enters a hospital and ends when he or she has not been an inpatient of a hospital or SNF for 60 consecutive days.

A beneficiary is entitled to 90 days of hospital care per spell of illness." Days 1-60 are subject to one deductible ($592 in 1990). Days 61-90 are subject to a daily coinsurance charge ($148 in 1990). Beneficiaries also have a total of 60 lifetime reserve days available to them. A beneficiary exceeding 90 days of care during a spell of illness may use lifetime reserve days, subject to a daily coinsurance charge ($296 in 1990). Lifetime reserve days can be used only once; any such days used by a beneficiary prior to 1989 are subtracted from the total available.

A beneficiary is also entitled to 100 days of SNF care per spell of illness. The three-day prior hospitalization requirement removed by MCCA has been restored. Days 1-20 of post-hospital SNF care are not subject to beneficiary cost-sharing. Days 21-100 are subject to daily coinsurance charges ($74 in 1990).

P.L. 101-234 establishes transition provisions for persons in a hospital on Jan. 1, 1990 whose inpatient stay began prior to that date. For these individuals, January 1, 1990 is considered to be the first day of the beneficiary's spell of illness; however,

no deductible is imposed if one was imposed for such stay in 1989. Also, if a deductible was imposed on an inpatient stay beginning in December 1989, no deductible is to be imposed for a spell of illness beginning in January 1990. Further, no deductible is imposed on an individual whose spell of illness began prior to Jan. 1, 1990.

P.L. 101-234 also establishes transition provisions for persons in a SNF on Jan. 1, 1990 whose SNF care began prior to that date. The 100 days of SNF care are deemed to start on Jan. 1, 1990. Thus, no coinsurance would be imposed on days 1-20; the daily $74 coinsurance charge would be imposed on days 21-100. Persons in the SNF prior to Jan. 1, 1990 would not be subject to the prior hospitalization requirement. The prior hospitalization requirement is also waived for persons discharged from a SNF during Dec. 1989 and readmitted in Jan. 1990 within 30 days of discharge.

Home Health Benefits. The expanded home health benefits (see MCCA summary) which were to become effective Jan. 1, 1990 are repealed.

Hospice Benefits. The 210 limitation is restored Jan. 1, 1990, except that it does not apply to persons electing hospice benefits prior to that date.

Blood Deductible. P.L. 101-234 retains the MCCA provision. MCCA provided that the Part A blood deductible is to be imposed on a calendar year basis; it is to be reduced by any such deductible imposed under Part B.

Part A Premium. The vast majority of the elderly are automatically eligible for Part A protection. Persons not automatically eligible may obtain coverage through payment of a monthly premium ($156 in 1989.) MCCA revised the calculation of that premium. P.L. 101-234 retains this modification.

PPS Payments. MCCA provided for transitional adjustments in PPS payments to take into account the new law. Further, for PPS-exempt hospitals, it provided for an adjustment in the target amount (the annual limit on total Medicare payments to such hospital) to take into account the additional days of care Medicare would be covering.

P.L. 101-234 terminates the transitional adjustments for PPS and PPS-exempt hospitals effective Jan. 1, 1990. Further, it requires the Secretary to make appropriate adjustments in the target amount to take into account services provided to an inpatient whose stay began before Jan. 1, 1990.

Part B Provisions

The following new Part B benefits which were to become effective Jan. 1, 1990 are **repealed:**

- **Limitation on out-of-pocket expenses (the so-called Part B cap)**
- **Screening mammograms**
- **Respite care**
- **Home intravenous drug therapy services**

Catastrophic Prescription Drugs

Coverage for outpatient catastrophic prescription drugs, which was to begin on a limited basis in 1990, is repealed.

MCCA required that physicians include the appropriate diagnosis code when requesting Medicare payment, effective Mar. 1, 1989. This requirement is retained.

Financing

MCCA provided that the supplemental premium was to be effective for tax years beginning after Dec. 31, 1988. P.L. 101-234 repeals this premium. While most persons would not have paid the premium until they filed their 1989 tax returns, some persons may have paid a portion of this as part of their estimated tax payments. A separate refund of this amount will not be made. Repeal of the premium results in reduced tax liability. If an individual's total 1989 tax payments exceed total 1989 tax liability, a refund will be made when the individual files his or her return.

MCCA also increased the monthly Part B premium by a specified amount to fund catastrophic expenses. This add-on amount was set at $4 per month in 1989 and $4.90 per month in 1990. The additional premium is deducted from individual's social security checks (as is the case for the basic Part B premium amount). The additional premium is repealed effective January 1990. Due to the late passage of the repeal legislation, the 1990 add-on amount will be deducted for several months until the system can be appropriately modified. Any resulting overpayment will be refunded.

MCCA extended indefinitely the hold harmless provision. This provision prohibits a beneficiary's check from dropping as a result of an increase in the Part B premium. This indefinite extension is retained.

MCCA also established several new trust funds and accounts. P.L. 101-234 repeals the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, the Federal Catastrophic Drug Insurance Trust Fund, and the Medicare Catastrophic Coverage Account.

MCCA required the Secretary of the Treasury to study and report to Congress by Nov. 30, 1988 on Federal tax policies to promote the private financing of long-term care. P.L. 101-234 delays the reporting date until May 31, 1990.

Medigap Provisions

Revised Certification Requirements. MCCA amended procedures for Federal certification of Medigap policies to reflect enactment of catastrophic coverage. (See above.) P.L. 101-234 amends the requirements to reflect repeal of catastrophic coverage. P.L. 101-234 provides a period of 90 days beginning with enactment for the NAIC to revise their model medigap regulation to improve such regulation and otherwise to reflect benefit changes made by the new law. The revised regulation would apply in a State effective on the date the State adopts Medigap standards

equal to or more stringent than the revised regulation or one year after the date the NAIC first adopts such revised regulation. If the NAIC does not revise the model regulation within 90 days, the Secretary must promulgate revised Federal model standards within the subsequent 60 day period. These standards would become effective on the earlier of the date the State adopts the standards equal to or more stringent than the revised standards or one year after the date the Secretary promulgates the standards. After the date the revised regulation (or the revised Federal model standards) are effective in a State, no Medigap policy may be certified by the Secretary and no Secretarial certification may remain in effect unless the policy meets the revised NAIC model standards (or the revised Federal model standards.)

P.L. 101-234 defines a transition deadline as one year after the NAIC adopts the revised model regulation, or one year after the Secretary promulgates revised Federal model standards, as the case may be. Medigap policies issued after the transition deadline must comply with the revised NAIC model regulation or the Federal model standards to be in compliance. Medigap policies issued before the transition deadline are deemed to be in compliance with the new standards if they comply with a transition provision to be issued by the NAIC no later than Dec. 15, 1989 (or failing that, by the Secretary by Jan. 1, 1990.) The NAIC transition provision ceases to apply on the earlier of either the date the State adopts standards equal to or more stringent than the revised NAIC model regulation (or the revised Federal model standards, if appropriate) or the date established for States requiring legislative action.

Medigap policies in effect on Jan. 1, 1990 would not meet the standards unless each policy holder or certificate holder who is eligible for Medicare is sent a notice by Jan. 31, 1990 explaining the changes in Medicare's benefits resulting from catastrophic repeal legislation and how these changes affect the policy's benefits and premium.

Continuation Provision. Special rules are established in the case of an individual who had a Medigap supplemental policy in effect as of Dec. 31, 1988 with an insurer (as a policy holder, or in the case of a group policy, a certificate holder) and terminated this policy before enactment of P.L. 101-234. The insurer must offer such policy holder or certificate holder (through written notice between Dec. 15, 1989 and Jan. 30, 1990) reinstitution coverage. The individual must be offered during a period of at least 60 days (beginning not later than Feb. 1, 1990) reinstitution coverage, with coverage effective as of Jan. 1, 1990. The offering must be under the terms which: (1) do not provide for any waiting period for treatment of pre-existing conditions; (2) provide for coverage which is substantially equivalent to coverage in effect before the date of such termination; and (3) provide for classification of premiums on terms which are at least as favorable to the policyholder or certificate holder as the premium classification which would have applied to that person had the coverage not been terminated. An insurer is not required to make this offer in the case of a policyholder or certificate holder in another Medigap policy as of the date of enactment of P.L. 101-234 if under that policy, as of Jan. 1, 1990, the individual is not subject to a waiting period with respect to a pre-existing condition.

Medigap Premiums. In November 1989, the GAO conducted a survey of commercial Medigap insurers to determine the expected increase in Medigap

premiums in 1990. For the 20 companies reporting, the average monthly premium was $58.71 in 1989. In the absence of repeal legislation, the estimated average 1990 monthly premium would be $60.10 in 1990. Repeal of MCCA would result in a 15.4 percent or $9.25 average increase in the 1990 monthly premiums. This represented increases ranging from 6.3% to 41.3% across reporting companies.

The Blue Cross and Blue Shield Association estimated the impact of repeal on member plans. A typical nongroup Medicare product costs an estimated $50 to $55 per month in 1989. Repeal of MCCA would result in increases of $8 to $24 per month in 1990.

Other Provisions

P.L. 101-234 **repeals** the following additional MCCA provisions, effective Jan. 1, 1990:

- **Maintenance of effort**. The repeal does not apply to duplicative Part A benefits for periods before Jan. 1, 1990. (See summary of MCCA above.)
- **Rate reduction for Federal annuitants.**
- **OPM study of offering Medigap policies to Federal annuitants** (This study has already been issued.)
- **Benefits counseling and assistance demonstration project**
- **Case management demonstration projects**
- **Advisory Committee on Medicare home health claims**
- **Research on long-term-care services for Medicare beneficiaries**
- **Study of adult day health services**

The following provisions were **retained:**

- **United States Bipartisan Commission on Comprehensive Health Care (the Pepper Commission)**
- **Mailing of notice of Medicare benefits and information describing the participating physician program**
- **Prohibition of misuse of symbols, names, or emblems in reference to Social Security or Medicare**
- **Demonstration projects for chronic ventilator dependent units in hospitals**
- **HMO provisions relating to adjustment of contracts and changes in civil monetary penalties with respect to certain actions**
- **Technical corrections to OBRA 1987**

P.L. 101-234 also requires prepaid health plans, for calendar year 1990 only, to provide the additional Part A and Part B benefits otherwise repealed. The adjustments in the 1990 premium rates are retained to cover the costs of these benefits.

Medicaid

P.L. 101-234 **retained** the Medicaid provisions of MCCA. These provisions are as follows:

- **Requiring Medicaid to pay Medicare premiums and cost-sharing charges for Medicare beneficiaries below poverty**

- **Spousal impoverishment provision** which, in the case of the institutionalization of one member of a couple, provides protection for a portion of the couple's income and resources for the maintenance needs of the community spouse
- **Requiring Medicaid coverage of pregnant women and infants below poverty**

In November 1989, GAO conducted a survey of the impact of repeal of MCCA's Medicare provisions on Medicaid budgets. The 37 States (and the District of Columbia) reporting data showed a total increase in 1990 budgets of $1 billion, of which an estimated $444 million would be State funds and $587 Federal funds.

Post-Repeal Action

During the second session of the 101st Congress, several measures have been introduced to restore selected benefits which had been added by MCCA and subsequently repealed. Generally the benefits proposed for restoration were some of the less costly. One measure which has received considerable attention is the proposed Medicare Benefit Improvement Act of 1990, H.R.3880 (Stark), which has over 100 cosponsors. This bill includes provisions, comparable to those included in MCCA, related to coverage of screening mammography, respite care, home health services, and hospice care.

The second session of the 101st Congress is also examining issues related to Medigap insurance. Of particular concern have been the substantial premium rate increases following the repeal of MCCA. Several Medigap bills have been introduced which address one or more of the following issues: premium increases, regulation of Medigap insurance, and beneficiary counseling.

LEGISLATION

P.L. 101-234, H.R. 3607

Medicare Catastrophic Coverage Repeal Act of 1989. Includes provisions repealing the Medicare provisions and the financing provisions of MCCA while retaining the Medicaid provisions. Retains the modified calculation of the Part A blood deductible and the requirement for the U.S. Bipartisan Commission on Health Care (known as the Pepper Commission). Repeals the Part A provisions (which have already gone into effect) at the end of 1989 and establishes transition requirements for persons who were in hospitals or SNFs during 1989. Revises Medigap requirements (including appropriate transition provisions) and includes a continuation provision. Introduced Nov. 7, 1989; passed House Nov. 8, 1989. (Provisions identical to catastrophic coverage repeal provisions included in House-passed H.R. 3299, the Omnibus Budget Reconciliation Act of 1989) Passed Senate amended Nov. 8, 1989. (Contained provisions of Senate-passed S.1726, with technical amendments.) Conference report filed Nov. 19, 1989. Signed into law Dec. 13, 1989.

H.R.3880 (Stark)

Medicare Benefits Improvements Act of 1990. Adds Medicare coverage for screening mammography services. Adds coverage for up to 80 hours a year of in-home respite care for certain chronically dependent individuals who have incurred Part B cost-sharing charges of $1,780 or more; this 1991 amount is indexed for years after 1991 so that an estimated 5.5% of beneficiaries are able to use this benefit each year. Modifies the home health benefit by expanding the "intermittent" skilled nursing care definition so that "daily" care is defined as 7 days-per-week for up to 38 days. Provides that the 210 day lifetime limit for hospice care may be extended. Specifies that payment for the expanded benefits is to be made by beneficiaries through an add-on to the monthly Part B premium of $0.80 in 1991, $1.00 in 1992 and 1993, $1.20 in 1994, and $1.30 in 1995. Introduced Jan. 24, 1990 and referred jointly to the Committees on Ways and Means and Enery and Commerce.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. House. Committee of Conference. Medicare Catastrophic Coverage Act of 1988; conference report to accompany H.R. 2470. May 31, 1988. Washington, U.S. Govt. Print. Off., 1988. (100th Congress, 2d session. House. Report no. 100-661)

U.S. Congress. House. Committee of Conference. Medicare Catastrophic Coverage Repeal Act of 1989; conference report to accompany H.R.3607. November 19, 1989. Washington, U.S. Govt. Print. Off., 1989. (101st Congress, 1st session. House Report no. 101-378)

FOR ADDITIONAL READING

U.S. Library of Congress. Congressional Research Service. Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), by Jennifer O'Sullivan. [Washington] March 3, 1989.
CRS Report 89-155 EPW

Finally, a health-cost cap

Catastrophic ills will bankrupt fewer elderly people, starting next year

■ The two-year struggle is over. This month, supporters of a greatly expanded health-insurance program for the elderly expect President Reagan to sign into law an overhaul of medicare benefits—the first since the program started in 1965. When the law takes effect next January, medicare for the first time will spring for unlimited hospital stays, will safeguard recipients against a crippling accumulation of physicians' fees and will begin sharing the cost of their prescription drugs.

While not a perfect shield, the new law goes a long way toward protecting people age 65 and over and the disabled against the ruinous costs of catastrophic illness. After a deductible of $564 a year, their hospital tabs will in the future be paid in full by medicare, no matter how long the stay. Currently, only 60 hospital days are covered in full after payment of a $540 deductible. Further, the new law caps at $1,370 the amount that beneficiaries will have to pay each year out of their own pockets for doctors' fees. Outpatient prescription drugs, in the past the responsibility of the patient, will be partially covered. (For a description of the new benefits, see box on page 64.) All this added assistance will be expensive—Congress estimates the cost at $30 billion over the next five years. It will be paid for by higher medicare premiums and an additional income tax on high-income recipients. (See box at right.)

Help with medications. Of greatest value to the greatest number of people will be the doctors'-fee cap and the coverage of drug costs. According to congressional estimates, about 2 million elderly people spent more than $1,370 each of their own funds last year on doctors' bills. An estimated 6 million have out-of-pocket medication expenses that take big bites out of their income. Medicare will pay a percentage of prescription-drug costs beginning in 1991—starting at 50 percent and rising to 80 percent by 1993.

Not all people facing crushing medical bills will find relief. Contrary to what many elderly people believe, the bill won't ease the financial burden of long-term nursing-home patients who require simple custodial care—help with eating, dressing and bathing. It only covers short-term nursing-home or home care that consists of actual medical attention and that is prescribed by a physician. And although the bill does offer a straw of defense against financial devastation for the spouses of people who need long-term care—by guaranteeing that they can keep a certain amount of their monthly income and $12,000 in liquid assets—many elderly people will continue to face a severe depletion of their assets if they or their spouses need nursing-home care.

Jacob Jimenez, 70, was lucky—his double-valve-replacement heart surgery meant only 33 days in the hospital, all covered by medicare. Under current law, he'd have begun paying on day 61

FOOTING A BIGGER BILL

Medicare beneficiaries will have to pay for their newly expanded health coverage through an increase in the medicare part-B premium, an additional drug premium and a supplemental federal income tax.

- From the current premium of $297 a year ($24.80 a month), the annual direct cost (including the increased part-B premium plus the new drug premium) will rise to $373 in 1989, $428 in 1990, $500 in 1991, $529 in 1992 and $571 in 1993.
- As has been true in the past, medicare premiums will be deducted from Social Security checks. No elderly person, however, will see any decrease in the size of his or her checks; rather, the checks might not increase as much as they otherwise would. A provision in the Social Security law called "hold harmless" prevents beneficiaries' checks from decreasing so much as to more than cancel out a given year's cost-of-living-allowance increase.
- The supplemental income tax will affect only the 40 percent of single beneficiaries with incomes above approximately $15,000 and couples with incomes above $20,000. The additional tax starts off at $22 for every $150 of income tax owed and rises to $42 for every $150 owed in 1993. In 1989, the maximum supplemental tax would be $800 for an individual and $1,600 for a couple. In 1993, the maximum would rise to $1,050 per individual and $2,100 per couple.

For many recipients, a beefed-up medicare system raises as many questions as it answers needs. One consideration will be whether to purchase or renew a private medigap policy, insurance that medicare recipients have relied on to fill in gaps such as deductibles and hospital co-payments—the share of the daily hospital bills medicare recipients now have to pay themselves after they've been in the hospital for 60 days. The medicare bill requires insurers to revise medigap plans to eliminate duplication of coverage, but medigap holders should still make sure that their policies do not overlap with the expanded medicare coverage. Come January, for example, you'll no longer need to worry about covering the cost of hospital co-payments. Instead, you should be focusing on plans that cover all deductibles, your share of your doctors' fees up to the $1,370 cap, and services medicare will not cover—routine physicals, immunizations and the cost of hearing-aid fittings, for example. Since these charges can quickly mount, the $500 or so you'll pay annually for an average medigap plan may be well spent. Says Joshua Wiener, a health-care analyst at the Brookings Institution: "I think a medigap policy is still going to be a good investment for most people."

Long-term care. If insurers have their way, medicare's lack of provision for nursing-home care will cause many recipients and soon-to-be recipients to conclude that the new long-term-care plans are a great investment, too. While you may want to investigate long-term-care insurance, terms vary greatly, and it's important to proceed cau iously. About

How the safety net will work

Where medicare has been reinforced

COVERAGE	OLD PROVISIONS	NEW PROVISIONS
Hospital inpatient care	First 60 days covered in full after $540 deductible for each hospital stay. Beneficiary pays $130 daily co-insurance (days 61-90), $260 (days 91-150). No coverage after 150 days. Lifetime reserve of 60 free hospital days.	All costs covered indefinitely; $564 deductible in 1989, $600 in 1990, rising thereafter. No matter how many hospital stays, you pay one deductible a year.
Doctors' fees	80% of all approved charges paid after $75 deductible. Beneficiary pays all costs beyond approved charges.	Same.
Cap, out-of pocket expenses for doctors' care (medicare part B)	No cap.	Cap of $1,370 per year, rising to $1,900 in 1993 on amount beneficiaries pay out of pocket—in co-payments and deductibles—for approved charges.
Prescription drugs	No coverage.	No coverage in 1989. 1990: Pays 50% of the cost of intravenous drugs used at home (annual deductible of $600). 1991: Pays 50% of the cost of all prescription drugs ($600 deductible). 1992: Coverage rises to 60%. 1993 and thereafter: Coverage rises to 80%.
Nursing-home care	Covers 100 days a year, with co-payment of $65 a day after day 20. Minimum three-day hospital stay required to qualify for coverage. Patient must need medical—not simply custodial—care.	Covers 150 days a year. Beneficiary pays 20% of average daily cost of first 8 days. Physician must certify medical care is needed; custodial care is not covered. No previous hospital stay is required.
Home health care	21 days per year of skilled-nursing care, generally limited to 5 visits per week.	38 24-hour days of skilled-nursing care per year when prescribed by a doctor. Extension possible in some cases.
Hospice care	Limit of 210 days. Pays up to $68 per day. Home care allowed.	No limit on days; other features unchanged.
Respite care	No coverage.	Covers up to 80 hours a year for nurse or home health aide to relieve family caring for patient at home. Available to those who exceed cap on doctors' fees or drug deductible.
Outpatient mental health care	Covers $250 a year.	Covers $1,100 per year. Visits to monitor medication dosage covered under part B and won't count toward this limit.
Low-income protection	State medicaid programs pay medicare premiums, co-payments and deductibles for beneficiaries with incomes below 80% of poverty level, which is now $6,870 for family, $5,440 for individual.	Medicaid will pay medicare premiums, co-payments and deductibles for beneficiaries with incomes below 100% of poverty line, and medical expenses of pregnant women and infants up to 1 year old whose family incomes are below poverty level.
Spousal impoverishment protection	Allow but don't require medicaid programs to protect assets of spouse. Most elderly have to "spend down" to poverty level to qualify for medicaid.	Medicaid programs must permit spouse of someone who enters a nursing home for long-term care to keep $786 of income per month—rising to $1,000 in 1993—and $12,000 in liquid assets. Homeownership, protected by other laws, is excluded.

70 companies now offer such "indemnity plans," which generally pay $25 to $60 a day in benefits for one to five years with no adjustment for inflation. A 65-year-old buying a plan today may not need coverage until he or she is 80; by then, nursing homes may cost an average $200 or more a day. The policies are also expensive, ranging from $600 to $800 a year for a 65-year-old to over $1,400 a year for a 75-year-old. Most have restrictions, too. People with a pre-existing illness such as Alzheimer's disease may be unable to purchase a plan. Most policies also require prior hospitalization for at least three days. A good plan will cover care in a skilled-nursing facility by doctors, nurses and therapists, *and* custodial care in a nursing home; also, it will be "guaranteed renewable," meaning the company has to renew the policy as long as you pay the premium. A growing number of home policies cover long-term care in your home, too.

Most long-term-care policies are less than adequate, *Consumer Reports* concluded in its May issue in rating 53 such plans. Their recommendations: If you're under 60, don't buy a long-term-care policy unless it provides some ratcheting up of benefits with inflation. If you're over 60 and of moderate-to-high income, a policy with at least an $80-a-day benefit and an unlimited number of days covered may be a "reasonable choice." If you're over 60 and of modest means, a long-term-care policy is probably a foolish expense, since you'll likely quickly qualify for medicaid and at least some of your assets will be protected.

Meanwhile, Congress doesn't view its job as over. Several long-term-care bills, including one that would significantly expand coverage of custodial-nursing care at home, have been proposed. Says Stephen McConnell, coordinator of Long Term Care 88, a national campaign to make long-term care a priority in the coming year: "The new coverage will help, but it doesn't solve the major problem. That's what we'll have to start addressing now." ■

by Steven Findlay

88-444 L

CRS Report for Congress

Catastrophic Health Insurance: Bibliography-in-Brief

Edith Sutterlin
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Library Services Division

August 1989

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CATASTROPHIC HEALTH INSURANCE: BIBLIOGRAPHY-IN-BRIEF

SUMMARY

This bibliography focuses on reactions to passage of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) and issues involved in financing catastrophic health care costs. A previous bibliography, CRS report no. 88-401, lists many congressional hearings and reports related to this legislation's consideration and passage.

Selection of citations was made from the Library of Congress Computerized Catalog and the Congressional Research Service Public Policy Literature data base.

CATASTROPHIC HEALTH INSURANCE: BIBLIOGRAPHY-IN-BRIEF

Beyond Medicare. Consumer reports, v. 54, June 1989: 375-391.
LRS89-5401

Contents.--What insurance do you need?--Which policies are best?--What an insurance package costs.--The top-rated plans: where they are sold.--The insurance hard sell.--Deceptive sales tactics.

Catastrophic health insurance: info pack. Washington, Congressional Research Service. Updated as needed. IP370C

This collected material discusses the Medicare Catastrophic Protection Act, signed into law on July 1, 1988. The law provides insurance to Medicare beneficiaries against the catastrophic expenses of serious illness or injury. The expanded benefits are financed through increases in Medicare premiums.

Donlan, Thomas G.
Just what the doctor ordered? Catastrophic health insurance: the benefits and the cost. Barron's, v. 68, Mar. 7, 1988: 13, 48-53.
LRS88-3580

Asserts that the legislation "is a classic example of the two-steps-forward, one-step-back school of legislating . . . . It's an equally classic example of budget gimmickry, . . . of a legislative pig in a poke, . . . and of promising more than could be delivered."

Dopkeen, Jonathan. Rappaport, Anna. Bergthold, Linda.
Crisis or opportunity? Business and health, v. 6, Nov. 1988: 24-29.
LRS88-13246

The Medicare Catastrophic Care Act of 1988 "presents an opportunity for employers to think through and redesign retiree medical plans that wrap around Medicare at a time when the future of these plans is under intense discussion. This redesign could take the form of cash as well as service benefits, long-term care as well as acute services, and even flexible benefits."

England, Robert S.
The catastrophic health care blunder. American spectator, v. 21, Nov. 1988: 25-28, 30. LRS88-9054

"The story of how Ronald Reagan, Otis Bown, and a rogue Congress came up with what might be the most expensive piece of social legislation since the Great Society--and still failed to provide real catastrophic care for our elderly."

Esenwein, Gregg A.

Financing catastrophic health care: possible effects on marginal and average income tax rates. Feb. 15, 1989. Washington, Congressional Research Service, 1989. 12 p. 89-132 E

Catastrophic health care will be partially financed through a new supplemental premium based on the covered individual's Federal income tax liability. The supplemental premium is, in essence, a surtax, and as such will effectively raise the marginal and average income tax rates of covered individuals. This report provides an overview of the design characteristics of the supplemental catastrophic health care premium and analyzes how it will affect marginal and average income tax rates. The implications for investment behavior are also addressed.

Greenwald, Mathew.

Bad news for the baby boom. American demographics, v. 11, Feb. 1989: 34-37. LRS89-1793

"Although demographers can already see the impact of the aging of the baby boom, the boomers themselves are only dimly aware of what awaits them. Their financial needs in old age will pose a tremendous challenge to employers and government, and the best way to meet the challenge is to begin now."

Haislmaier, Edmund F.

Catastrophic health legislation: Congress's case of Medicare malpractice. Washington, Heritage Foundation, 1988. 15 p. (Issue bulletin no. 139) LRS88-4257

This April bulletin suggests alternatives involving private insurance and cutting health care costs rather than congressional proposals to "tax and spend."

Iglehart, John K.

Medicare's new benefits: 'catastrophic' health insurance. New England journal of medicine, v. 320, Feb. 2, 1989: 329-336. LRS89-948

Reviews the history and coverage of the Medicare Catastrophic Coverage Act.

Jackson, Wendy.

Catastrophic health care coverage bill: Medicare beneficiaries be alert! Employee benefits journal, v. 13, Sept. 1988: 26-28. LRS88-14629

"Whether the Catastrophic Health Care Coverage Bill does more harm than good remains to be seen. Its designers have good intentions--to provide some federal aid to Medicare beneficiaries so that, when a catastrophic illness or condition occurs, their total savings will not be depleted."

Martin, Sara.

The Medicare drug benefit: challenges for pharmacists. American pharmacy, v. NS29, July 1989: 22-25. LRS89-5605

Analyzes drug-utilization review, and the coverage of prescribed medications specified in the 1988 Medicare Catastrophic Coverage Act.

Medicare Catastrophic Coverage Act: collection of editorials, May 31, 1988 through July 6, 1989. July 14, 1989. Compiled by the Library Services Division, CRS. 15 p. LRS89-5459

Collects viewpoints showing a range of reactions to the 1988 Medicare catastrophic health insurance law from selected newspapers from around the nation.

Melbinger, Michael S. O'Donnell, Timothy.

The Medicare Catastrophic Coverage Act of 1988 and its impact on employer-sponsored retiree medical plans. Employee relations law journal, v. 14, winter 1988: 399-406. LRS88-12207

"The Medicare Catastrophic Coverage Act of 1988 (MECCA) significantly enlarges the scope of federally funded health care benefits for elderly Americans. Since Medicare's inception in 1965, several inadequacies have become apparent, especially the absence of coverage for catastrophic illnesses. Now MECCA inhibits the potential financial ruin of elderly Americans faced with overwhelming, extended medical costs. The Act is budget-neutral and can reduce employers' Social Security payroll tax costs."

O'Sullivan, Jennifer.

Catastrophic health insurance: Medicare; issue brief. Washington, Congressional Research Service. Regularly updated. 14 p. IB87106

Catastrophic medical costs are broadly defined as large unpredictable health care expenses usually associated with a major illness or serious injury. Since enactment of the Medicare Catastrophic Coverage Act, a number of issues have been raised, particularly about the financing mechanism. Several bills have been raised to amend, delay, or repeal the Act.

Health insurance that supplements Medicare: background material and data, by Jennifer O'Sullivan and David Koitz. July 19, 1989. Washington, Congressional Research Service, 1989. 35 p. 89-421 EPW

Most Medicare enrollees do have other forms of health insurance, and some of them are now questioning the need for the new Medicare benefits and having to pay new premiums. This paper provides background information on the nature and extensiveness of these various forms of supplementary health benefits.

Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). Mar. 3, 1989. Washington, Congressional Research Service, 1989. 150 p. 89-155 EPW

Provides an overview of the new law, including a summary of the provisions, background and legislative history, potential impact, implementation status, and a review of current issues.

Robinson, Michele L.

Taxes and health policy: worlds apart. Hospitals, v. 63, Mar. 20, 1989: 52-56, 58. LRS89-1692

Argues that "the special tax that Congress created to finance Medicare catastrophic benefits is just one indication that Congress is using the U.S. tax code in more innovative ways to influence the consumption, distribution, and financing of health care benefits."

Rovner, Julie.

Catastrophic-coverage law narrowly survives test. Congressional quarterly weekly report, v. 47, June 10, 1989: 1400-1402. LRS89-5322

Reports on Senate debate on making changes to the new Medicare catastrophic insurance program.

Panel may pave way for death of catastrophic-costs law. Congressional Quarterly weekly report, v. 47, July 15, 1989: 1781-1783. LRS89-5604

Reports that House "Ways and Means members seek ideas on how to cut premiums without jettisoning most valuable benefits."

Rubin, Rosie M. Wiener, Joshua M. Meiners, Mark R.

Private long-term care insurance. Medical care, v. 27, Feb. 1989: 182-193. LRS89-1296

Research "results indicate 1) the potential market for private long-term care insurance is substantial, 2) moderately comprehensive long-term care policies are affordable by a significant minority of the elderly, 3) policies are considerably more affordable to those under age 65, and 4) long-term care insurance has somewhat less potential to pay for nursing home costs for high risk groups than for other elderly."

Smith, William.

The Catastrophic Coverage Act of 1988: past proposals, current law, and future options. Washington, House Republican Research Committee, 1989. 8 p. (RRC occasional paper) LRS89-1196

"Generally, there is a cross section of opinion about the new law among Republicans. But as the new Medicare premiums take effect, the new law may be given additional scrutiny. The following report is a short history of the early Republican proposals and the final legislation, as well as a number of options currently being discussed."

U.S. Congress. Conference Committees, 1988.
Medicare Catastrophic Coverage Act of 1988; conference report to accompany H.R. 2470. Washington, G.P.O. 1988. 273 p. (Report, House, 100th Congress, 2nd session, no. 100-661) LRS88-3835

U.S. Dept. of Health and Human Services.
Expenses incurred by Medicare beneficiaries for prescription drugs: report to Congress. [Rockville, Md.] U.S. Dept. of Health and Human Services, 1989. 41, 12 p. LRS89-5403

Addresses the extent of third-party insurance coverage of outpatient drugs and "the potential for induced demand resulting from the coverage of covered outpatient drugs," under Medicare.

U.S. Office of Personnel Management.
A report on offering Medicare supplemental plans to Federal annuitants. Prepared by the Office of Personnel Management as required by section 423 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988. Washington, O.P.M., 1989. [48] p. LRS89-5404

Partial contents.--Medicare and the FEHBP [Federal Employees Health Benefits Program].--The case for and against Medicare supplemental plans.--Medicare supplemental program.

Where coverage ends: catastrophic illness and long-term health care costs. Washington, Employee Benefit Research Institute, 1988. 274 p. (EBRI-ERF policy forum) LRS88-6789

Partial contents.--The emerging politics of catastrophic and long-term care policy.--Private insurance policies for catastrophic and long-term health care coverage.--The optimal role for the Federal Government in financing catastrophic and long-term care.

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Medicare and Medicaid
IP 67M

Medicare and Medicaid are the popular names given to two programs enacted by Congress in 1965 that help the aged and certain low-income individuals pay for the costs of their medical care. Medicare is a nationwide health insurance program for the aged and disabled, while Medicaid is a federally-aided, State-operated-and-administered program for certain categories of low-income persons.

Recent legislation enacted by Congress has made significant changes in the Medicare and Medicaid programs, focusing largely on ways to reduce spending. In addition to providing general background information on Medicare and Medicaid, we include information on provisions of recently enacted or proposed legislation. For more detailed information on prospective payments to hospitals and physician reimbursement under Medicare, see Info Pack 317M.

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Medicare" and "Medicaid" and in the latest *Update* under "Health."

Additional information can be located at a local library by consulting periodical indexes such as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), and various newspaper indexes.

Individuals who wish to determine their eligibility and coverage under Medicare should check with their local Social Security office; for Medicaid they should check with their local human services office. Both are listed in the telephone directory.

We hope this information will be helpful.

Congressional Reference
Division

89-134 EPW

CRS Report for Congress

Medicare: Its Use, Funding, and Economic Dimensions

Prepared at the Request of the
Senate Committee on Finance

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March 1, 1989
(With Revisions)

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MEDICARE: ITS USE, FUNDING, AND ECONOMIC DIMENSTIONS

SUMMARY

Medicare is a nationwide health insurance program providing benefits to 30 million aged and 3 million disabled individuals. In general terms, it is an acute-care insurance program. That is, while it provides coverage for most acute-care medical services, it does not provide extensive coverage for long-term care services, such as extended nursing home stays. The program consists of two separate but complimentary programs--each provides coverage for a different group of benefits and is separately financed. Part A, the Hospital Insurance (HI) program provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance (SMI) Program, covers physician services and a range of other outpatient health services.

Medicare expenditures have been rising rapidly. Benefit payments have been growing at the rate of 12.2 percent per year between 1980 and 1989. While expenditures under both parts rose rapidly in the early 1980s, enactment of the Prospective Payment System (PPS) for hospitals in 1983 slowed the rate of growth in Part A to only 4.6 percent per year between 1985 and 1989. Over the same period, expenditures under Part B, primarily for physician services, have continued to grow at a rapid rate, 15.5 percent per year.

Medicare benefits are financed through a combination of payroll taxes on current wage earners (58 percent of total Medicare revenues in 1988), general revenues, and premiums paid by current beneficiaries. The payroll tax finances the HI program. This tax is based on a flat rate (1.45 percent) on both workers and employers (2.9 percent total tax) on the first $48,000 of earned income. The Part B program is financed by a combination of beneficiary premiums (25 percent of program costs) and transfers from general revenues. The Part B premium is $27.90 per person per month in 1989. Medicare's new catastrophic benefits are financed by a combination of an increase in the Part B premium ($4 in 1989) and an income tax surcharge (15 percent for the 1989 tax year) for Medicare beneficiaries, up to a maximum of $800 per person.

Medicare has increasingly become a significant and growing part of the Federal budget, national health expenditures, and the economy. Medicare outlays represent a substantial portion of the Federal budget (7.6 percent of outlays in FY89) and of national health expenditures (18 percent in calendar 1987). By itself, Medicare represents 1.8 percent of the Gross National Product (GNP). The program's tax revenues account for nearly 7 percent of total Federal revenues. The magnitude of the Medicare program combined with its persistent rapid growth raises a variety of issues, including the role of Medicare in deficit reduction efforts, whether the program is adequately financed now and in the foreseeable future, and the effects of continued growth on the Federal budget and the economy.

CONTENTS

MEDICARE: ITS USE, FUNDING, AND ECONOMIC DIMENSIONS

INTRODUCTION

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The authors would like to give special thanks to Ilene Shapiro for her assistance in preparing the charts and graphs used in this report.

I. HOW MEDICARE WORKS

As a health financing program, Medicare's purpose is to pay claims for services rendered to its enrollees by providers of health care. The program has two basic parts: Hospital Insurance (HI), sometimes referred to as Part A, pays claims for hospitalization and related nursing home and home health care. Supplementary Medical Insurance (SMI), sometimes referred to as Part B, pays claims for physician, outpatient, other auxiliary medical services, and for dialysis for those with end-stage renal (kidney) disease. New catastrophic benefits limit out-of-pockets costs enrollees must bare under both aspects of the program and for prescription drug expenses.

Most people gain eligibility for HI in the same way they do social security: by paying the HI tax while they work. The HI tax is part of the social security tax, sometimes referred to as the payroll tax. Working in employment where the tax is levied gives a worker credit toward HI in the form of *quarters of coverage*. With a minimum number of *quarters*, an individual can become entitled to HI coverage at age 65 or after being on the social security Disability Insurance (DI) rolls for at least 2 years.[1] A spouse also can obtain coverage through the worker's earnings credits. The basic coverage is free, however, an *income-related* premium is now required of people eligible for HI *or who would be if they applied* to cover the costs of catastrophic protection. Aged individuals who are not otherwise eligible for HI may purchase coverage.

Eligibility for SMI does not require a work record. It is available on an optional basis to all resident citizens age 65 and older (and certain aliens) and to people who have been on the DI rolls for at least 2 years. Those who enroll must pay a fixed-rate monthly premium, part of which goes for basic coverage and another part for catastrophic protection. The basic portion is designed to cover only one-fourth of the program's non-catastrophic costs. The catastrophic portion together with a portion of the *income-related* premiums covers the full cost of the catastrophic protection.

Various arms of the Government administer the programs: The Treasury Department has the tax collection and disbursement functions; the Social Security Administration (SSA) takes enrollment applications and serves as the first point of contact with the public; and the Health Care Financing Administration (HCFA), through its 88 contractors (Blue Cross/Blue Shield

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[1]People reaching age 65 in 1994 or later will need 40 *quarters of coverage* to be eligible. DI recipients may become eligible with less than 40 *quarters* (depending on their age when the disabling conditions began), but they must have worked in covered employment fairly recently before their disabling conditions began. The 24-month waiting period does not apply to people with end-stage renal disease, but they are subject to a 3 month waiting period unless they are enrolled in a self-dialysis training program or scheduled for a kidney transplant.

and other private insurers), operates the claims processing and program management side.

Some 32.6 million people are covered for HI services, and 32.5 million are covered by SMI. Approximately 6,700 hospitals, 7,400 skilled nursing facilities, and 5,800 home health agencies serve the enrollees.

In a broad sense Medicare is a multi-faceted Government-run money machine. In part it resembles a private insurance operation: it takes in premiums and provides protection to those who pay them. However, to a much larger extent, the program is underpinned by the principle that people finance the program while they work so that they may receive benefits when they retire or become disabled. In effect, they build credit toward their later eligibility. Moreover, while eligibility is earned, the money people pay is not set aside to meet their own health expenses. Instead, it is used to pay the health bills of those who are immediately eligible.[2] In a contemporaneous sense, this makes Medicare what economists call an "income-transfer" program, where income is taxed away from one group so that it can be redirected to another, presumably with a bias toward taking resources from those who have them and spending them on others in need. Taking the long view, it is an intergenerational transfer program where today's workers pay for the health expenses of their parents, with the expectation that their children will pay for theirs.

Thus, Medicare represents a blend of insurance and social welfare features. As such, it is called social insurance. The Government is the insurer, underwritten by its power to tax. The Nation's workers are a "mandatorily" insured group, but for protection that is deferred until retirement or disability occurs, and the current elderly and disabled populations are the immediate risk group.

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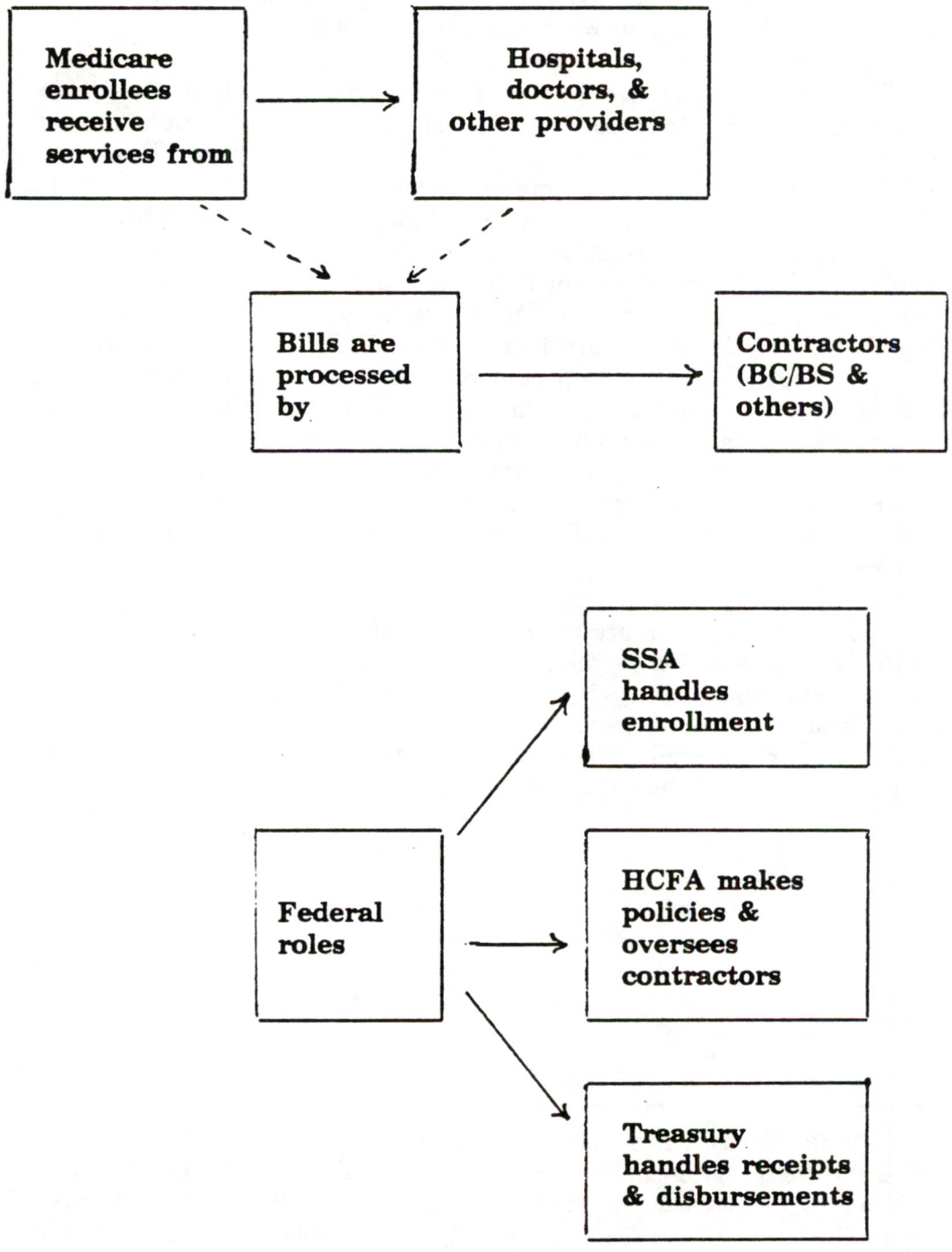
[2]While the recent enactment of "catastrophic" coverage will increase the share of the program financed by premiums paid by enrollees, the vast share of the program's costs will continue to be financed through payroll taxes and general receipts of the Government. The Congressional Budget Office (CBO) estimates that premiums from enrollees will cover only 14.9 percent of aggregate Medicare payments in 1993 (i.e., after catastrophic protection becomes fully effective), in contrast to 10.3 percent today. See U.S. Congress. Congressional Budget Office. *The Medicare Catastrophic Coverage Act of 1988.* Staff working paper, Oct. 1988. p. 34.

CHART 1. HOW MEDICARE OPERATES



II. BENEFITS

Medicare is a nationwide health insurance program providing benefits to 30 million aged and 3 million disabled individuals. In general terms, it is an acute-care insurance program. That is, while it provides coverage for most acute-care medical services, it does not provide extensive coverage for long-term care services, such as extended nursing home stays. As described in chapter I, the program consists of two separate but complimentary programs, each providing coverage for different groups of benefits. Part A, the Hospital Insurance (HI) program provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance (SMI) Program, covers physician services and a range of other health services including outpatient hospital services, physical therapy, diagnostic laboratory and X-ray services, and certain medical equipment. Beginning in 1990, under the provisions of the recently passed Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), coverage of outpatient prescription drugs is being phased in.

This section provides a basic description of Medicare's current scope of benefits under both Part A and Part B. This section also includes a separate brief discussion of how the benefits under each Part were changed by the Medicare Catastrophic Coverage Act (MCCA).

Part A Benefits

Inpatient hospital services. Medicare covers all expenses without limit for acute-care inpatient hospital services, subject to a single annual deductible ($560 in 1989) paid by the enrollee. Since October 1983, payments for inpatient hospital services have been made under the Prospective Payment System (PPS) for Hospitals. Under PPS, hospitals are paid a predetermined fixed price for each discharge that varies depending on the diagnosis of the patient. Hospitals also receive payments for certain other costs that are excluded from the PPS. While Medicare's payment may be higher or lower than the hospital's actual charges or costs, enrollees are not liable for any amount other than the annual deductible. There were 6,715 hospitals participating in Medicare in 1988. As described in the following section, hospital services account for the vast majority of benefit payments under Part A.

Skilled nursing home services. Part A provides coverage for up to 150 days per year in a skilled nursing facility (SNF) for patients requiring daily skilled nursing care. Such services include: nursing care; bed and board; physical, occupational and speech therapies; medical social services; drugs, biologicals, appliances and equipment furnished for use in the facility that are ordinarily provided by the facility; and certain other services. Stays in nursing homes by patients that do not meet the qualifying criteria or in nursing homes that are not certified by Medicare as an SNF are not a covered benefit. SNFs generally are reimbursed for their services on a reasonable cost basis, subject to certain limits. Enrollees are liable for a daily

coinsurance amount equal to 20 percent of the national average daily cost for SNF services for the first 8 days of SNF care in each year. The coinsurance amount for 1989 is $25.50 per day. Prior to January 1, 1989, SNF coverage was limited to individuals who were recently discharged from a hospital. This prior hospitalization requirement was eliminated by the MCCA. There were 7,379 SNFs participating in Medicare in 1988.

Home health services. Medicare provides unlimited coverage for home health care visits for beneficiaries who, as a result of their medical condition, are qualified to receive such care. To qualify, the individual must be confined to his or her home, and must be in need of intermittent skilled nursing care, or physical or speech therapy. As defined by law, Medicare home health services include: part-time or intermittent nursing care; physical, occupational or speech therapy; medical social services provided under the direction of a physician; to the extent permitted in regulation, the services of a home health aide; medical supplies and durable medical equipment, and certain other services. Both the HI and SMI programs provide coverage for home health services. Persons covered under both programs (the majority of enrollees) have payments for these services made under Part A. Persons enrolled in Part B but not Part A have their home health benefits paid under Part B. There is no limit on the number of home health visits covered, no prior hospitalization requirement, and no deductible or coinsurance charges to enrollees. Program guidelines generally limited daily home health care to 2 to 3 weeks. The MCCA clarified the extent to which intermittent skilled nursing care is covered on a daily basis. That is, the limit on consecutive days of care is raised to 38 days on January 1, 1990. Medicare pays for home health services on a per visit basis, subject to certain cost limits. There were 5,769 home health agencies participating in Medicare in 1988.

Hospice services. Effective November 1, 1983, Medicare covers stays in a hospice for terminally ill beneficiaries with a life expectancy of 6 months or less. Subject to certain limits, benefits under a hospice program include: home health services; outpatient drugs and biologicals; physician services; counseling with respect to care of the terminally ill patient and adjustment to his or her death; and short term inpatient care (in a hospital, skilled nursing facility or free-standing inpatient unit associated with the hospice) for pain control, symptom management, and respite care. Under Medicare, an enrollee who elects to receive hospice care waives entitlement to Medicare benefits related to the treatment of the terminal condition or related conditions, except for the services of the patient's attending physician. Medicare payments for hospice services are made under a prospective reimbursement system and vary depending on the intensity of care provided each day. Payments also are subject to a cap per enrollee per year, $8,406 for the 12 month period ending October 31, 1988. Enrollees are liable for copayments for outpatient drugs and respite services. Coverage for hospice services is currently subject to a lifetime limit of 210 days. Beginning in 1990, coverage will be extended beyond this limit. There were 449 hospices participating in Medicare in 1988.

Part B Benefits

Physician services. Part B of Medicare provides coverage of physician services, including surgery, consultations, and office, home and institutional visits. This includes the services of licensed doctors of medicine and osteopathy. Under certain limited circumstances, the term "physician" is defined in Medicare law to include services provided by dental surgeons, podiatrists, optometrists, and chiropractors. Physician services are reimbursed on a fee-for-service, "reasonable charge" basis. That is, separate payments are made for each service, and Medicare determines a reasonable charge for each service. Generally, the reasonable charge is the smallest of the actual charge, the physician's usual charges for the service, and the prevailing charge for the service by other physicians in the same locality. Payments for these services, as well as payments for most other Part B benefits, are made at 80 percent of Medicare's reasonable charge and are subject to the $75 annual Part B deductible. Enrollees are liable for the deductible, a coinsurance payment equal to 20 percent of the reasonable charge, and in some cases for the difference between Medicare's reasonable charge and the physician's actual charge for the service. Payments for physician services account for over 70 percent of total benefit payments under Part B.

Medical and other health services. Part B also provides coverage for a wide variety of medical services that are known as "medical and other health services." Payments for these services are generally made on a reasonable charge basis, and enrollees are liable for the annual Part B deductible, 20 percent coinsurance, and in some cases the difference between Medicare's reasonable charge and the actual charge for the service. The rules for determining the reasonable charge vary depending on the specific service provided. As defined in the law, medical and other health services include: (1) outpatient hospital services; (2) diagnostic laboratory and X-ray services; (3) therapeutic radiology services; (4) outpatient occupational and physical therapy; (5) rural health clinic services; (6) services of clinical psychologists in certain settings; (7) kidney dialysis services including home dialysis supplies and equipment; (8) immunosuppressive drugs furnished in the first year following a Medicare covered transplant procedure; (9) durable medical equipment including prosthetic and orthotic devices; (10) services of certified registered nurse anesthetists (CRNAs); (11) services of physician assistants in certain settings; and (12) services in ambulatory surgical centers.

Effective January 1, 1990, the MCCA adds three new services to the scope of benefits under Part B. Mammography screening will be covered once every other year for women over age 65. Intravenous (IV) drug therapy services provided in the home will be a covered benefit. IV drug therapy services are defined to include nursing, pharmacy and related services. The cost of the IV drugs themselves will be covered under the new drug benefit described below. There are no Part B deductible or coinsurance for IV drug therapy services. Eighty hours of in home care for a chronically dependent individual would be covered for persons who meet either the catastrophic cap or the outpatient prescription drug deductible. This type of services is known as respite care

and is intended to relieve the routine caretaker (a spouse, family member, or other person living with the patient and providing daily care without pay) from the daily responsibility of caring for the chronically dependent individual.

Health maintenance organizations and competitive medical plans. Health maintenance organizations (HMOs) and competitive medical plans (CMPs) are organizations that provide health care services on a prepaid basis. These plans generally provide a specified scope of benefits in return for a fixed monthly premium known as a capitation payment. These organizations differ from traditional health insurance plans in that they not only perform an insurance function, but also directly provide or arrange for the provision of services. HMOs and CMPs may enter into so-called "risk-sharing" contracts with Medicare. Under these contracts, a plan may enroll Medicare enrollees and is paid a predetermined monthly capitation payment for each such individual. If the HMO or CMP provides services for less than the plan's capitation revenues, it keeps the residual as profits; if services to enrollees cost more than the capitation payments, the HMO or CMP loses money. Each participating HMO and CMP must provide, at minimum, the same benefits that are otherwise available under Medicare, including both Part A and Part B benefits if the enrollee is eligible for both Parts. These plans may, subject to certain limits, charge enrollees additional premiums, coinsurance, or copayment amounts. Persons enrolling in these plans agree to receive all covered services through the plans. Out-of-plan services are only covered on an emergency basis and are paid for by the HMO or CMP. Enrollees are liable for the cost of non-emergency out-of-plan services that have not been authorized by the HMO or CMP.

Cap on out-of-pocket expenses. Effective January 1, 1990, the MCCA provides for a maximum enrollee liability for the Part B deductible and coinsurance charges. After the cap is reached, Medicare would pay any coinsurance amounts due on Part B claims. Cost-sharing payments under Part A are not included under the cap and enrollees would still be liable for these amounts. The outpatient prescription drug deductible and coinsurance charges also are not included under the cap. The cap is set at $1,370 in 1990, and is indexed such that 7 percent of enrollees would exceed the cap in subsequent years.

Outpatient Prescription Drugs

Under the MCCA, an outpatient prescription drug benefit is to be phased in, beginning in 1990. In the first year, coverage is limited to home IV drugs and immunosuppressive drugs provided after the first year following a transplant; immunosuppressive drugs in the first year after a transplant are already a covered benefit under Part B. Reasonable charges for covered drugs vary depending on whether the drug is a single source or multiple source drug. Payments are subject to a $550 deductible in 1990, except that the deductible does not apply to home IV drugs initiated during a hospital stay. Coinsurance amounts are 20 percent for home IV drugs and 50 percent for immunosuppressive drugs. Effective January 1, 1991, the drug benefit

expands to include all outpatient prescription drugs subject to a $600 annual deductible and 50 percent coinsurance charges. The deductible changes to $652 in 1992, and in future years is indexed such that 16.8 percent of beneficiaries will reach the deductible each year. The coinsurance rate is slated to be lowered to 40 percent in 1992 and to 20 percent in 1993. The drug benefit is separately financed from other Part B benefits, and the Secretary has limited authority to implement special cost control measures in 1993 and 1994 if financing for the drug benefit is inadequate.

Exclusions

While Medicare covers most acute-care medical services, there are certain services that are specifically excluded. Explicit exclusions are provided for cosmetic surgery, routine physical checkups, services which constitute personal comfort items (e.g., a telephone during an inpatient hospital stay), expenses for custodial care, routine dental care, routine foot care, services that are paid for directly or indirectly by a governmental entity, and certain other specified services. In addition, there is a general exclusion for services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." This has been interpreted to exclude payment for experimental procedures or procedures whose value has not been proven. For example, Medicare does not pay for liver transplants for adults even though it would pay for the same service provided to enrollees who are under 18 years of age and who have certain medical conditions. With the exception of immunosuppressive drugs in the first year following a transplant, self-administered outpatient drugs have been excluded from coverage. However, coverage for these drugs will be phased in beginning in 1990 as described below.

Modifications to Medicare Benefits Due to the Catastrophic Health Insurance Benefits Act of 1988

The MCCA provides for changes to existing benefits and adds new benefits under Medicare (many already described). These include expanded coverage for institutional services under Part A as well as new benefits and an out-of-pocket expense limit under Part B. The only new benefits under MCCA that are already effective are the expanded coverage for inpatient hospital, SNF services, and hospice services. Most other new benefits will become effective on January 1, 1990. The outpatient drug benefit is being phased in, beginning in 1990. The following table summarizes the changes in Medicare's benefits under the MCCA.

TABLE 1. Capsule Summary of Major Benefit Changes in MCCA

Benefit	Before implementation of MCCA: Coverage/beneficiary charges	After implementation of MCCA: Coverage/beneficiary charges	Effective date
PART A			
Inpatient hospital services	--Per spell of illness a/ --First 60 days-deductible ($540 in 1988) b/ --61st-90th day-daily coinsurance ($135 in 1988) b/ --60 lifetime reserve days-daily coinsurance ($270 in 1988) b/	Unlimited number of days subject to 1 annual deductible ($560 in 1989) b/	1/1/89
Skilled nursing facility (SNF) services	100 days post-hospital care per spell of illness a/ --First 20 days-no coinsurance --21st-100th day-daily coinsurance ($67.50 in 1988) b/	150 days per year --First 8 days: daily coinsurance (25.50 in 1989) b/ --9th-150th day-no coinsurance	1/1/89
Home health services	No coinsurance Consecutive days of care limited to 21	Consecutive days of care limited to 38	1/1/90
Hospice	Lifetime limit of 210 days	Limit may be extended	1/1/89
Blood	Deductible-3 units per spell of illness	Deductible-3 units per year (reduced by any Part B blood deductible)	1/1/89

See footnotes at end of table.

TABLE 1. Capsule Summary of Major Ben[redacted] Changes in MCCA--continued

Benefit	Before implementation of MCCA: Coverage/beneficiary charges	After implementation of MCCA: Coverage/beneficiary charges	Effective date
PART B			
Physicians and other medical services	--$75 deductible on approved charges --20 percent coinsurance on approved charges --Beneficiary pays any amount above approved amount on unassigned claims ("balance billing")	Same, except limit ($1,370 in 1990) c/ on beneficiary deductible and coinsurance charges	1/1/90
Screening Mammograms	Not covered	Biennial screenings subject to payment limit and Part B coinsurance charges	1/1/90
Respite Care	Not covered	80 hours a year if the beneficiary reaches either the catastrophic or prescription drug limit; subject to 20 percent coinsurance charges	1/1/90
Home Intraveneous Therapy	Not covered	Covered (drugs paid under drug benefit)	1/1/90

See footnotes at end of table.

TABLE 1. Capsule Summary of Major Benefit Changes in MCCA--continued

Before implementation of MCCA		After implementation of MCCA	
Benefit	Coverage/beneficiary charges	Coverage/beneficiary charges	Effective date
Outpatient Prescription drugs	Immunosuppressive drugs for 1st year after organ transplant-covered under regular Part B program	Same	
		Phase-in catastrophic prescription drug program:	
		Coverage	
		--Home intravenous (IV) drugs and immunosuppressive drugs after 1st year following an organ transplant	1/1/90
		--All outpatient prescription drugs	1/1/91
		Deductible d/	
		--$550	1/1/90
		--$600	1/1/91
		--$652 e/	1/1/92
		Coinsurance	1/1/90
		--20 percent for home IV drugs	1/1/90
		--50 percent for other drugs f/	

See footnotes at end of table.

a/ A spell of illness is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been an inpatient in a hospital or SNF for 60 days.

b/ Part A deductible and coinsurance amounts are increased annually. Before implementation of MCCA, SNF coinsurance was a percentage of the hospital deductible; after implementation of MCCA, it is 20 percent of estimated reasonable SNF costs.

c/ Amount indexed annually so that an estimated 7 percent of beneficiaries would be eligible for benefits each year.

d/ Does not apply for IV drugs furnished in connection with home IV therapy services initiated in the hospital.

e/ Amount indexed each year so that an estimated 16.8 percent of beneficiaries would be eligible for benefits each year.

f/ Coinsurance slated to decrease to 40 percent in 1992 and 20 percent thereafter.

III. EXPENDITURES AND USE OF SERVICES

Medicare is one of the fastest growing components of the Federal budget. Its share of total Federal outlays has risen from 3.9 percent in FY 1975 to 7.6 percent in FY 1989. The effects of rising Medicare costs on the Federal deficit and on the Medicare trust funds themselves are discussed further in section V. This section provides an overview of the trends in Medicare spending during the last decade and identifies some of the factors contributing to those trends.

General Trends

Table 2 shows the growth in program enrollment and payments during the 1980s. (The figures for FY 1990 are HCFA current law estimates and include the impact of the Medicare catastrophic legislation.) The growth of enrollment has been fairly steady in both parts A and B, averaging about 2 percent a year. Expenditure trends, however, are very different for the two programs. Costs for both parts were rising sharply in the early part of the decade, but the rate of increase in part A payments has moderated, largely as a result of the implementation of the PPS for inpatient hospital services in 1983. Part B costs, on the other hand, continue to grow rapidly.

Population growth plays only a minor part in increased program expenditures. More important are changes in the proportion of enrollees who actually use covered services, the quantity of services they consume, and the price Medicare pays for those services.

As table 2 indicates, the percentage of Part A enrollees using services has actually dropped slightly over the last 10 years. This may reflect the substitution of outpatient (Part B) services for inpatient hospital care, a phenomenon to be discussed later in this section. Under Part B, however, the proportion of enrollees receiving covered services has grown considerably. This is partly attributable to the fact that the Part B deductible, the amount an enrollee must pay for services during a year before Medicare will cover any charges, has been held at $75 since 1982, even though medical care prices were rising. This means that some enrollees whose charges during a year would once have been insufficient to meet the deductible may now, using the same amount of services, reach the $75 limit.

Finally, Parts A and B show different patterns of growth in the amounts paid for each enrollee using services. Early in the decade, payments per user rose at about the same rate under both programs, 13.2 percent for Part A and 12.5 percent for Part B. Part A growth has since dropped sharply, to 4 percent a year, again because of PPS. Annual growth in costs for users of Part B services has continued almost unabated.

TABLE 2. Medicare Enrollment and Payments, FY 1980-FY 1990

	1980	1985	1990[a]	Annual growth rate (%) 1980-85	Annual growth rate (%) 1985-90
Hospital insurance (Part A):					
Enrollees (thousands)	27,531	30,109	33,228	1.8	2.0
Payments (millions)	$23,776	$47,710	$63,069	14.9	5.7
Average payment per enrollee	$864	$1,585	$1,898	12.9	3.7
Number of enrollees receiving reimbursed services (thousands)	6,660	7,175	7,790	1.5	1.7
Percent receiving services	24.19%	23.83%	23.44%	-0.3	-0.3
Average payment per user of services	$3,570	$6,649	$8,096	13.2	4.0
Supplementary medical insurance (Part B):					
Enrollees (thousands)	27,120	29,781	32,778	1.9	1.9
Payments (millions)	$10,144	$21,808	$46,145	16.5	16.2
Average payment per enrollee	$374	$732	$1,408	14.4	14.0
Number of enrollees receiving reimbursed services (thousands)	17,787	21,227	26,581	3.6	4.6
Percent receiving services	65.59%	71.28%	81.09%	1.7	2.6
Average payment per user of services	$570	$1,027	$1,736	12.5	11.1
Total payments, Parts A and B	$33,920	$69,518	$109,214	15.4	9.5

[a]Current law projection, including proposed regulatory changes and effect of Medicare catastrophic legislation.

Source: Health Care Financing Administration.

Components of Part A and Part B Cost

Table 3 shows the breakdown by service type of Part A and Part B expenditures.

TABLE 3. Components of Medicare Expenditures, FY 1980-FY 1990

	1980	1985	1990[a]	Annual growth rate (%) 1980-85	Annual growth rate (%) 1985-90
Inpatient hospital	22,842	45,017	58,620	14.5	5.4
Skilled nursing facility	387	567	1,202	7.9	16.2
Home health	547	2,111	3,187	31.0	8.6
Hospice	0	15	160	0.0	60.5
Total Part A	23,776	47,710	63,169	14.9	5.8
Physician	7,814	16,789	31,275	16.5	13.2
Hospital outpatient	1,847	3,903	10,190	16.1	21.2
Other	483	1,116	4,680	18.2	33.2
Total Part B	10,144	21,808	46,145	16.5	16.2
Grand total	33,920	69,518	109,314	15.4	9.5

[a]Current law projection, including proposed regulatory changes and effect of Medicare catastrophic legislation.

Source: Health Care Financing Administration.

Under Part A, while inpatient services remain by far the most important component of spending, their share is expected to drop somewhat, from 96 percent in FY 1980 to 93 percent in FY 1990. Rapid growth in payments for skilled nursing facility services is expected, largely because the Medicare catastrophic legislation extended coverage and reduced coinsurance requirements for these services.

Growth in payments for home health services, once the fastest rising component of Part A spending, has slowed significantly for two reasons. First, payment limitations beginning in 1984 have reduced the annual growth in the average charge per visit from 10 percent a year during 1980-85 to 6 percent a year in the 1985-90 period. Second, the period of rapid growth in the use of Medicare home health services appears to have ended. Annual visits per enrollee quadrupled in the decade ended 1984, from 0.3 to 1.3, but have remained stable ever since. Finally, payments for hospice services, first covered in 1984, have been growing rapidly, although they remain an insignificant part of program expenditures.

Under Part B, the share of expenditures accounted for by physician services has dropped from 77 percent in FY 1980 to a projected 68 percent in FY 1990. Payments for outpatient hospital services, which were rising at about the same rate as physician payments in the first half of the decade, have since grown much more rapidly. This change, too, is partially attributable to the substitution of outpatient for inpatient services. For example, surgical procedures or diagnostic tests which would once have required a hospital admission may now be performed on an ambulatory basis.

The services labeled "other" in table 3 include some of the fastest growing components of Part B expenditures. Payments for independent laboratory services grew from $114 million in calendar year 1980 to $878 million in calendar year 1987, rising almost 34 percent a year. Payments for group practice plans, such as HMOs, grew nearly as rapidly, from $203 million in 1980 to $1,361 million in 1987.

Although the share of total Medicare expenditures accounted for by inpatient hospital and physician services has dropped somewhat, they remain the most important components of program expenditures and program growth. The remaining parts of this section look more closely at the trends in use and costs for these two major services.

Inpatient Hospital Services

For most of its history, the Medicare program paid for inpatient hospital care on a retrospective cost basis. Medicare paid in full the reasonable costs a hospital incurred in providing services to Medicare enrollees. Although attempts to contain the rate of increase in these costs began early in the 1970s, they were generally unsuccessful. By 1981, outlays for inpatient services were rising at an annual rate of 21 percent. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) imposed limits on the rate of increase in a hospital's costs for each case. A hospital whose costs rose faster than the target rate would be reimbursed only for costs below those limits. This change immediately reduced the rate of increase in Medicare inpatient costs to 10 percent between 1982 and 1983. The TEFRA limits were, however, a one way system. A hospital that failed to improve its efficiency could lose money, but any savings achieved by a hospital benefited only the Medicare program; the hospital could not share. The hospital

industry therefore initially supported the shift to the current PPS for inpatient services, established by the Social Security Amendments of 1983 (P.L. 98-21).

Hospitals included in PPS are paid a predetermined fixed payment rate, which varies depending on which of the approximately 470 Diagnosis Related Groups (DRGs) the patient has been classified into. The DRG payment is intended to cover the cost of treating the typical case in that DRG in a reasonably efficient hospital. Since hospitals are allowed to keep any difference between the PPS payment and their actual costs, PPS provides incentives for hospitals to contain costs, thus potentially reducing costs to the Medicare program. The new system was phased in over a 4 year period, beginning in FY 1984. Initially, each hospital's PPS rates were based largely on that hospital's historic costs. Now most hospitals are paid on the basis of national average rates.

Payment rates under PPS are adjusted to allow for differences among hospitals in the types of patients treated and services provided, through such mechanisms as an adjustment for teaching hospitals. The payment rates are also adjusted to account for differences in local hospital market conditions, through an area wage adjustment and different payment rates for urban and rural hospitals. PPS hospitals are also eligible for additional payments intended to cover certain additional costs of maintaining a hospital (e.g., capital-related costs such as interest expense, depreciation, etc.), operating special programs (e.g., medical education programs) or operating in special circumstances (e.g., serving low-income patients).

For the first 2 years, PPS rates were supposed to be "budget neutral," set at levels projected to result in the same annual increase in total Medicare inpatient expenditures as would have occurred under the previous system of TEFRA cost limits. Beginning in the third year, FY 1986, rates would increase according to an annual update factor established by the Secretary. This factor would take into account inflation, as measured by the market basket index, a gauge of the prices hospitals pay for the goods and services they purchase. The Secretary was also authorized to consider other trends, such as increased hospital efficiency or changes in medical technology. The final update factor could, then, be higher or lower than the rate of increase in the market basket index.

The 99th and 100th Congresses repeatedly postponed the Secretary's authority to set the update factor, and instead set the factors for FY 1986 through FY 1989 directly in legislation. (Under current law, the factor for FY 1990 and later years is to be equal to the market basket index.) As table 4 indicates, these update factors were below the market basket index. At the same time, however, the average Medicare payment per case rose faster than the update factors. This is because the update factor is not the only element affecting payment increases. For example, there have been changes in policies relating to add-on payments (such as those for medical education, disproportionate share hospitals, and capital costs). More important, there has

been a steady change in the kinds of Medicare cases hospitals have reported treating; each year, more cases fall into the higher-paying DRGs and fewer into the lower-paying ones. The "case mix index" shown on table 4 is a measure of this trend. Part of the change is real, reflecting hospitals' decisions to admit only more seriously ill patients while treating others on an outpatient basis, while part of the change results from improved accuracy in hospitals' reporting on their patients.

TABLE 4. Historical Trends in Factors Affecting the PPS Rates and Average Payments per Case (percentage change from the previous year)

	1982	1983	1984	1985	1986	1987	1988	1989	1990
Market basket index	8.3	5.9	4.9	4.1	3.1	4.5	4.7	5.4	4.7
Annual update factor					0.5	1.115	1.6	3.3	4.7
Case mix index			8.4	2.5	2.7	2.4	2.0	1.0	1.0
Average payment per discharge	14.0	10.4	10.4	14.9	7.1	4.1	2.9	3.8	7.7
Average payment per enrollee	15.4	11.7	7.2	6.3	2.9	1.8	2.4	4.7	9.0
GNP deflator	6.4	3.8	3.9	3.4	2.9	3.2	3.1	4.0	3.6

NOTE: Update factor for FY 1986 effective beginning with the eighth month of the fiscal year. Factors for FY 1988 and FY 1989 are weighted averages of the separate update factors for large urban, other urban, and rural areas, effective Apr. 1, 1988.

Source: U.S. Congress. House. Committee on Ways and Means. *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means.* [1989 volume in press.] Based on data from the Health Care Financing Administration.

While PPS was the major factor in moderating the growth in Medicare inpatient costs, other recent trends have affected the use of services by both Medicare and non-Medicare patients. The average length of hospital stays began declining in the late 1970s. Much of the decline in length of stay for the elderly occurred before PPS, although it accelerated slightly just after PPS was implemented in late 1983. A similar drop in length of stay was occurring for all patients, not just those over 65. Among the factors that may have contributed to earlier discharges are new technologies and changes in medical practice, the greater availability of home health services and other post-hospital care, and stricter utilization review by third party payers. More recently, length of stay for all patients has leveled off.

A second major change has been a drop in total hospital admissions. Admissions for younger patients were already declining in the early 1980s, at a time when those for patients over 65 were still rising. For those over 65, the drop did not come until the implementation of PPS. The decline in admissions for the Medicare population as a result of PPS was not anticipated. It had been thought that, in the face of limitations on revenues from each individual case, hospitals might admit more patients or admit some patients more than once. As noted earlier, however, hospitals apparently chose to treat some kinds of cases on an outpatient basis, admitting only the more severely ill as inpatients. This may explain why length of stay leveled off shortly after PPS was implemented. Although the fixed payment system gave hospitals a continued incentive to reduce length of stay, further reductions might not have been possible when hospitals began admitting more seriously ill patients.

The drop in total admissions for patients over 65 apparently ended in 1987. In 1988, admissions in this age group are estimated to have increased by 2.4 percent, approximately the same as the growth in the over 65 population. This may mean that admission rates are now steady, and that total Medicare admissions may be expected to rise in proportion to the size of the elderly population. As this change is very recent, however, it is too soon to know whether it is really the beginning of a long-term trend.

Physician Services

The increase in Part B expenditures for physician services is due to several factors. First, as noted earlier, the number of persons enrolled in Part B has been growing at a rate of approximately 2 percent per year. In addition, medical care prices have increased. The prices recognized by Medicare have increased somewhat more slowly than the rate of inflation in medical care prices in general, due in part to limits placed on increases in Medicare's allowed charges.

Medicare's basic fee-for-service payment system for physician services, modeled after reimbursement systems in use in the private sector, has remained relatively unchanged since the program's inception. Generally, separate payments are made for each individual service rendered. The price Medicare recognizes for each service is based on what is known as the

reasonable charge for the service. Medicare generally pays 80 percent of the reasonable charge. The patient is liable for 20 percent of the reasonable charge plus, in some cases, the difference between the actual charge and the reasonable charge.

The reasonable or approved charge for a service (in the absence of unusual circumstances) is the smallest of:

- the actual charge for the service by the physician;
- the physician's usual or customary charge for the service wherein the customary charge is usually defined as the median charge for that service by that physician during a preceding time period; and
- the "prevailing charge" for the same or similar services billed by all (or all similar) physicians in the locality (set at a level no higher than is necessary to cover the 75th percentile of physicians' customary charges for the service in the locality).

The customary and prevailing charge amounts are known as "fee screens" and are used to limit the amount Medicare pays for any individual service.

Before 1984, fee screens were updated annually on the basis of actual charges submitted by physicians in the preceding year. Since 1975, these annual updates have been subject to limits based on an economic index known as the Medicare Economic Index (MEI), which reflects changes in operating expenses and earnings levels of physicians. Physicians' actual fees generally have increased at a faster rate than this economic index. Between 1973 and 1984, the MEI increased by 106 percent while physician fees, as measured by the physician services component of the Consumer Price Index (CPI-U), increased 157 percent. Thus each year, an increasing percentage of physicians' actual and customary charges have exceeded the index-adjusted prevailing charge screens.

Since 1984, Congress has repeatedly acted to restrain increases in allowable physician fees. Physicians' customary and prevailing charges were frozen from July 1, 1984 through April 30, 1986: the annual update in the fee screens did not occur. Subsequent updates have been subject to congressionally mandated limits on MEI increases. Some categories of physicians or types of services have received special treatment. The first update after the freeze, on May 1, 1986, applied to "participating" physicians only (participating physicians are those who agree to accept Medicare's approved charge as payment in full). In later updates, participating physicians have been granted higher increases than non-participating ones. Higher increases have also been granted for primary care services, such as office visits, than for such services as surgical procedures. In addition to limiting the overall rate of increases in allowable charges, Congress applied special limits on payments for certain services believed to be relatively overpriced, such as cataract surgery and coronary artery bypasses. Finally, the Secretary

of Health and Human Services (HHS) may reduce charges not found to be "inherently reasonable," because the charges for a service are in excess of the estimated costs of the resources used in performing that service.

Largely as a result of congressional limitations, allowed charges for physician services under Medicare increased at a rate of about 5.5 percent per year over the 5 year period 1981-1986, as compared to about 9 percent per year for the physician services component of the Consumer Price Index. Increases in allowed charges per service, together with population growth, accounted for only about half of the annual rate of growth in physician payments over this interval.

The remaining growth in expenditures for physician services, often referred to as the "net residual" amount, is due to several factors including changes in the volume of services per enrollee, changes in technology, changing patterns of practice, and increasing intensity of care. In some cases, these changes may be related to increasing the quality of care or improving access to necessary services. On the other hand, some believe that not all of the increases in volume and intensity or changes in technology and patterns of practice are medically necessary and appropriate. That is, some portion of the "net residual" may represent unnecessary services that could be reduced or eliminated as part of an overall effort to control the growth in Part B expenditures.

Table 5 shows the shares of total allowed physician charges in 1987 attributable to different types of practitioners and different types of services. Surgery, the most important single component of spending, accounts for about the same share in 1987 as in 1980. However, there has been a shift in the performance of surgery from inpatient to outpatient settings. In 1987, allowed charges for surgery in outpatient departments and physicians' offices made up 46 percent of total allowed surgical charges, up from just 15 percent in 1980.[3]

The major change in recent years has been in expenditures for laboratory, radiology, and other diagnostic services. In 1987, diagnostic services accounted for 21 percent of total Part B expenditures (this figure includes expenditures for non-physician services), up from 15 percent in 1980.[4] The share of expenditures attributable to medical services, such as office and hospital visits, has declined proportionately. Part of this change may be due to the increased practice of "defensive medicine," the use of more diagnostic tests because of concerns about potential malpractice liability. The implementation of PPS for inpatient hospital services may also have had an impact. For example, hospitals often require a battery of diagnostic tests for each patient admitted. If these tests are performed on an inpatient basis, their cost is included in the

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[3]Physician Payment Review Commission. Annual Report to Congress. Washington, Mar. 1988. p. 22.

[4]Ibid.

flat PPS payment for the case. If they are performed on an outpatient basis just before the admission, they are billable under Part B. (This "site shifting" is one of the factors considered by the Prospective Payment Assessment Commission and others in recommending PPS rate increases below the rate of inflation for the last several fiscal years.)

TABLE 5. Medicare Allowed Charges for Physicians' Services, by Type of Practitioner and Type of Service, 1987

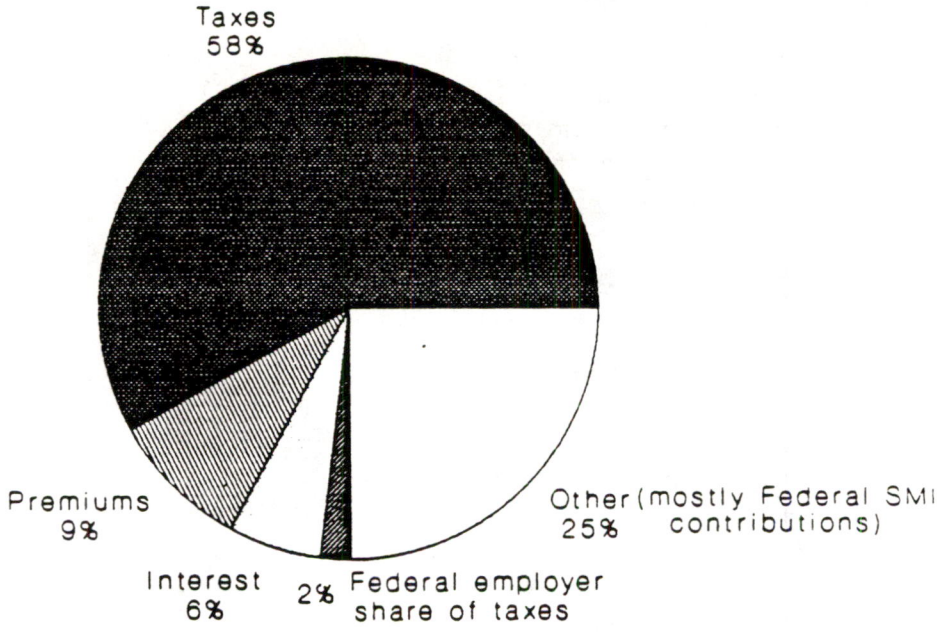
	Allowed amounts (millions)	Percent of total	Percent inpatient
Type of practitioner:			
Primary care physicians and clinics	$7,809	32.3	40.6
Nonsurgical specialists	3,989	16.5	56.3
Surgical specialists	8,717	36.1	48.6
Radiologists, pathologists and anesthesiologists	3,548	14.7	53.7
Osteopaths	87	0.4	26.4
Total	$24,151	100.0	47.9
Type of service:			
Medical care	$8,199	33.9	43.0
Surgery and assistance at surgery	8,805	36.4	57.9
Anesthesia	1,051	4.4	78.7
Diagnostic lab & radiology	4,187	17.4	31.1
Therapeutic radiology	351	1.5	11.5
Consultations	1,081	4.5	68.5
Other	477	2.0	10.3

Source: Health Care Financing Administration. Based on tables scheduled to appear in U.S. Congress. House. Committee on Ways and Means. *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means.* [1989 edition in press.]

IV. FUNDING AND BOOKKEEPING

Unlike ordinary health insurance, Medicare does not rely on *prepayments* or premiums from enrollees. Instead, its primary income sources are Federal taxes levied on workers earnings (payroll taxes) and so-called *internal payments from the Government* (i.e., credits from one Government account to another). Premiums play a relatively small role. On an aggregated basis (HI and SMI combined) in fiscal year 1988, 58 percent of Medicare's financing came from payroll tax levies, 33 percent came from internal payments from the Government, and 9 percent came from premiums. Even with the introduction of additional premiums this year for coverage against catastrophic health expenses, aggregate premiums will still represent a small share of the program's total income.[5]

CHART 2. SOURCES OF MEDICARE INCOME, FY 1988



Note: HI and SMI combined
Source: Office of Management and Budget

[5]CBO estimates show that if the new catastrophic provisions had been fully effective in 1988, premium receipts would have represented 15 of overall Medicare income, instead of 9 percent.

Payroll tax receipts are the primary source of funding for HI. People who work pay the tax, with few exceptions. Even people who are currently enrolled in Medicare must pay it if they work. Thus, HI's costs are borne by virtually everyone who has earnings in the economy. Relying heavily on general resources of the Government, most of SMI's funding ultimately comes from income taxes and public borrowing. Thus, SMI's costs also are borne broadly within the economy, although through very different means than HI. In contrast, the costs of the catastrophic protections--funded entirely through premiums--are borne exclusively by those who are eligible, largely the aged.

The receipts and expenditures of the program are accounted for through separate trust funds that are maintained by the Treasury Department. However, the trust funds themselves do not actually provide the program's financing. Money received and spent for Medicare purposes is through the general treasury. The trust funds hold non-marketable Federal securities. When the Government receives revenues on behalf of the program, the Treasury Department posts securities to the appropriate trust fund. As payments are made from the treasury for the program, the balance of securities recorded in the trust funds is reduced. In effect, the receipts and outgo of the program occurs through the Federal treasury and is reflected by a rise or fall in the securities balances of the trust funds. As long as there are balances posted to the trust funds, the Treasury Department is authorized to make expenditures on the program's behalf.

HI Financing Sources

HI's financing is very similar to that of the social security programs. Its primary source is taxes under the Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA), commonly referred to as FICA and SECA taxes. In 1988, 90 percent of HI's income came from these taxes.

The FICA tax is a flat-rate tax on earnings of wage and salary workers (i.e., people in the employ of others). It is paid by workers with a matching amount paid by their employers (the employer is responsible for withholding and submitting both its own and its employees' shares). The SECA tax is a flat-rate tax on net self-employment income. There is a limit on the amount of earnings that can be taxed in a given year ($48,000 this year); thus, not all earnings are necessarily taxed. Moreover, neither the FICA nor SECA tax is levied on non-work income, i.e., dividends, interest, capital gains, or other forms of investment income. Only earnings from work are affected.

The other 10 percent of HI's income comes (1) from credits from the Government itself in the form of interest earned on non-marketable securities held by its trust fund--the HI trust fund--and reimbursement for various other purposes, and (2) premiums paid by people not otherwise eligible.

The HI tax rate. Today, the FICA tax rate is 7.51 percent, 15.02 percent when the employee's and employer's shares are combined; the SECA

rate also is 15.02 percent, but the law provides a 2 percentage point credit that effectively lowers the rate to 13.02 percent. Both FICA and SECA taxes have three components: two are for the social security programs of Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) and the third is for HI. The HI component is 1.45 percent for the employee and employer each (2.9 percent on a combined basis) and 2.9 percent for the self employed. Wage earners, salaried workers, and their employers account for about 95 percent of HI tax receipts; the self employed account for the other 5 percent. About 19 percent of FICA and SECA receipts is allocated to HI.

Although increases in the social security portions of the tax rates are currently scheduled to take effect in January 1990, the HI portions are fixed in the law for the indefinite future.

TABLE 6. FICA and SECA Tax Rates under Current Law

	FICA			SECA			
	OASDI (employee/employer each)	HI	Total	OASDI	HI	Credit	Total
1988-89	6.06	1.45	7.51	12.12	2.9	(2.0)	13.02
1990	6.20	1.45	7.65	12.40	2.9	*	15.3*

* The self-employment credit expires at the end of 1989, but beginning in 1990 self-employment taxes will be computed on a lower net earnings basis and half of SECA taxes will be deductible for income tax purposes.

The taxable earnings base. FICA and SECA taxes are levied on earnings up to an annual ceiling or cap known as the taxable earnings base. Earnings above the base are not taxed. Usually, payment of FICA and SECA taxes commences at the beginning of a calendar year and continues throughout the year until the cap is reached. Thus, someone whose earnings reach the cap by July would stop paying the tax at that point and would not resume paying it until the beginning of the next year.

Starting at $3,000 in 1937 (when the social security tax was first levied), the base has been increased 23 times and stands at $48,000 in 1989. When the HI portion of the tax was first levied in 1966, the base was $6,600. It has been raised 19 times since then. Under current law, an increase in the base is triggered whenever social security recipients are granted an automatic cost-of-living adjustment (COLA). Earnings base increases have occurred annually since 1972, although many of the hikes were not automatic. Since

1982, the increases consistently have matched the growth in average earnings in the economy. The base is projected to rise to $65,700 by 1995.[6]

Most workers pay the HI tax on all their earnings. In 1986, an estimated 94 percent of workers who were required to pay the HI tax in 1985 had annual earnings below the taxable earnings base, and 91 percent of all earnings in covered employment was taxable (up from 88.5 percent in 1980 and 78 percent in 1970).

HI "buy-in" premiums. Although a minor income source, premiums are paid by people who buy HI coverage. People age 65 and older who are not otherwise eligible for HI, i.e., they do not have sufficient *quarters of coverage* or do not have a spouse who has earned eligibility, can purchase HI for a monthly premium. The premium is $156 a month during 1989 ($1,872 on an annual basis). It will be increased automatically in future years. Premiums represented only 0.1 percent of the program's aggregate income in 1988.

The 1989 premium is lower than the 1988 level of $234 a month. This was done as part of the new Medicare catastrophic provisions to better reflect the costs to the program. The procedures used prior to the change tended to overstate the actuarial value of the program. The new procedures tie the premium to *the average per capita amount payable from HI for aged enrollees.*

Interest on securities and other internal payments. Also providing financing to the program are interest on securities held by the HI trust fund and other internal credits from the Government. The other internal credits are for the costs of HI benefits provided to certain uninsured individuals,[7] and those resulting from gratuitous wage credits given to military personnel. Interest is by far the largest of these internal payments, comprising 8 percent of all income posted to the HI trust fund in 1988.

SMI Financing Sources

In contrast to HI, the SMI program does not rely on payroll taxes. General resources of the Government are its principal source of funding with monthly premiums paid by people enrolled in the program accounting for most of the remaining portion.

SMI standard monthly premiums. SMI is voluntary; most people 65 and older can enroll in it regardless of whether they elect HI coverage or

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[6]Under revised 1988 Trustees' report Intermediate II-B assumptions.

[7]People who attained age 72 before 1968 and who generally are not eligible under other provisions of the program because of little or no earnings credits.

social security benefits.[8] When the program began in 1966 monthly premiums paid by enrollees were set in the law to finance half of the program's costs. Over the years, however, the premium's growth did not keep pace with the rapidly rising costs of the program. As a result, the basic program (i.e., the non-catastrophic portion--see following description of *catastrophic protection financing sources*) currently receives only one-fourth of its financing from premiums.

Annually, the Secretary of HHS determines what the basic or so-called standard monthly premium will be, based on the projected costs to be incurred by enrollees age 65 and older for the year in which the premium will be in effect.[9] For the past few years, the law required that the standard premium be set so that aggregate premium receipts cover 25 percent of the aged's SMI costs. Thus, the premium rose roughly in tandem with program costs. However, beginning in 1990 the law reinstates a limit on how much the premium can rise--a limit that was in effect prior to 1984. It will preclude the premium from rising at a faster rate than social security COLAs. The COLAs are based on the general level of inflation in the economy as measured by increases in the CPI. If SMI costs continue to rise faster than the overall CPI after 1989, the share of the program financed through premiums will decline again.

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[8]People receiving social security cash benefits are automatically enrolled in HI and SMI when their Medicare entitlement begins. They have to decline SMI coverage, if they do not want it. SMI is not voluntary for people who "buy into" HI (the "uninsured"); they must also enroll in SMI. People with end-stage renal disease who enroll in SMI must also take HI coverage.

[9]While SMI costs vary by type of enrollee--aged, disabled, and those suffering from end-stage renal disease--the premium rate is derived from the costs of the aged and is the same for all enrollees.

TABLE 7. Level of Standard SMI Premiums, 1966-89

Calendar year	Standard monthly premium	Annual cost to enrollee	SMI premium income as % of total SMI income
1970	$5.30	63.60	49.8%
1980	9.60	115.20	27.7
1985	15.50	186.00	22.4
1989	27.90*	334.80*	25.4

* These figures exclude the new catastrophic coverage premium; which for most SMI enrollees is $4.00 a month. This *add-on* makes the 1989 SMI premium $31.90 a month.

Source: Derived from 1988 SMI trustees' report and supplemented by data from the Health Care Financing Administration.

Government contributions to SMI. The Government, through internal credits to the SMI trust fund, matches the standard premiums paid by enrollees (the non-catastrophic portion) with so-called "Government contributions." In contrast to the single premium level applicable to all SMI enrollees, separate matching rates are determined for the aged and disabled (including enrollees suffering from end-stage renal disease) based on the projected costs to be incurred by each group. The matching rates are basically intended to cover the difference between the premium income and costs of the program. Appropriate adjustments are made to reflect interest earnings and the amount needed to maintain an adequate contingency reserve in the SMI trust fund.

Government contributions are the largest source of financing for the program. The Government's matching rate grew steadily from a little more than one-to-one in the early years of the program to roughly three-to-one by the early part of this decade. In recent years the rate has remained fairly steady as a result of repeated congressional action to hold it at the three-to-one level for the aged. However, after 1989, when the law will again limit the premium increase to the percentage increase in social security COLAs, the rate will resume growing if SMI costs continue to rise faster than the overall cost of living--i.e., the Government's share will start rising again.

Interest on securities. Interest on securities held by the SMI trust fund also provides financing to the program. As with interest earned by the HI trust fund and the Government's contributions to SMI, SMI's interest is

basically an internal credit from the Government. It has never been a major factor in financing the program. At its peak in 1985, it was equal to roughly 5 percent of SMI expenditures. In 1988, it was equal to only 2 percent.

Catastrophic Protection Financing Sources

New Medicare protection against unusually large health expenses--so-called catastrophic expenses--was enacted with passage of the Medicare Catastrophic Coverage Act of 1988 and is being phased in over a 5 year period beginning in 1989. It improves the benefits provided through HI (beginning in 1989) and SMI (beginning in 1990) by affording broader coverage of health expenses and placing limits on the out-of-pocket costs enrollees pay for medical goods and services. In addition, in 1991 the program will begin phasing in prescription drug coverage (very few prescription drug costs were previously covered). The enactment of these benefits introduced a new concept in the financing of the program: the costs were to be borne entirely by the recipient population.

There actually are two components of the new financing, both of which are in the form of premiums paid by those who are eligible for or enrolled in Medicare. Envisioned in the legislation is that, at least to start, 63 percent of the financing would come from an income-related premium--basically a surtax on the income tax liabilities of the affected population. CBO estimates that about 36 percent of Medicare enrollees will pay it in 1989, rising to 42 percent by 1993. The remaining 37 percent would come from a flat-rate monthly premium added to the standard SMI premium. Each of these premiums is divided into (1) a basic catastrophic component and (2) a prescription drug component. Congress intended that together these new premiums would fully cover the costs of the new benefits.

Supplemental premiums. An income-related premium--referred to as the supplemental premium--is mandatory for people who are (1) enrolled in HI for at least 6 months during the year or (2) even if they are not enrolled, would be eligible if they did. This encompasses most of the population 65 and older and those people eligible for Medicare because they have been receiving social security disability benefits for 2 years or more. The premium is derived from their income tax liabilities. In 1989, the premium is $22.50 for each $150 of income tax liability incurred, up to a maximum premium of $800 for the year ($1,600 for a couple when both are eligible). In effect, the premium amounts to a surtax of 15 percent (up to a dollar limit). The law specifies larger premium levels for 1990 through 1993 that effectively impose progressively higher surtaxes.

TABLE 8. Income-Related Catastrophic Premiums, 1989-93

Calendar year	Premium per $150 of tax liability	Implicit surtax rate	Maximum potential premiums for individual	Maximum potential premiums for couple[10]
1989	$22.50	15%	$800	$1,600
1990	37.50	25	850	1,700
1991	39.00	26	900	1,800
1992	40.50	27	950	1,950
1993	42.00	28	1,050	2,100

For years after 1993 the law prescribes procedures for raising the premium rate if necessary to help keep new premium income and expenditures in line. The new income would be expected to rise as the affected population's tax liabilities rise, but if the new expenditures rise faster--as determined by measures of actual recent per capita experience of both, *not projections*--the Secretary of Health and Human Services (HHS) is required to raise the premium rate accordingly. Additional adjustments are required to reflect the recent inflation rate (the latter serving primarily as an added contingency margin in the event inflation accelerates) and to maintain adequate balances in new trust funds created for the expanded coverage. The premium rate cannot go up by more than $1.50 in any year (per $150 of tax liability), and if that precludes the new premiums from rising in tandem with the new expenditures, the new flat-rate premium is to be increased to make up the difference.

Flat-rate catastrophic premiums. The new flat-rate catastrophic premium is an add-on to the standard SMI premium. It is not mandatory in

[10]This is the maximum potential premium when both members are eligible and file a joint return. However, where only one member of a couple that files a joint return is eligible for at least 6 months during the year, the maximum premium is limited to the amount that applies to single persons (e.g., $800 in 1989) and the premium is computed using only one-half of the couple's income tax liability. This does not apply to a member of a couple filing separate returns who must count all of his or her respective tax liabilities, and each is subject to a *couple's maximum*--$1,600 in 1989. If both are Medicare eligible, the potential maximum is $3,200 in 1989. Further, if they did not live apart the entire year, both are deemed to be Medicare eligible even if only one member is.

the same way as the income-related premium. It must be paid only if an individual is actually enrolled in SMI. The law explicitly establishes the premium levels for 1989 through 1993.

TABLE 9. Flat Rate Monthly Catastrophic Premiums, CY 1989-93

Calendar year	1989	1990	1991	1992	1993
	$4.00	$4.90	$7.40	$10.20	$10.20

*Alternative pre-set premiums are established for (1) residents of Puerto Rico and other U.S. Commonwealths and territories, (2) for people enrolled in Part B only, and (3) for those who buy into HI.

As with the income-related premium, for years after 1993, the law specifies procedures for indexing the flat-rate premium in order to keep the costs and financing of the new benefits in balance.[11] If necessary, additional adjustments are required to make up for any potential revenue loss caused by limitations on how much the income-related premium can be raised.

Medicare Trust Funds

Medicare's financial operations are accounted for through four trust funds and a special catastrophic coverage account, all of which are maintained by the Department of the Treasury. Two separate trust funds have existed since the beginning of the program for HI and SMI and two additional funds were created this year for the new catastrophic benefits: one for the new drug-related benefits and another for the expansion of HI protections. In addition, a special catastrophic coverage account--referred to as *the Account*--has been established to separately keep track of the full range of new HI and SMI receipts and expenditures.

Three out of four of these trust funds reflect both income and outgo flows. One, however, a new HI catastrophic coverage *reserve fund*, reflects only income flows. Expenditures recorded against the basic HI and SMI trust funds include their standard benefits and expenses and, as well, their respective shares of the new catastrophic costs. HI payroll tax receipts and other internal payments from the Government are credited to the HI fund, however, HI's share of the new catastrophic premiums are credited to the new reserve fund. All of the new income-related premiums (the non-drug portion)

[11]The indexing procedures become effective in earlier years for Puerto Rico and the Commonwealths and territories.

are first credited to the reserve fund, and then, to the extent these premiums exceed HI's new catastrophic-related expenditures, they are credited (or transferred) to the SMI fund. The law currently does not permit any transfers from the reserve fund to the HI fund to recognize the new HI expenditures, however, the conference report accompanying the new law states that the conferees anticipated that Congress "may at some future time transfer funds from the reserve fund to the HI trust fund to bolster the solvency of the fund."[12] The standard SMI premiums, the Government's matching contributions and other internal payments, and the new catastrophic "add-ons" to the standard SMI premiums are all credited to the SMI trust fund. Beginning in 1990, the Catastrophic Drug Insurance fund will be credited with its shares of the income-related and flat-rate premiums.

The new catastrophic coverage *account* is not credited or debited with receipts and expenditures in the same way as the various trust funds--Federal securities are recorded to the trust funds; but not to this account. It serves as a centralized means of keeping track of catastrophic receipts and expenditures overall and the separate HI and SMI components. Its primary function is to be a record keeping device for measuring whether and by how much the new catastrophic premiums need to be raised.

The trust funds themselves are not actually repositories for money. In a sense, like the new catastrophic coverage *account*, they are record keeping devices. When it is said that one or another of them receives income what is being described is the crediting of securities to them by the Treasury Department. However, the money received by the Government (payroll taxes and premiums) and the money spent by the Government to pay claims and administrative expenses moves in and out of the treasury along with other governmental receipts and payments. As Medicare taxes and premiums are paid into the treasury, a corresponding amount of new securities is posted to the trust funds. Similarly, when internal credits from the Government are due to the trust funds--e.g., for interest on securities held by the funds--new securities are posted to them. Conversely, when Medicare expenditures are made, the money is paid out of the treasury and a corresponding amount of securities is deleted from the trust funds.

In any given accounting period, income posted to the trust funds (the new securities) is always a larger figure than the actual Medicare receipts the Government takes in. Interest income, for instance, is not derived from sources outside of the Government, since the trust funds only hold securities of the Government itself. Interest is simply a credit from one Government account to another. The Government's SMI contributions are similarly just internal

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[12]In effect, the expenditures are recorded against one trust fund and the corresponding premiums are credited to another, but no transfer is permitted between them. See conference report on the Medicare Catastrophic Coverage Act of 1988, p. 225.

transactions; the securities of the SMI trust fund are raised when that posting is made, but the Government has not actually received any new money.

The securities held by the trust funds function like a checking account balance. As long as there are securities in the funds, the Treasury Department has authority to write checks to meet the program's commitments. This is in contrast to many other Government programs where Congress must give express approval each year to keep payments flowing by enacting appropriations laws. The balances of the trust funds, in a sense, provide indefinite approval to spend on behalf of the program.

V. POSITION IN THE ECONOMY[13]

How significant is Medicare in the economy? How much does it finance of what the Nation spends on health? How much do the Nation's hospitals, doctors, and other medical providers receive from it? What is its share of the Federal budget and the amount the Government spends on health programs? How much do its enrollees depend on it? And how big of a tax bite does it take? Simply put, how big is Medicare as a financial institution?

Medicare As a Part of The Overall Economy

In 1987, expenditures made in the U.S. economy for health-related services and activities were $500 billion, or 11.1 percent of the Gross National Product (GNP). In lay terms, $1 out of every $9 spent in the economy was for health purposes. This represented more than a three-fold rise in dollar terms from 1965 (in constant 1987 dollars), and nearly a doubling of the share of the Nation's spending directed at the health sector. Moreover, projections suggest sizeable future growth, with health spending increasing by 200 percent by the year 2000 and accounting then for nearly $1 out of every $6 of GNP. Medicare has been part of and is expected to remain a contributor to this growth. By itself the program represents a notable element of the economy with expenditures equaling 1.8 percent of GNP (in 1987). Its payments account for one-sixth of national health expenditures with their greatest impact being in the hospital sector where the program pays for almost 30 percent of the services provided. It has a similar marked impact on physician services where it finances $1 out of every $5 of care.

Thus, in a little more than 2 decades Medicare has assumed a major role in financing the Nation's medical care. Implemented in 1966, the program's spending grew at an average annual rate of 15 percent from fiscal year 1970 to 1988 (11.9 percent from 1980 to 1988). This was a faster pace than the overall inflation rate (as measured by the CPI), wages in the economy, GNP, and national health expenditures generally.

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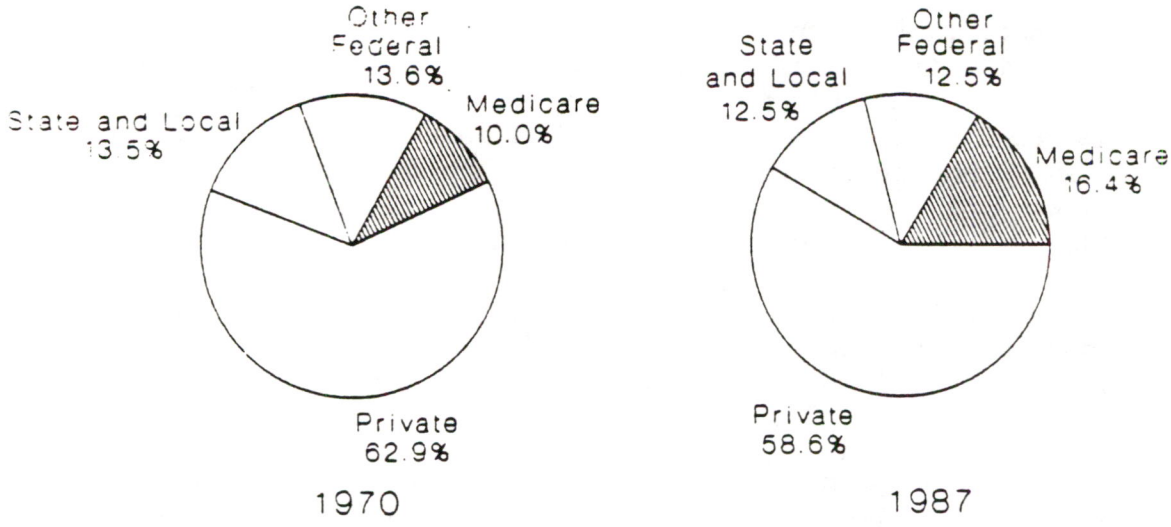
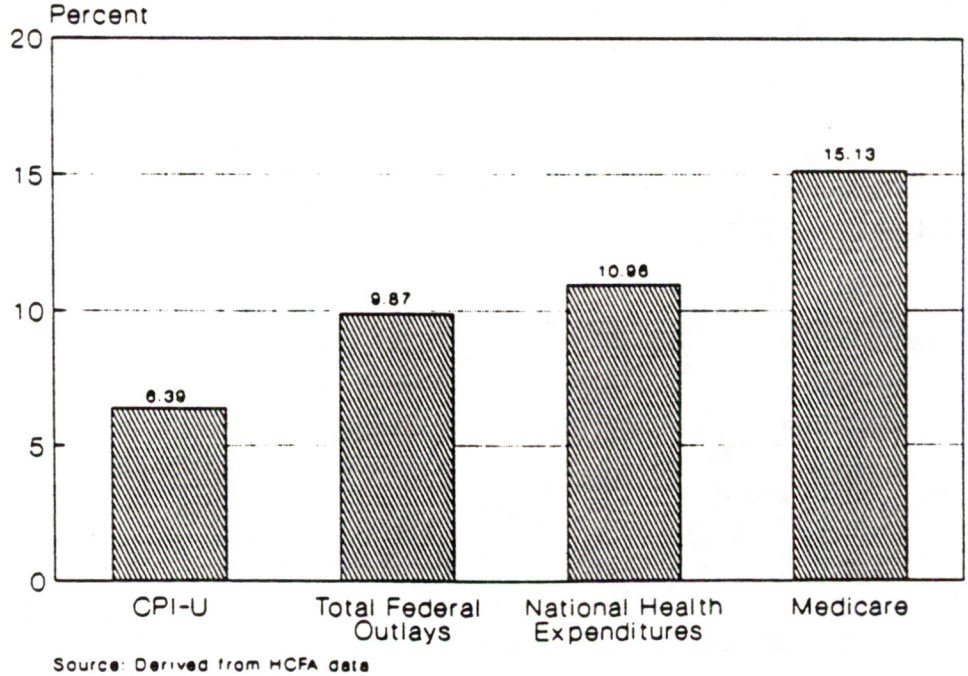
[13]The information contained in this section was derived from three HCFA studies of national health spending; one reported through a press release on Nov. 18, 1988, and the other two reported in the summer 1987 and fall 1986 issues of the *Health Care Financing Review*.

CHART 3. MEDICARE'S SHARE OF NATIONAL HEALTH EXPENDITURES 1970 AND 1987



Source: Dept. of HHS and Medicare trustees' reports.

CHART 4. MEDICARE'S RATE OF GROWTH COMPARED TO OTHER ECONOMIC MEASURES, FY 1970-88 (average annual growth rate in percent)



Source: Derived from HCFA data

While Medicare's rate of growth has moderated some in recent years, current projections suggest that the program will continue to grow faster than GNP, and by 2000 its expenditures would exceed of three percent of GNP--representing more than a 50 percent increase.[14] Moreover, these projections do not reflect the impact of the new catastrophic provisions, which may increase Medicare expenditures by 7 percent or more.[15]

TABLE 10. Projected Average Annual Growth Rate of GNP, National Health Expenditures, Federal Health Expenditures, and Medicare, 1986-2000

Projected average annual growth rate in percent 1986-2000			
GNP	National health expenditures	Federal health expenditures	Medicare
6.5	9.0	9.8	10.8

NOTE: Figures do not reflect new catastrophic expenditures.

Medicare As a Federal Health Program

In 1965 the Federal Government accounted for 13 percent of the Nation's health spending; by 1987, its share had grown to 29 percent. The entire amount of that growth can be attributed to Medicare. In 1987 Medicare's expenditures accounted for 57 percent of all Federal health spending (up from 42 percent in 1970) and nearly 17 percent of national health expenditures (up from 10 percent in 1970).[16]

Prior to the advent of Medicare and Medicaid in 1965, the Federal Government had a relatively modest role in paying for personal medical services, which was mostly confined to veterans and the military. Its presence was more pronounced in the medical research, hospital construction, and public health fields. However, from 1965 to 1987, the Government's share in

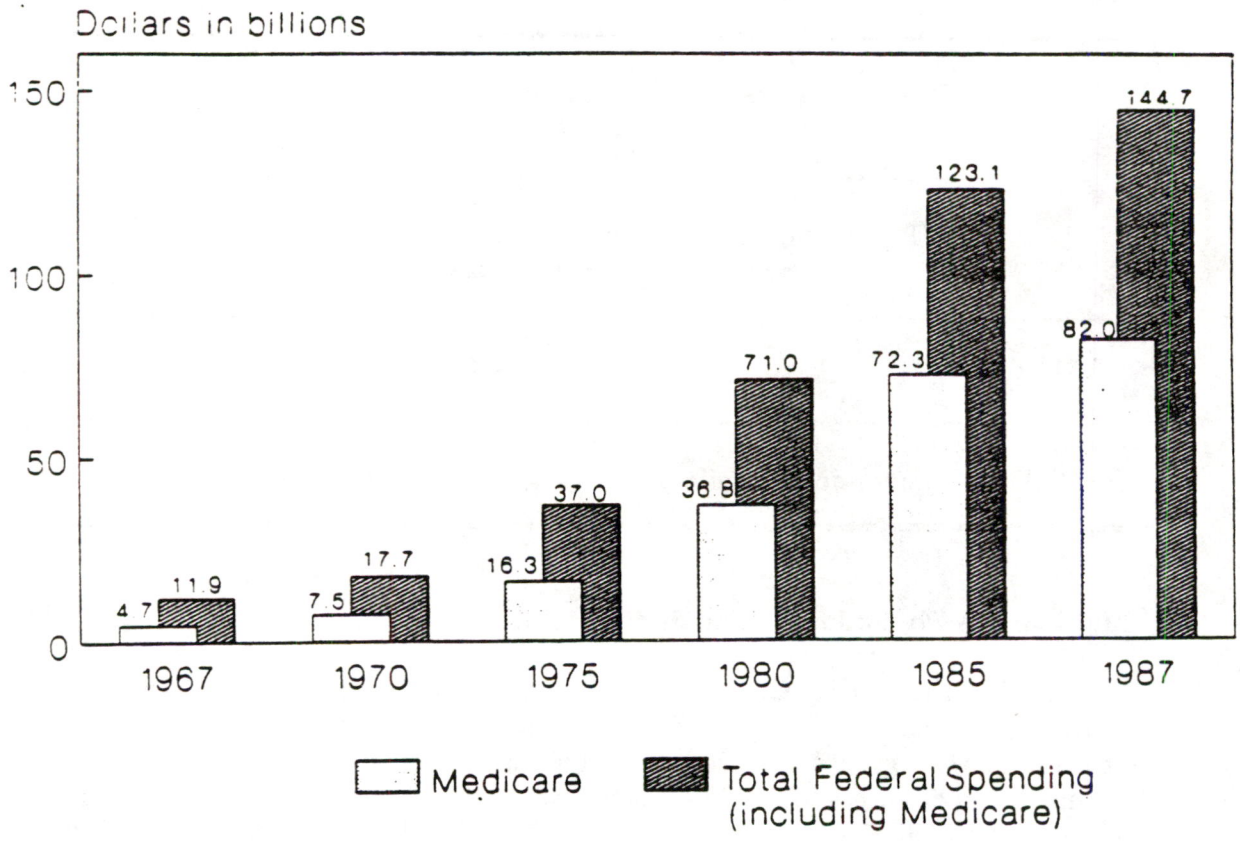
[14]See National health expenditures, 1986-2000, loc. cit.

[15]See CBO, Oct. 1988, loc. cit.

[16]Dept. of HHS press release, Nov. 18, 1988, loc. cit.; and *1988 HI and SMI trustees'* reports.

the financing of personal medical care rose from 10 to 30 percent, while the combined shares paid by individuals and private insurers dropped from 78 percent to 60 percent. Medicare was the dominant factor in that growth, with the means-tested Medicaid program running second.

CHART 5. MEDICARE'S SHARE OF FEDERAL HEALTH EXPENDITURES, 1967-87

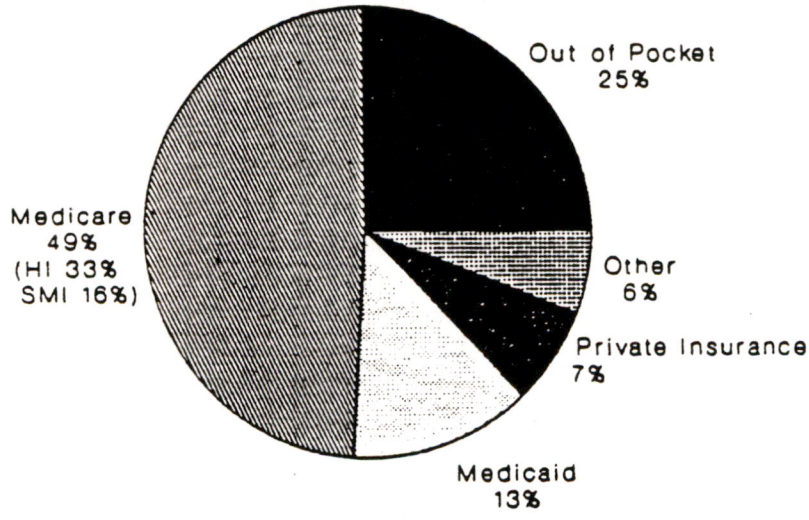


Source: Derived from National Health Expenditure data.

Medicare's Insurance Value for its Recipients

In 1984, 97 percent of the population 65 and older was covered by one or both parts of Medicare and nearly 70 percent of these enrollees were served by the program--i.e., Medicare payments were made on their behalf or to them directly. The program is not a source of cash income to the aged in the same way social security, earnings from work, or private pensions are. It does not provide regular periodic payments, not everyone enrolled in it receives reimbursement every year, and when reimbursement does occur it can vary widely depending on utilization. However, Medicare has substantial value to the aged as a source of insurance. While the aged comprise about 12 percent of the population, they account for nearly one-third of the Nation's expenditures for hospital care and one-fifth of those for physician care. Overall, Medicare payments covered almost 50 percent of the per capita health expenditures incurred by people 65 and older, with an equivalent value of 20-25 percent of their reported money income for the year.[17]

CHART 6. SOURCE OF FINANCING OF ELDERLY'S MEDICAL COSTS, 1984



Source: Waldo and Lazenby. Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984.

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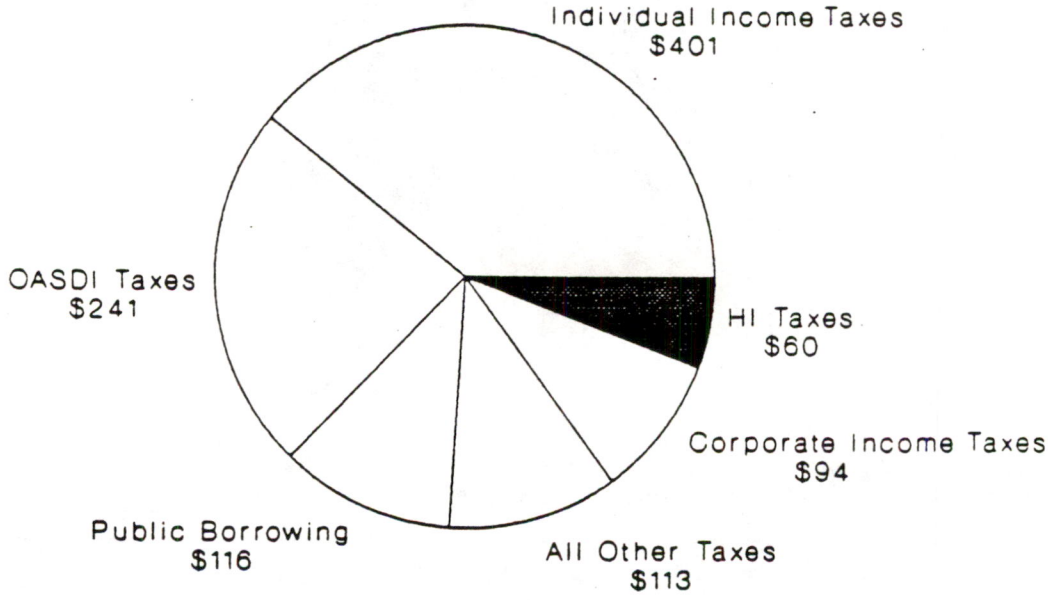
[17]Derived from national health expenditure data; Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984, by Daniel R. Waldo and Helen C. Lazenby. *Health care financing review.* fall 1984; and *Income and resources of the population 65 and over.* SSA. Washington, U.S. Gov't. Print Off. SSA publication no. 13-11727. Using data from the Bureau of the Census' March 1985 Current Population Survey, SSA estimated the median money income of aged households with social security payments to be $10,260 in 1984. For aged households not receiving social security payments, the median was $8,020. HCFA estimated that Medicare financed $2,051 of the per capita health expenditures incurred by the population 65 and older in that year.

Medicare As a Federal Tax

As have social security and other forms of Federal social insurance taxes, Medicare receipts have become a very substantial source of Federal revenues. In FY 1988 HI taxes of $60 billion make up 18 percent of the $334 billion in social insurance taxes and contributions collected by the Government and 6.6 percent of the $909 billion in total Federal receipts (excluding public borrowing). SMI premiums added another $8.8 billion although they are treated by the Treasury as offsets to outlays (most are deducted directly from social security recipients' checks). Overall, Medicare was the Government's fourth largest source of receipts.

The HI tax is broad based, with more than 95 percent of the workforce required to pay it. The only major group still exempted are employees of State and local governments who have been with their respective government employers since March 31, 1986, and have not elected social security or HI-only coverage. Federal workers were mandatorily covered in 1983.

CHART 7. HI AS A SOURCE OF FEDERAL FINANCING, FY 1988 ($'S in billions)



Source: Final Treasury statement for FY 1988

The HI tax is a flat-rate tax on earnings from work. Thus, low wage earners pay less than high wage earners. A person earning minimum wages (about $7,000 per year) pays only $100 in HI taxes (excluding the employer share). A person earning over $48,000 per year pays about $700 in HI tax. A person with average earnings ($20,000) pays $290.[18]

From the perspective of how much the tax weighs on families at different income levels, data derived from a Congressional Budget Office (CBO) study shows that 80 percent of social insurance taxes, of which HI taxes are a part, are paid by families in the upper half of the income spectrum (above $26,000 annually in 1988 dollars), with 25 percent coming from those in the highest 10 percent (above $68,000 annually).[19] However, these taxes represent a smaller share of the total Federal taxes they pay than it does for those in the lower half. As shown in table 11, for persons at the lowest income levels, the HI tax represents about 10 percent of Federal tax liability. The HI tax represents only 4 percent of Federal tax liability for persons in the highest income category. This is due in part to the fact that social insurance taxes are levied only on wages, and wages are a greater share of the income of people in the lower half of the income spectrum, and because income taxes have an increasingly greater effect on the higher income brackets.

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[18] Higher amounts apply to the self employed.

[19] U.S. Congressional Budget Office. *The Changing Distribution of Federal Taxes: 1975-1990.* Oct. 1987.

TABLE 11. Significance of HI Tax as a Federal Tax, by Income Level

Income levels	HI taxes as a percent of the total 1988 Federal taxes paid by people in the:
lowest 10th	9.3%
2nd "	12.4
3rd "	11.8
4th "	10.4
5th "	9.7
6th "	9.3
7th "	8.9
8th "	8.9
9th "	8.2
highest 10th	4.1

Source: Derived from distributional data on social insurance taxes contained in the CBO study, *The Changing Distribution . . .* , loc. cit.

While the HI tax is a more significant form of Federal taxation for people in the lower half of the income spectrum, the effective HI tax bite is still small. According to the CBO study, HI taxes absorb only 1 percent of the incomes of families in the lowest tenth of the income spectrum, with the figure rising to no more than 2 percent for those with average incomes. The smaller percentage at the lower levels is due to the fact the nontaxable transfer payments are a major income source for families in those income brackets. A much more significant bite is taken by social security retirement and disability taxes and Federal excise taxes.

VI. RELATIONSHIP TO THE FEDERAL BUDGET

Medicare's Growing Position in The Budget

Currently, Medicare is counted in the Federal budget. With FY 1988 outlays representing 7.4 percent of Federal spending, and revenues representing 6.6 percent of Federal tax receipts, Medicare has acquired a significant position in the budget.

Rapid growth of entitlement programs caused spending on human resource programs to jump from 33 percent of Federal outlays in 1968 to almost 55 percent 10 years later.[20] While the human resource share has since leveled out at about 50 percent, Medicare's spending has continued to surge. Its share of Federal outlays rose from 3.9 percent in 1975 to 5.4 percent in 1980 to 7.4 percent in 1988, making the program one of the fastest growing segments of Federal spending. Coupling this rapid growth with the financial strain caused by large overall deficits, proposals to constrain Medicare spending have been high on the list of congressional budget options.

TABLE 12. Medicare: Comparing its Growth to Other Forms of Federal Spending, 1975-88

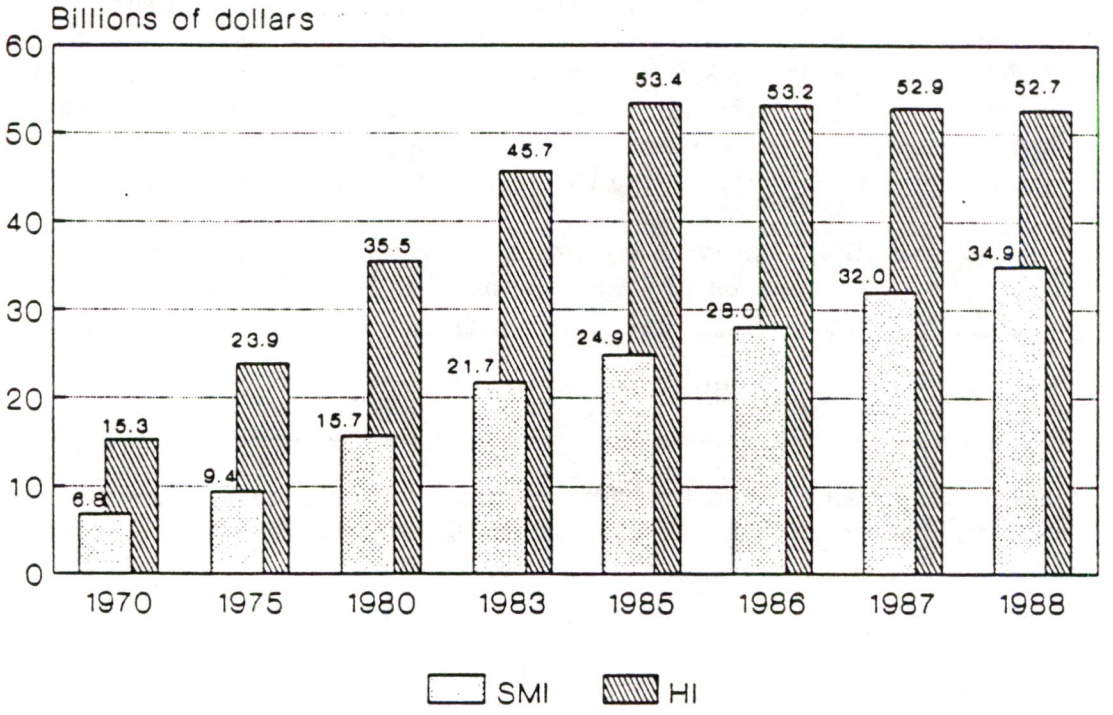
Fiscal year	Share of total Federal outlays				
	Medicare security	Social resource	Other human defense programs	National on debt	Interest
	(in percent)				
1975	3.9	19.5	28.7	26	7
1980	5.4	20.1	27.5	22.7	8.9
1988*	7.4	20.6	22.1	27.3	14.3

Source: U.S. Library of Congress. Congressional Research Service. *1990 Budget Perspectives: Federal Spending for the Human Resource Programs*. CRS Report for Congress No. 89-87 EPW, by Gene Falk and Keith Hurt. Washington, Feb. 2, 1989. Figures do not total to 100 percent.

[20]The major human resource programs include social security, medicare, other health programs, veterans' benefits, education and social services, and other cash benefits, e.g., unemployment insurance and civil service retirement.

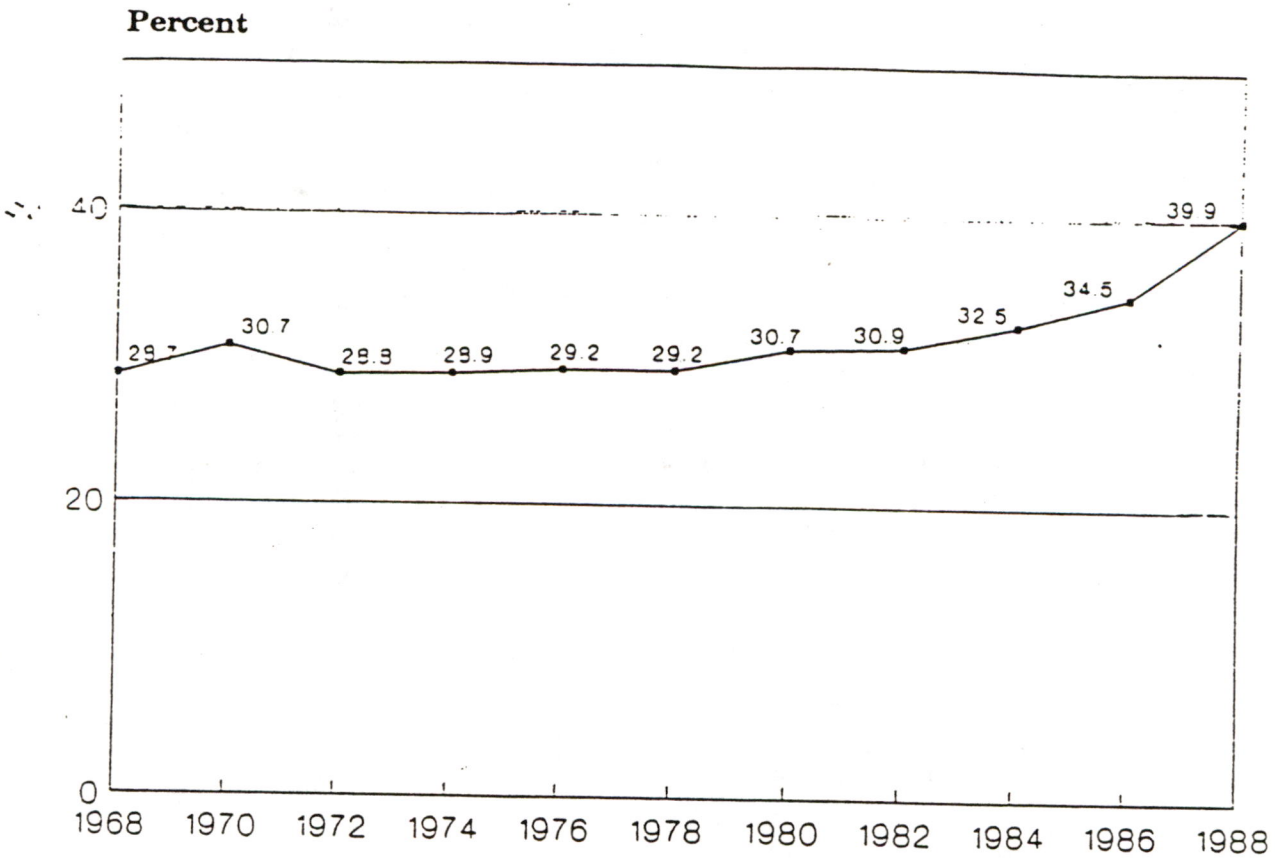
While HI's growth tended to slow in the 1980s, SMI's continued to surge. In 1967, SMI accounted for one-fourth of Medicare spending. By 1988, its share had grown to 40 percent. In the last 7 years, it grew three-fold, while HI doubled, and Federal spending overall only grew by 20 percent. Thus, SMI is likely to draw particular attention in the ongoing debate about the budget deficit and the appropriate level of Federal spending.

CHART 8. GROWTH OF HI AND SMI EXPENDITURES, FY 1970-88
(In 1988 constant dollars)



Source: Historical Tables, Budget of the U.S. Government

CHART 9. SMI AS A PERCENT OF TOTAL MEDICARE EXPENDITURES, FY 1968-88



Source: Derived from Historical Tables, Budget of the U.S. Government

How Medicare is Treated under Gramm-Rudman-Hollings

In 1985 Congress adopted special procedures to deal with the Federal budget deficits, which had grown from $74 billion in 1980 to $212 billion in 1985. The procedures, designed to bring the budget back into balance, have come to be known as the Gramm-Rudman-Hollings deficit-reduction law. Originally set to expire in FY 1991, the procedures were modified in 1987 and extended for 2 years, with the goal of bringing the budget into balance by FY 1993. Under the procedures a deficit estimate must be made prior to the beginning of each fiscal year. If the estimate exceeds the target by a certain defined margin, automatic spending reductions must be made by the President unless Congress intercedes and passes alternative deficit-reduction measures.[21]

In computing the estimated deficit, virtually all Federal income and outgo are counted under a so-called "unified" budget concept. Medicare's income and outgo are included (as are social security's). Thus, if the program's receipts are higher or lower than its expenditures, Medicare can affect the Gramm-Rudman-Hollings deficit figure and the amount of deficit reductions that may have to be implemented by the President or enacted by Congress. If the President must take action under the automatic procedures, Medicare reductions must be part of that action. However, the law limits the reduction, so that the so-called "sequester" order causes no more than 2 percent reduction in the projected benefit payout.[22]

In summary, under the current budgeting law Medicare directly affects the size of the overall Federal deficit, and benefit changes to constrain its spending may be part of the actions taken by the Administration or Congress to achieve certain prescribed budget goals.

How Medicare Affects the Deficits

People sometimes ask why, if Medicare is financed through trust funds, is it part of any budget discussions?

Since Medicare receipts and expenditures flow in and out of the general treasury, the difference between what the Government receives and spends for the program helps to shape the Government's overall financial condition.

There is no defined use of excess Medicare receipts, and there are no defined Federal resources earmarked to cover a Medicare shortfall. Excess HI taxes, for instance, are not used automatically to reduce the deficit. People

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[21]The law requires the President to act, if the estimated deficit exceeds the Gramm-Rudman-Hollings target by more than $10 billion in FY89-92; if it exceeds zero in FY93.

[22]The reduction could be less than 2 percent, if the "uniform reduction" pertaining to non-defense spending is smaller.

sometimes assume, ipso facto, that because excess HI receipts cause the Treasury Department to increase the securities posted to the HI trust fund, the Government "is simply borrowing money from the trust fund" rather than from financial markets. Since the amount the treasury borrows from financial markets represents the deficit, the immediate supposition is that excess HI taxes reduce the deficit.

However, while the law requires the Treasury Department to post securities to the HI trust fund when it receives HI taxes, it does not determine the ultimate use of the money. As with all other forms of Federal receipts, on a day-to-day basis the money is deposited in the treasury and pooled with other resources, and thereby helps to meet the Government's expenses as they arise. There is no way to track explicitly the flow of any Federal taxes from receipt to use. It can no more be said for HI taxes than for income taxes that they are used first to reduce government borrowing and then to meet spending obligations. The taxes become fungible once they reach the treasury. As the Government's bills come in, the monies in the treasury are used to pay them regardless of how the monies were raised or what the bills are for.

"Lower borrowing from the public" is only one of three possible uses that can be made of excess HI taxes. Ultimately, how excess taxes are used depends of fiscal policy decisions made by Congress and the Administration, not by the Treasury Department's day-to-day management of cash flow or accounting. To the extent policymakers are influenced to spend more or tax less because of the existence of one or more forms of excess taxes, then it could be said that the excess taxes haven't reduced the deficit. The basic point is that so long as excess HI taxes are part of the general operating pool of resources available to the Government, their use is determined by overall fiscal policy decisions.

By the same token a shortfall of HI receipts and the Government's contributions to SMI (the 75 percent share of SMI costs not covered by enrollee premiums) do not automatically cause the deficit to be higher. The Government may be making up the difference between Medicare receipts and expenditures with general resources, but this in turn could cause other spending to be lower or other taxes to be higher. Again, the impact is intertwined with aggregate fiscal policy decisions.

In summary, Medicare directly affects the Government's overall fiscal condition: how much it borrows, how much it spends, how much it taxes, and what the deficits are. However, there is no concrete way to determine exactly how, since it is difficult to ascertain how any one Federal program by itself influences the ultimate outcome of fiscal policy decisions.

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CRS Issue Brief

Medicare: FY1991 Budget

Updated June 19, 1990

by
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Education and Public Welfare Division

CONTENTS

NOTE: For additional information on Medicare, see CRS Report 89-134, *Medicare: Its Use, Funding and Economic Dimensions*; and CRS Issue Briefs 87106, *Catastrophic Health Insurance: Medicare*; 87180, *Medicare: Prospective Payments for Inpatient Hospital Services*; and 89116, *Medicare: Physician Fee Schedule*.

Medicare: FY1991 Budget

SUMMARY

Medicare provides health insurance protection for 33 million aged and disabled individuals. Medicare outlays for FY1990 are estimated to be $96.6 billion ($108.2 billion in gross outlays, offset by $11.6 billion in beneficiary premium payments). The program is composed of two parts: Hospital Insurance (Part A) covers inpatient hospital and related institutional care; Supplementary Medical Insurance (Part B) covers physician services and other related medical services and supplies. Payments for inpatient hospital services under Part A are made according to a prospective payment system.

President Bush's proposed FY1991 budget, released on Jan. 29, 1990, includes legislative proposals to save $5.6 billion from the baseline estimates, plus $70 million in regulatory proposals, for a total of $5.67 billion in program reductions in FY1991. In addition, the budget would add $1.9 billion in FY1991 Medicare trust fund revenues by mandating program participation by all State and local government employees, some of whom are currently exempt from participation. The Administration estimates that total Medicare outlays for FY1991 would be $98.6 billion if the proposals contained in the proposed budget were enacted, and would account for 8% of Federal spending.

The budget includes reductions of $3.4 billion in reimbursement for inpatient hospital services paid under Medicare's prospective payment system (PPS), including a $70 million reduction in payments for skilled nursing facilities, offset by $100 million increase in HMO payments for Part A services. The largest Part A savings would result from two proposals: reducing payment for capital-related costs (15% reduction for rural hospitals, 25% reduction for urban hospitals), and reducing the indirect medical education adjustment from the current level of 7.7% to 4.05%.

The President recommends reductions of $2.234 billion in Part B payments, offset by an $80 million increase in payments to HMOs for a net reduction of $2.154 billion. The reductions would be $1.065 billion in physicians' services, with the remaining $1.169 billion in other Part B services, excluding $80 million in increased Part B payments to HMOs. The recommended reductions in physicians' services largely expand cost-savings measures implemented in previous years pending the implementation of a new physician payment structure in 1992. The largest single reduction in physicians' services would reduce outlays by $450 million by freezing fee updates except for primary care services. Most of the reductions recommended for nonphysician Part B services are similar to those offered in past years. The largest single cut in other Part B services would be a 10% reduction in payments for hospital outpatient services, which is projected to save $570 million in FY1991.

ISSUE DEFINITION

On Jan. 29, 1990, President Bush submitted his proposed FY1991 budget to Congress. The budget projects FY1991 Medicare outlays under current policy of $104.2 billion ($116.1 billion in expenditures offset by $11.9 billion in beneficiary premiums). The budget includes legislative proposals to save $5.6 billion from the baseline estimates, plus a reduction of $70 million in regulatory proposals. In addition, the budget would add $1.9 billion in FY1991 Medicare trust fund revenues by mandating program participation by all State and local government employees, some of whom are currently excluded.

BACKGROUND AND ANALYSIS

Description of Medicare

Medicare provides health insurance protection for 33 million aged and disabled individuals. The program covers hospital services, physician services, and other medical services for those eligible, regardless of income. Medicare includes two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Medicare outlays for FY1990 are estimated to be $96.6 billion ($108.2 billion in outlays, offset by $11.6 billion in premiums and collections).

Part A of Medicare covers inpatient hospital care. In some cases, it also covers short-term skilled nursing facility care after a hospital stay, home health agency visits, and hospice care. Patients are responsible for a deductible ($592 in 1990) each time a hospital admission begins a new benefit period (i.e., the period beginning when a patient enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for 60 days). Part A is financed chiefly from Hospital Insurance payroll taxes. A small number of persons over age 65 are not entitled to Medicare because they are not eligible for Social Security or railroad retirement benefits; these persons may enroll under Part A by paying a monthly premium.

Medicare pays for inpatient hospital services according to a prospective payment system (PPS). Under this system, each Medicare patient is classified according to his or her medical condition into diagnosis-related groups (DRGs). Hospitals are paid a predetermined rate for each patient treated within a given DRG. Hospitals with costs below the payment rate are allowed to keep the surplus, while hospitals with costs above the payment rates must absorb the loss. (For more information, see CRS Issue Brief 87180, Medicare: Prospective Payments for Inpatient Hospital Services.)

Part B, the Supplementary Medical Insurance (SMI) program, is a voluntary program; individuals must enroll and pay a premium to receive benefits. All persons entitled to Part A and all persons over age 65 are eligible to enroll. The program covers the services of physicians, outpatient hospital care, laboratory and x-ray services, and other related medical services and supplies. The program is financed by beneficiary premiums and general revenues. The premium ($28.60 in 1990) accounts for about 25% of program costs. Medicare generally pays 80% of the

reasonable charges for covered services, after the beneficiary has met the $75 annual deductible. The beneficiary is liable for 20% of the reasonable charge, an amount known as coinsurance.

Medicare pays for most Part B services of a reasonable charge. The reasonable charge is the lesser of the actual charge, the physician or supplier's customary charge for the service, and the prevailing charge for the service in the community. By accepting "assignment" on a claim, a physician or supplier agrees to accept Medicare's reasonable charge as payment in full. If assignment is not accepted, the beneficiary is liable for the full difference between what Medicare pays (i.e., 80% of the reasonable charge) and the actual charge. There are incentives for physicians and suppliers to enter into agreements to accept assignment on all Medicare claims. Persons who enter into such agreements are known as participating physicians and suppliers.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89), P.L. 101-239, enacted a new payment system for physicians' services. Instead of a reasonable charge basis, physicians' services will be paid on a fee schedule that uses a resource-based relative value scale (RBRVS). Under RBRVS, physician payments will be determined according to the resources and effort (including physician time) needed to perform a service. In general terms, the fee schedule will reduce payments for most surgical services, while increasing payments for primary care services such as office visits. The fee schedule will be phased in over a 5-year period beginning in 1992. (For further information, see CRS Issue Brief 89116 EPW, Medicare: Physician Fee Schedule.)

Medicare is administered by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. Many of the day-to-day operations, including reviewing and paying claims, are performed by organizations such as Blue Cross/Blue Shield plans or private insurers under contract to HCFA. These organizations are referred to as Part A intermediaries and Part B carriers.

FY1991 Budget

On Jan. 29, 1990, President Bush submitted his proposed budget. As published, the budget projects FY1991 Medicare outlays under current policy of $104.2 billion ($116.1 billion in expenditures offset by $11.9 billion in beneficiary premium payments). The budget includes legislative and regulatory proposals that, according to the Administration, would reduce Medicare outlays for FY1991 by $5.6 billion ($3.35 billion for Part A, $2.15 billion for Part B, and $0.1 billion for administration). The baseline estimate includes $98 million in administrative savings for which legislative authority is required. As a result, these savings should be included with legislative proposals (see **TABLE 1**). The budget also includes proposals that would increase Medicare trust fund revenues by $1.9 billion.

TABLE 1. Impact of FY1991 Budget Proposals on Total Medicare Outlays
($ in millions)

	1989	1990	1991	Percent change, 1990-91
Current policy:				
Part A benefits	$55,365	$59,844	$65,352	9.20
Part B benefits	36,854	42,964	47,980	11.67
Regulatory proposals:			(70)	
PROs	129	456	381	-16.45
Administration	2,254	2,412	2,471	2.46
Gross outlays	96,557	108,225	116,114	7.35
Less premium income	(11,590)	(11,609)	(11,899)	2.50
Net outlays	84,967	96,616	104,215	7.94
Legislative proposals:				
Part A			(3,350)	
Part B			(2,154)	
Administration			(98)	
Premiums			2	
Total legislative savings			(5,600)	
Final net outlays	84,964	96,616	98,615	2.07

Source: CRS analysis of President's FY1991 budget.

Increases in Medicare expenditures continue to outstrip general inflation and fuel concern over growing Federal budget deficits. Rising Medicare expenditures also limit the government's ability to expand services. The Administration estimates that outlays for Medicare will increase at a rate of 7.9% in FY1991 under current law. The President's budget includes legislative proposals that would reduce outlays by an estimated $5.6 billion (excluding $70 million in regulatory proposals), limiting program growth to 5.1% in FY1991 (see **TABLE 1**).

Administration Proposals Affecting Outlays

Part A Expenditures

The Administration budget proposal for FY1991 includes reductions of $3.4 billion in reimbursement for inpatient hospital services paid under Medicare's prospective payment system (PPS) and a $70 million reduction in payments for skilled nursing facilities. Some of these reductions would be applied equally to all PPS hospitals, while others would affect only certain types of hospitals. As shown in **TABLE 2**, the largest Part A savings would result from two proposals: reducing payment for capital-related costs (15% reduction for rural hospitals, 25% reduction

for urban hospitals), and reducing the indirect medical education adjustment from the current level of 7.7% to 4.05%.

TABLE 2. Impact of FY1991 Budget Proposals on Medicare Part A Outlays ($ in millions)

Benefit payments, current law	$65,352
Legislative proposals:	
Capital -- Rural hospitals at 85%	(170)
Capital -- Urban hospitals at 75%	(1,360)
PPS update factor	(640)
Indirect medical education at 4.05%	(1,030)
Cap intern-resident to bed ratios	(10)
Reduce direct medical education	(170)
Eliminate SNF return on equity	(70)
Pay HMOs at 100% of AAPCC	100
Total legislative savings --	(3,350)
Net Part A	$62,002

Source: CRS analysis of President's FY1991 budget.

Capital payments. Hospitals' capital-related expenses, including such costs as interest, depreciation, and rental costs, are excluded from the PPS payment and are reimbursed separately on a reasonable cost basis. Medicare's share of these costs is computed by multiplying a hospital's total capital costs by Medicare's share of the hospital's total inpatient services. For FY1987 through FY1990, Congress reduced capital payments by fixed percentage amounts, so that Medicare actually pays less than its computed share of capital costs. For FY1990, the reduction is 15%. Under current law, Medicare would resume paying a full 100% of its share of capital costs during FY1991. By Oct. 1, 1991, the Secretary is required to establish a system for including capital costs in the hospital's regular PPS payments.

The President's FY1991 budget proposal would extend the current 15% reduction in capital payments to rural hospitals, and increase the capital payment reduction to 25% for urban hospitals. The Administration contends that continued reductions are necessary because, under the reasonable cost system currently in place, hospitals would otherwise have no incentive to control their expenditures for expanded facilities or new equipment. The capital payment reduction of 15% for rural hospitals is estimated to save Medicare $170 million, and the 25% capital payment reduction for urban hospitals is estimated to save the program $1.36 billion in FY1991.

PPS Update Factor. The overall increase in PPS payment rates each year is determined by an update factor. This factor is based in part on the projected increase in "market basket index" (MBI), which estimates the costs of the goods and services hospitals must purchase to provide care. However, other factors that may affect costs, such as changes in hospital efficiency or the adoption of new medical

technologies, may also be considered in determining the update factor. It may therefore be higher or lower than the projected increase in the MBI. Beginning with FY1986, Congress has repeatedly set the update factor at a level below the MBI increase. However, current law provides that the update factor for FY1991 and all later years is to be equal to the projected change in the MBI. The President's budget proposed instead to set the average update factor for FY1991 at 4.1%, an amount 1.5 percentage points less than the projected MBI increase. The Administration estimates the FY1991 savings from this proposal to be $640 million.

Congress in past years set update factors below the rate of inflation because of evidence that most hospitals were realizing a profit on their Medicare payments under PPS. More recent data indicate that these profits have been shrinking and that as many as half of all hospitals are receiving Medicare payments that are below their costs for treating Medicare patients. However, the Administration argues that hospitals are not yet operating at maximum efficiency and that a smaller increase should be enough to allow hospitals to maintain high quality care.

Indirect Medical Education. Medicare currently pays PPS teaching hospitals for the indirect costs associated with approved intern and resident programs. These indirect costs may be due to a variety of factors, such as extra demands placed on hospital staff due to the teaching activity, additional tests and procedures ordered by residents, or more severely ill patients treated at teaching hospitals. The payment adjustment is currently based on a formula that increases the DRG payment by approximately 7.7% for each 10% increase in the ratio of interns/residents to beds. The increase is calculated on a curvilinear basis (e.g., an increase in the resident-to-bed ratio does not result in a proportional increase in payment). In FY1995, the factor is scheduled to increase to 8.3%. (This increase is intended to coincide with the scheduled expiration of a separate PPS payment adjustment for hospitals which treat a disproportionate share of low-income patients.)

The FY1991 budget proposes a reduction of the factor used to calculate payments for hospital indirect medical education costs to 4.05% indefinitely. This figure was derived from a 1985 Congressional Budget Office (CBO) analysis that separated costs clearly related to teaching activity from some of the other costs teaching hospitals might incur, such as those possibly related to treating more severely ill patients. The payment adjustment has been set higher than 4.05% in the belief that some costs of teaching hospitals are not adequately reflected in other components of the PPS payment. The Administration's position is that the indirect medical education payments should be used solely to pay for teaching-related costs and not to compensate for other perceived inadequacies in PPS. A recent report by the General Accounting Office (GAO) concurs in this view. However, representatives of teaching hospitals argue that the adjustment was not merely intended to compensate hospitals for costs directly attributable to teaching activities. They note that congressional report language indicates that the adjustment also was meant to account for other factors not already considered in PPS, such as greater severity of illness in patients hospitalized in teaching hospitals. Savings to the Medicare program from the proposal is estimated to be $1.03 billion in FY1991.

Cap on Intern-Resident-to-Bed Ratio. Under current law there is no limit on the intern-and-resident-to-bed (IRB) ratio used to determine the indirect medical education adjustment. The President's budget for FY1991 proposes a cap on the IRB

ratio at FY1989 levels. The proposal is intended to discourage hospitals from closing beds solely to raise their IRB ratios and receive higher payments. This proposal is estimated to save the Medicare program $10 million in FY1991.

Direct Medical Education. Under current law, teaching hospitals also receive additional payment for the direct costs of medical education programs, such as the salaries and other education costs of interns, residents, nurses, and allied health professionals. These costs are not included in the PPS payment rates. Instead, payments for graduate medical education are currently based on Medicare's share of each hospital's historic costs per resident, as updated each year by the consumer price index.

The FY1991 budget proposes revising payments for the direct costs of graduate medical education (i.e., internship and residency training programs for physicians) by basing the payment on a per-resident payment derived from the national average of FY1987 salaries paid to residents, updated by the CPI. The proposal would also include a system of different weights applied to primary care residents, nonprimary care residents in their initial residency period, and nonprimary care residents not in their initial residency period. Payments for primary care residents would be weighted at 180% of the per-resident amount, those for nonprimary care residents in their initial residency period would be weighted at 140% of the per-resident amount, and those for nonprimary care residents not in their initial residency period would be weighted at 100%.

The Administration's view is that the present diversity in graduate medical education payments results from historical patterns of hospital accounting practices and that uniform per-resident payments are more equitable.

Payments for the direct costs of medical education for nurses and allied health professionals would not be affected by this proposal. The expected FY1991 savings to Medicare from enactment of the proposal are estimated to be $170 million.

Eliminate Return on Equity (ROE) Payments to Skilled Nursing Facilities (SNFs). Under current law, proprietary SNFs receive a return on equity payment from Medicare. Return on equity payments are intended to provide the owners of such facilities a reasonable return on their investment. SNFs are the only providers receiving ROE payments. The President's FY1991 budget proposes eliminating the ROE payments for SNFs. The FY1991 Medicare savings from this proposal are estimated to be $70 million.

Part B Expenditures

TABLE 3 provides summary information regarding projected savings from all Part B spending reductions for FY1991. Part B outlays, excluding the President's proposals, would result in outlays of $47.9 billion, 11.5% higher than FY1990 projected outlays. Enactment of all the President's budget proposals would result in net Part B outlays of $45.7 billion or an increase of 6.1% over expected FY1990 outlays.

TABLE 3. Impact of FY1991 Budget Proposals on Medicare Part B Benefit Payments ($ in millions)

Benefit payments, current policy	$47,980
Regulatory savings:	
Eliminate coverage of seat-lift chairs	(40)
Eliminate coverage of glasses after cataract surgery	(30)
Net benefit payments, current law	47,910
Legislative proposals:	
Reduce overpriced procedures	(110)
Reduce radiology and anesthesiology	(230)
Update for primary care physicians only	(450)
Reduce overvalued localities	(50)
Reduce payments for surgery services	(170)
New physician customary charges	(50)
Physician assistant offset	(5)
Reduce outpatient capital payments	(100)
Reduce outpatient payments by 10%	(570)
Durable medical equipment proposals	(250)
Reduce clinical laboratory payments	(60)
Technical component of diagnostic service	(60)
Prior authorization by carriers	(64)
Extend ESRD secondary payer period	(30)
Reduce direct medical education payments	(35)
Pay HMOs at 100% of AAPCC	80
Total legislative savings --	(2,154)
Net Part B Benefits	$45,756

Source: CRS analysis of President's FY1991 budget.

Physician Payments

In OBRA 89, Congress enacted a 3-part physician payment reform measure consisting of: a Medicare fee schedule based on a resource-based relative value scale (RBRVS); volume performance standards; and increased research on effectiveness of medical care. The impetus for physician payment reform arose from a long-standing recognition of the inequities in the reasonable charge reimbursement system, in which physicians performing "high-tech" procedures and physicians practicing in urban areas tended to receive much higher reimbursement. Volume performance standards were enacted to slow the rapid rate of growth in volume of physicians' services delivered to Medicare beneficiaries in recent years. The anticipated outcome of increased funding for medical effectiveness research is improved quality and reduced delivery of unnecessary medical care.

In addition to physician payment reform, other 1990 budget reconciliation provisions mandated short-term savings in physicians' expenditures. The President's FY1991 budget proposal assumes the 1992 implementation of the Medicare fee

schedule and offers short-term savings similar to those enacted in 1989 as a bridge to its implementation.

Reduce Payments for Overvalued Procedures. Under current law, payment for physician services cannot exceed the prevailing charge for the service in the community. Subject to certain limits, the prevailing charge is based on historical charges for the service. OBRA 89 provided for reductions of up to 15% for a list of procedures that were identified as being at least 10% overvalued by the Physician Payment Review Commission. The amount of the reduction equaled one third of the difference between the 1989 prevailing charge and a locally adjusted reduced prevailing charge up to a maximum of 15%.

The President's 1991 budget proposes deeper reductions in payments for an expanded list of overvalued procedures by reducing the remaining two-thirds of the amount by which the procedures are overvalued, up to a maximum of 25%. This year's proposal expands the list to include procedures overvalued by least 5%. With this proposal, the Administration is clearly signalling its intent to continue reducing payments it considers excessive during the interim period before the implementation of the RBRVS fee schedule. The Administration projects savings of $110 million in FY1991 if this measure is adopted.

Reduce Payments for Radiology and Anesthesiology Services. Current law provides for some delays in payment updates for radiologists and anesthesiologists until Apr. 1, 1990; a 1% reduction in fee schedule updates for radiologists after that; and a more precise measurement of time for anesthesiologists that slightly reduces payments to them.

In FY1991, the Administration proposes to reduce payments for radiology and anesthesiology services by a maximum of 25% for any locality. The reductions are to be based on estimates of the amount that current payments exceed payments that would be made under a RBRVS fee schedule. HCFA would estimate the fee schedule by reducing the national average conversion factor by 10% and then adjusting it by a geographic cost-of-practice adjustment factor. Whether the Administration's proposal would result in overall reductions larger or smaller than those anticipated under the Medicare fee schedule is unclear because of the uncertain effects of using a geographic adjustment factor. A likely outcome is that the reductions will be less than RBRVS reductions in some geographic areas and greater in others where the geographic adjustment factor has more pronounced effects.

The Administration also proposes to pay the same amount for anesthesia services regardless of whether an anesthesiologist personally performs the service or medically directs a certified registered nurse anesthetist (CRNA). This measure is designed to reduce duplicative payments for anesthesia services. To accomplish this, payment to an anesthesiologist would be equal to the difference between the amount that would be paid if the anesthesiologist personally performed the service and the Medicare payment for the CRNA. Payments to CRNAs would not be reduced. Implementation of both of these measures is expected to save $230 million in FY1991.

Freeze MEI for Physician Nonprimary Care Services. Under current law, increases in prevailing charges for services are limited by the increase in the Medicare Economic Index (MEI). In the past several years, Congress has granted less than a

full MEI update in an attempt to control physician expenditures. In the most recent years, primary care services have been granted a higher update than other types of services. Current law delays the 1990 update until Apr. 1, 1990 (except for ambulance services and clinical lab services) and specifies that the MEI 1990 update for radiology, anesthesiology and overpriced procedures is zero. The update is 2% for all other services, except primary care services, which will receive a full MEI update.

The President's FY1991 budget follows a similar strategy by recommending a full MEI update only for primary care services, with a freeze for all other services. In addition, the budget proposes to consolidate prevailing and customary charges by locality in 1991, so that the reasonable charge for a service would consist of the lower of the actual charge or the weighted average of the prevailing and customary charge. As in past years, frozen or reduced fee updates are being recommended as one of the primary tools to constrain increases in expenditures. In the absence of strong volume controls, price constraints such as these generally had limited effects. This measure is anticipated to save $450 million in FY1991.

Reduce Payments for Overvalued Localities. The Administration's budget proposes to reduce payments for certain procedures in localities where payments have been overvalued relative to the national average, after the national average has been adjusted by a geographic practice cost index. The maximum reduction proposed is 25%, and no reductions would be made in payments for procedures reduced by other measures.

Although this is the first time a proposal of this type has been made, it addresses a long-standing problem of payment inequities among localities. Data show that average allowed charges in very large metropolitan areas are 23% higher than the national average, while rural areas have average allowed charges 10% below the national average. If enacted, this proposal is not expected to rectify the fundamental inequities in the current locality structure, but it will produce savings and lessen payment differences across localities. The Administration projects $50 million in savings in FY1991.

Reduce Payments for Assistants-at-Surgery and Surgical Global Fees. Medicare reimbursement is currently made to assistants-at-surgery under certain circumstances. Typically, payments for the services of an assistant-at-surgery are set at 20% of the prevailing charge in the locality for the surgical procedure performed by the primary care physician. Based on data showing wide geographic variation in the use of assistants-at-surgery and use of primary care physicians as assistants-at-surgery, the Administration proposes to pay the same amount for a surgery regardless of whether an assistant-at-surgery is used. This would be accomplished by reducing the payment to the primary surgeon by the amount that is paid to the assistant-at-surgery. Its intent is to reduce arbitrary and unnecessary use of assistants-at-surgery.

The Administration also proposes to reduce total payments for global surgical services to account for the reduced number of inpatient hospital visits attributable to a decline in length in hospital stay since the implementation of PPS. The reduction would either be a procedure specific amount (where data are available) or 2% across the board. The Administration anticipates that $170 million will be saved in FY1991 from implementing this measure.

Other Physician Payment Proposals. The budget includes three other legislative proposals to reduce physician payments. Under current law, an 80% limit applies to the first year practice in a locality and an 85% limit applies to the second year of practice. The budget proposes to establish limits on the Medicare customary charges of new physicians on the grounds that charges of new physicians should not be as high as those of established physicians. The additional limits would be 90% in the third year and 95% in the fourth year, with no limits after the fourth year.

The President's budget also proposes to limit payments made for the technical component of rendering diagnostic and radiology services. The technical component payment, which covers costs such as equipment, technician and supply costs associated with tests, is made in addition to a professional fee for interpretation of the test. The proposal would limit payment for the technical component to 100% of the national median for radiology and diagnostic tests. Third, the Administration's budget proposes to reduce duplicate payments for physicians' services in hospital settings by subtracting the amount paid for physicians' assistants services in hospitals from payments made to hospitals. Finally, the Administration's budget also includes a proposal that would not result in lower federal Medicare spending, but would save beneficiaries money. This proposal would extend the participating physician concept to hospitals. A hospital could sign a participation agreement with Medicare so that assignment would be accepted for emergency, radiology, anesthesia, pathology and consultation services. Beneficiaries could benefit substantially because these are services in which they frequently have little or no choice of physician and must pay unexpected balance bills. Hospitals could gain a competitive advantage because they could advertise the fact that beneficiaries would not incur balance bills.

A total of $115 million in savings in FY1991 is anticipated from implementing these three cost savings measures.

Other Part B Proposals

Reduce Hospital Outpatient Capital Payments. Payments for services in hospital outpatient departments represent one of the fastest growing components of the Part B program. Current law applies a 15% reduction in reimbursement for capital expenditures related to outpatient services. The Administration's budget proposes an expansion of this policy. The 15% reduction would be maintained for rural hospitals, while urban hospitals would be subject to a 25% reduction. Sole community hospitals would be exempt from the reduction. Implementation of this proposal is expected to decrease projected outlays by $100 million.

Reduce Hospital Outpatient Payments. The budget would reduce payments 10% across the board for certain hospital outpatient department services. Services otherwise reduced by other budget proposals would be exempt from the reductions. This proposal is expected to save $570 million in FY1991.

National Cap on Durable Medical Equipment (DME) Fee Schedules. Current law provides fee schedules for six categories of Durable Medical Equipment. The budget proposes to limit payments for two categories of equipment: a category actually titled durable medical equipment, which includes manual wheelchairs and hospital beds; and other items which are not considered to be durable medical equipment, which includes prosthetics and orthotics. The Administration considers

payments for these categories of DME to be excessive. Payments under the fee schedule for these two items would be limited to the median fee schedule amount for each item. In addition, fees above the median limit would receive no update in 1991.

Modify Fee Schedule for Durable Medical Equipment Rentals. Current law payments for five of the six categories are based on average reasonable charges from a previous period. The fee schedule for items in the sixth category, DME provided on a rental basis (such as wheelchairs and hospital beds), is based on average submitted charges, which are about 25% higher than average reasonable charges. The budget proposal would base payments for rental items on average reasonable charges to make it consistent with the other five categories.

Reduce Oxygen Payments. Current law payments for oxygen and oxygen equipment and supplies is set at 95% of the local average reasonable charge in 1986, updated by the increase in the Consumer Price Index (CPI) for the last 6 months of 1987. For 1990 and subsequent years, regional fee schedules are phased-in to replace the local ones and recognized payment amounts are gradually restricted. The Administration proposes to reduce current payments by an additional 5% based on evidence that payments are still unreasonably inflated.

Fee Schedules for Enteral Products. Enteral nutritional products and supplies are used by patients who, as a result of chronic illness or traumatic injury, cannot ingest food orally. Under current law, payment for enteral products is the lowest of: the actual charge, the customary charge, the prevailing charge, a "lowest charge level" screen, or an inflation adjusted charge. The Administration believes this system produces excessive Medicare payments and recommends that fee schedules be based on wholesale and retail price information.

Combined DME fee reductions are expected to save $250 million in FY1991.

Clinical Laboratory Services. Clinical laboratory services are currently paid on the basis of area-wide fee schedules, subject to a nationwide cap equal to 93% of the median value of the area-wide fee schedules. The President's budget for FY1991 proposes to further limit the payment to 90% of the median for nonprofile tests and 80% for profile tests standardized test packages. Profile tests are done in standardized groupings and are cheaper to perform. The budget also proposes no fee update for tests above the limit. In addition, the budget would require independent clinical laboratories to report charges for the same test when provided to a non-Medicare patient. The Administration believes that prices charged to non-Medicare patients are higher than those charged to Medicare patients and would use these charge data to reduce carrier fee schedules in future years. These measures are estimated to save $60 million in FY1991.

Regulatory Proposals

Eliminate Coverage for Seat-Lift Chairs. The Administration proposes a regulatory initiative to eliminate coverage of seat-lift chairs on the grounds that they are not medically necessary and have been subject to abuse. Implementation of this measure is expected to save $40 million in FY1991.

Eliminate Coverage of Eyeglasses After Cataract Surgery. Through regulation, the Administration proposes to eliminate coverage of eyeglasses after cataract surgery. In FY1991, this measure is expected to produce $30 million in savings.

Initiatives Affecting Both Parts A and B

Extend Secondary Payor Period for End Stage Renal Disease. Under current law, Medicare is a secondary payor to employer-based health plans for the first 12 months of beneficiaries' eligibility for Medicare if their eligibility is based solely on having end stage renal disease. The Administration proposes to extend this period to 18 months, so that employers would pay full primary benefits for an additional six months. Their reasoning is that employer-based insurance should be used to defray the high costs of treating ESRD patients. This measure is expected to save $30 million in FY1991.

Increase in Payments to Medicare's Risk-Contracting Health Maintenance Organizations (HMOs). Under current law, Medicare pays risk-contracting HMOs at a level equal to 95% of the estimated per capita cost for beneficiaries served by fee-for-service providers, the adjusted average per capita cost (AAPCC.) The Administration's budget for FY1991 would increase the payment level to 100% of the AAPCC. A portion of the payment increase would be provided directly to beneficiaries in the form of a reduction or partial rebate of their Part B premium. HMOs would receive the remainder of the payment increase, allowing them to expand benefits or reduce enrollee premiums. This provision represents a deliberate attempt by the Administration to make HMO enrollment more attractive. The Administration estimates the cost of this provision to be $180 million in FY1991 ($100 million in Part A funds and $80 million in Part B funds).

Administration Proposals Affecting Receipts and Revenues

Part A Premium. Most of the elderly over 65 are automatically eligible to coverage under Part A of Medicare. Persons over 65 who are not insured may obtain coverage by paying monthly premiums for Part A benefits. In 1990, the monthly premium is $175.

The premium is based on the average cost of funding Part A benefits. Revenues from the Part A premium offset program spending for services. The Administration's FY1991 budget proposal includes provisions to lower Part A benefit outlays. Since the Part A premium is based on average costs, if the average cost of Part A is lowered, then the premium would be expected to decrease and program outlays would increase. If all the budget proposals are enacted, outlays for FY1991 are projected to increase by $2 million.

Part B Premium. From 1984 through 1990, the Part B premium has been set at 25% of program costs for the elderly, including an appropriate reserve and an adjustment for interest income. The remaining 75% is covered by general revenues. In 1991, however, the method for calculating the premium will revert to the formula

used prior to 1984 when increases in the Part B premium will be limited by the Social Security cost-of-living adjustment (COLA).

The premium originally covered 50% of program costs. However, due to legislation in 1972 limiting the annual increase to the Social Security COLA, this share declined to 23% until 1983 when the 25% rule was enacted. The Administration considers the 25% share to be a reasonable split of the burden of program costs between the government and beneficiaries. However, others are concerned that out-of-pocket medical care costs are consuming a growing portion of the income of the elderly.

The Administration's FY1991 budget includes a proposal to set a floor on the premium rate increase in CY1991 so that the premium increases would be equal to the greater of the amount needed to finance 25% of costs or the Social Security COLA rate increase. Current premium costs are projected at $29.90 for FY1991. The Administration argues that if their Part B program cuts are adopted, the costs of providing Part B services would drop and the projected Part B premium would drop to $29.70 in FY1991. However, if the Administration's proposal for a Part B premium floor is enacted, then the actual Part B premium would be $29.90, which results from using the Social Security COLA.

State and Local Government Employees. Under current law, Medicare coverage and payment of Hospital Insurance taxes are mandatory for new State and local government employees hired on or after Apr. 1, 1986. States have the option to extend Medicare coverage (without extending Social Security coverage) to State and local government employees hired before Apr. 1, 1986. The President's FY1991 budget proposes to mandate Medicare coverage (and payment of Hospital Insurance taxes) for all State and local government employees, including those hired before Apr. 1, 1986.

The Administration's view is that this proposal would correct an inequity in the current program. Most State and local government employees become eligible for Medicare because they work outside government for some part of their career, or because their spouses do. Such employees receive Medicare benefits without having to pay Hospital Insurance taxes throughout their working lives. Because of the payroll tax which employers are required to pay, this proposal could have had a significant financial impact on those State and local governments (or certain departments within those governments) that have not already enrolled a large share of their employees. In addition, the Office of the Inspector General examined a sample of retirees from State and local agencies not covered by Medicare and found that approximately 85% of the retirees were enrolled in Part A. The Administration's position is that since many of these individuals receive full Medicare benefits, the proposal would require that these individuals contribute their fair share to the HI trust fund. The increase in revenue from this proposal is estimated to be $1.87 billion in FY1991.

Catastrophic Health Insurance. In 1989, Congress repealed the Catastrophic Health Insurance (CHI) Act of 1988. The Act had expanded Part A benefits for hospitalization and SNF care, set a maximum on out-of-pocket expenses under Part B, and created a new Medicare outpatient prescription drug program. The Part A benefits were in effect in CY1989, and the other provisions under CHI were to be

phased in over the next four years. The financing of CHI was through a combination of tax-related supplemental premiums and monthly flat premiums.

Although the supplemental premiums were not scheduled to go into effect until 1990, some premiums were paid by those individuals who file estimated quarterly tax returns. With the repeal of the law, all collected funds are to be refunded. In anticipation of expanded Part B benefits, the monthly flat premium under CHI was paid during 1989 and deposited in the SMI trust fund. No Part B benefits were paid during 1989 from the SMI trust fund. The Administration proposes that the monthly flat premiums currently in the SMI trust fund be transferred into the HI trust fund to offset the costs of catastrophic hospital and SNF benefits paid from the trust fund during 1989.

Program Management Budget

The President's FY1991 budget also included funding requests for HCFA's administration and research activities.

Research, Demonstrations and Evaluations. The FY1991 budget requests $36 million for HCFA's research, demonstration and evaluation activities. This represents a decrease of $14 million from FY1990. Much of the decrease is attributable to a proposal to cease further funding of the rural health care transition grant program authorized by OBRA 87. HCFA's general ongoing level of research would be increased by $4 million.

Medicare Contractors. The FY1991 budget requests $1.5 billion for Medicare contractors, primarily Part A intermediaries and Part B carriers who review and process claims. This figure is $129 million above FY1990. The increased funding was requested to invest in productivity improvements to facilitate implementation of OBRA 89, including $173 million in contingency funds set aside primarily for unanticipated workloads and the implementation of OBRA 89 provisions.

Medicare State Survey and Certification. The Administration proposes to finance health facility surveys through user fees assessed on the facilities themselves. Under the proposal, health facilities would be required to pay a fee covering the costs associated with the survey, including indirect costs. Facilities requiring additional or extended surveys will pay additional fees. Revenues generated would be deposited in the Survey and Certification Revolving Fund, and all outlays will be made from the same fund.

The FY1991 budget assumes total survey and certification funding of $510 million, including $183 million for Clinical Laboratory Improvement Amendments of 1988 (CLIA) workloads. These expenditures would be wholly offset by user fees.

Federal Administrative Costs. The FY1991 budget requests $285 million for Federal administrative costs, a decrease of $12 million from FY1990 level. The request includes a decrease in personnel as a result of the repeal of the Catastrophic Health Insurance program.

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CRS Issue Brief

Medicaid: FY1991 Budget and Child Health Initiatives

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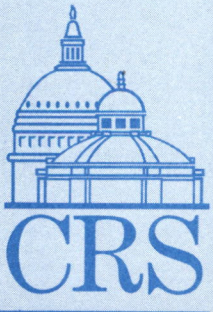

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Medicaid: FY1991 Budget and Child Health Initiatives

SUMMARY

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance to approximately 26 million low-income persons who are aged, blind, disabled, or members of families with children. The Federal share of program expenditures for Medicaid is from general revenues. It is expected that the Federal share for FY1989 will total $34.8 billion while the Federal share for FY1990 is projected to reach over $40 billion. Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. The Federal share of expenditures for Medicaid services is tied to a formula inversely related to the square of a State's per capita income. For FY1990, the Federal matching percentages range from 50% to 80.18%. Federal matching for State program administration is generally at 50%. However, current law provides higher matching rates for certain activities, such as operation of data systems and health care quality monitoring.

The Bush Administration's FY1991 budget proposal includes proposals for increasing beneficiaries' participation in managed care plans and for eliminating Federal costs of inspecting and certifying institutional Medicaid providers. The 101st Congress is considering a variety of Medicaid changes, including expansion of community services for the frail elderly and the developmentally disabled. However, options for improving coverage for low-income mothers and children have received the greatest attention, because of concerns about the Nation's infant mortality rate and the problem of access to care for children without health insurance coverage. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), includes expansion of eligibility for pregnant women and infants, and increases the availability of providers for them. The Act also makes substantial changes to another major Federal health program targeted at mothers and children, the Maternal and Child Health Block Grant program.

Many proposals in the 101st Congress focus on Medicaid eligibility. They would either mandate or permit coverage of individuals at higher income levels and would remove other barriers to coverage, such as assets tests, and delays in eligibility determination. Other bills address issues beyond basic eligibility for benefits. There are proposals to increase provider participation in Medicaid, to ease the Medicaid application process and to provide home visitation services to high-risk pregnant women and infants.

ISSUE DEFINITION

Medicaid is a Federal-State matching program providing medical assistance to approximately 26 million low-income persons. In FY1989, the Federal share of Medicaid costs was $34.8 billion. The FY1990 total Federal cost of Medicaid is expected to reach $40.2 billion, a 15.5% increase over FY1989. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) expanded Medicaid coverage to larger numbers of pregnant women and children and took other measures to improve access to prenatal and early childhood health care. The FY1991 budget includes $300 million for this expansion. Under the Administration's budget, Federal Medicaid expenditures in FY1991 would increase by $4.8 billion to $45.0 billion, 12% over the FY1990 level. Two legislative proposals included in the budget would have the net effect of reducing Federal outlays in FY1991 by $88.5 million. One proposal is intended to extend the use of managed care and is projected to cost $25 million in FY1991. The other would assess annual fees on nursing facilities and suppliers to cover the program and administrative costs of surveying and certifying the facilities and is intended to save $113.5 million in FY1991.

BACKGROUND AND ANALYSIS

Description of Medicaid

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance to a projected 26 million low-income persons in FY1989. FY1990 program expenditures are expected to reach $70.5 billion, of which the Federal share will be $40.2 billion. Although Federal funds account for 56.9% of total program expenditures, each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. Thus, there is considerable variation among the States in terms of eligibility requirements, range of services offered, limitations placed on those services, and reimbursement policies.

Every State except Arizona participates in the Medicaid program, as do the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. (Arizona currently provides federally funded medical assistance through a demonstration program that has received waivers of certain Medicaid requirements.) At the State level, Medicaid is administered by a designated single State agency. Federal oversight of the Medicaid program is the responsibility of the Health Care Financing Administration (HCFA) within DHHS.

The Federal share of expenditures for Medicaid services is tied to a formula inversely related to the square of a State's per capita income. For FY1990, the Federal matching percentages range from 50% to 80.18%. In FY1991, the highest match is expected to be 79.93% for Mississippi. The matching rate for administrative costs is generally 50% for all States. Higher matching, at levels ranging from 75% to 90%, is available for certain management and control activities. The remaining costs of the program are paid by the State; in some States local governments may also contribute.

Eligibility

Eligibility for Medicaid benefits has traditionally been linked to actual or potential receipt of cash assistance under either of two programs: Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI) for the aged, blind, and disabled. Recently States have been given the option to extend Medicaid to other low-income groups. Coverage of some of these new populations was made mandatory by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). Although P.L. 101-234 repealed the Medicare provisions of the Act, Medicaid provisions were left intact.

All States must cover the **categorically needy**. These include all persons receiving AFDC and, in most States, persons receiving SSI. States have the option of limiting Medicaid coverage of SSI beneficiaries by using more restrictive standards for Medicaid, if those standards were in effect on Jan. 1, 1972 (before implementation of SSI). Fourteen States continue to use more restrictive standards. States must also cover as categorically needy a number of groups that are not receiving AFDC or SSI. The following are among the more important of these groups:

-- Pregnant women, infants, and children up to age six, with family incomes up to 133% of the poverty level, by Apr. 1, 1990.

-- Certain persons whose family income and resources are below AFDC standards but who fail to qualify for AFDC for other reasons, such as family structure. These include pregnant women, as well as children born on or after Oct. 1, 1983, to age 7.

-- Families losing AFDC benefits as a result of increased employment income or working hours or increased child or spousal support payments. States must continue coverage for these families for various periods, depending on the reason for the loss of AFDC benefits.

-- Persons who have been receiving both Social Security and SSI benefits and who become ineligible for SSI because of increases in their Social Security payments.

-- Certain disabled people who lose SSI after returning to work but who remain disabled and who could not continue working if their Medicaid benefits were terminated.

In addition to the mandatory groups, there are several optional groups that States may elect to treat as categorically needy for Medicaid purposes. These include families with unemployed parents and "Ribicoff children" in families with income below AFDC standards; these are children whom the State is not required to cover but who are under a maximum age set by the State, which may be 18, 19, 20, or 21. States may also cover persons in institutions who meet a special institutional financial standard set by the State; this standard may not exceed 300% of the SSI payment level. Finally, States may cover disabled children who are not in an institution but who would be eligible if they were in an institution.

Thirty-nine States and other jurisdictions also provide Medicaid to the **medically needy**. These are persons whose income or resources exceed the standards for the cash assistance programs but who meet a separate medically needy financial standard established by the State and also meet the nonfinancial standards for categorical eligibility (such as age, disability, or being a member of a family with dependent children). The separate medically needy income standard may not exceed 133.3% of the maximum AFDC payment for a household of similar size. Persons may qualify as medically needy after their incurred medical expenses are deducted from their income or resources. This process, known as "spenddown", is a frequent route to Medicaid eligibility for persons in nursing facilities.

Beginning with the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Congress has permitted States to extend Medicaid coverage to certain **target populations**, using eligibility standards which are not directly linked to those used in the cash assistance programs. The Act allowed States the option of covering pregnant women and young children and/or aged and disabled persons meeting State-established income standards as high as 100% of the Federal poverty level.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) converted the options to mandates for several of the target groups. States were required to phase in coverage of pregnant women and infants under 1 year old, and aged and disabled persons eligible for Medicare with family incomes below 100% of poverty. Coverage for the aged and disabled may be restricted to Medicare premiums and cost-sharing amounts. States may choose to cover older children with family incomes below 100% of poverty. This option permits States to cover children through age 7 beginning Oct. 1, 1990.

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) further expanded States' options by allowing coverage, beginning July 1, 1988, of pregnant women and children up to age 1 with incomes less than 185% of the Federal poverty level. The State may impose a premium for this coverage, equal to no more than 10% of the amount by which the family's income exceeds 150% of the poverty level.

The Omnibus Budget Reconciliation Act of 1989 (P.L. 100-239), mandated coverage of pregnant women and infants with family incomes up to 133% of the Federal poverty level by Apr. 1, 1990.

Services

All States must cover a minimum set of services under Medicaid and may at their option offer additional services. The minimum service requirements differ for the categorically needy and the medically needy. For the categorically needy, the State must provide inpatient and outpatient hospital services, ambulatory services provided by federally qualified health centers, physician services, laboratory and x-ray, family planning, skilled nursing facility (SNF) services for those over age 21, and home health care for persons entitled to SNF care. The State must also provide early and periodic screening, diagnosis, and treatment (EPSDT), a preventive health program for persons under 21. As required by OBRA 89 (P.L. 100-239), States must provide coverage for treatment to correct physical or mental problems identified during EPSDT screening, even if the follow-up services are not otherwise covered by the State. If the State covers the medically needy it must provide, at a minimum,

ambulatory care for children and prenatal and delivery services for pregnant women. States may limit coverage for the mandatory services in a variety of ways. They may impose ceilings on the number of inpatient days or physician visits that will be reimbursed, require prior authorization or second surgical opinions, and deny coverage for services deemed to be experimental.

Among the additional services that States may choose to provide are prescription drugs, dental care (some dental coverage is mandatory for children under EPSDT), eyeglasses, and care in inpatient psychiatric facilities for persons under 21 or over 65. In terms of overall expenditures, the most important optional Medicaid service is care in intermediate care facilities (ICFs). All of the States and the District of Columbia cover ICF services, and every State except Wyoming also covers services in an ICF for the mentally retarded, or ICF-MR.

Whatever services the State chooses to cover, it must offer them uniformly throughout the State and must, with minor exceptions, offer comparable coverage to all persons in the categorically needy groups. Finally, beneficiaries must generally be allowed to obtain services from any qualified provider. All three of these requirements -- statewideness, comparability, and freedom of choice -- may be waived under circumstances described below.

Payment for Services

States are generally free to develop their own reimbursement methodologies and levels for covered services. There are statutory guidelines for certain services, with only three rules applicable to every service type. First, providers must accept Medicaid payment as payment in full and may not seek to collect from beneficiaries. Second, Medicaid pays only after any other insurance or third party payment source available to the beneficiary has been exhausted. In particular, when beneficiaries are eligible for both Medicaid and Medicare, Medicare pays first for the services it covers. Medicaid pays what would ordinarily be the beneficiary's share (deductible or coinsurance) and covers services not available under Medicare. Finally, P.L. 101-239 codified the regulatory requirement that payments be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. That Act also requires States to pay federally-qualified health centers 100% of their reasonable costs, effective Apr. 1, 1990.

States use two basic payment methodologies for institutional care: retrospective and prospective. In a retrospective system, payment amounts are determined after services are rendered and are based on the actual costs incurred by the provider in furnishing those services. In a fully prospective system, payment amounts are determined in advance. The provider receives a specified rate for each defined unit of service, such as a day of care or a total hospital stay, regardless of whether the provider's actual costs are more or less than that rate. States are increasingly shifting towards prospective systems for both hospital and nursing facility care.

For services of physicians or other individual practitioners, payment amounts are usually the lesser of the provider's actual charge for the service and a maximum allowable charge established by the State. In setting these maximums, some States use methods comparable to those used by Medicare in establishing reasonable charges

for physician services. Other States have developed fixed fee schedules, specifying a flat maximum payment amount for each type of service; the maximum may be unrelated to actual provider charges.

Alternative Delivery Systems

States are permitted to develop alternative ways of providing Medicaid benefits, through a variety of structured systems. Use of some of these alternatives is wholly at the State's option; others require waivers of Federal requirements approved by the Secretary.

First, States may contract with health maintenance organizations (HMOs), or other prepaid health plans for the enrollment of Medicaid beneficiaries. For each beneficiary enrolled in a plan, the State issues a fixed monthly premium payment, out of which the plan provides all covered services.

Second, States may obtain waivers to restrict the providers from whom beneficiaries may obtain services. Some States have used this option, established by Section 2175 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35, OBRA 81), to enter into selective contracting arrangements. The State may, for example, choose participating hospitals through a system of competitive negotiation. The more common use of the 2175 waiver authority is to establish primary care case management programs. Beneficiaries are required to select a single primary care provider. Except in an emergency, care from other providers must be authorized by the primary care physician.

Finally, States may obtain waivers, authorized by Section 2176 of OBRA 81, to provide home and community-based services to persons who would otherwise require continuing care in hospitals or nursing homes. The waivers allow the State to design a comprehensive package of medical and social services to allow a target population, such as the frail elderly or the mentally retarded, to remain in the community.

FY1991 Budget

Federal Medicaid outlays for FY1989 were $34.8 billion. The Administration projects that under current law, Federal outlays will reach $40.2 billion in FY1990, and $45.0 billion in FY1991. President Bush's FY1991 budget includes two legislative proposals. One proposal is intended to increase the use of managed care in the Medicaid program at a cost of $25 million in FY1991. The other would have users pay the costs of Medicaid survey and certification activities. This new activity is expected to reduce Federal Medicaid costs by $113.5 million in FY1991.

Current law permits States to enter into risk contracts with health maintenance organizations (HMOs), or other prepaid entities. Under a full risk contract, the organization agrees to make available the set of Medicaid covered services to an individual beneficiary in return for a fixed monthly premium payment issued by the State Medicaid program. Enrolled beneficiaries may obtain services covered by the contract only from providers affiliated with the contractor. If the beneficiaries use more, or more costly, services than anticipated, the organization may suffer a loss. If enrollees use fewer services than anticipated, the organization may realize a profit.

The risk arrangement is intended to give the organization a financial incentive to provide appropriate services efficiently. States are also permitted to enter into contracting arrangements known as primary care case management programs. These programs restrict the providers from whom beneficiaries may obtain services. The primary care physician/case manager (who is not at financial risk) controls the overall care of the patient. Patients assigned to the manager must obtain all covered services from or with the authorization of the manager, except in emergencies.

Under the Administration's proposal to extend the use of managed care, States would receive financial incentives to increase managed care enrollment. Beginning in FY1991, States would receive a 3 percentage point bonus over their normal matching rate for expenditures made on behalf of beneficiaries newly enrolled into full risk HMO-type managed care plans. Beginning in FY1993, the 3 percentage point bonus would be available for beneficiaries who were already enrolled in managed care plans. Also beginning in FY1993, the matching rate paid to States for expenditures under traditional fee-for-service systems would be reduced to offset the cost of the higher matching rates paid for managed care. Reductions could be as high as 1 percentage point in FY1993, 2 percentage points in FY1994, and 3 percentage points in FY1995 and beyond. Reductions would not apply to payments made on behalf of beneficiaries living in rural or underserved areas, pregnant women and infants, or individuals in nursing facilities. Nor would penalties be assessed for beneficiaries restricted to nonrisk managed care arrangements.

Currently, States cannot require recipients to enroll in a managed care system unless they apply for waivers of requirements. The Administration's proposal would allow States the option of implementing mandated managed care programs without having to apply for waivers. Finally, the proposal would relax certain requirements for HMO participation in Medicaid programs. The Administration's FY1991 budget adds $25 million for the managed care initiative to the $45.0 billion Medicaid outlay projected at current law levels.

The Administration's position is that managed care arrangements ensure access to primary care, continuity of care and coordination of special services, and contain costs as care is delivered efficiently and appropriately. However, some say providers under risk contracts may have incentives to reduce costs by underserving enrollees; they maintain that States will need to exercise care in provider selection, set performance standards, and implement monitoring and evaluation procedures to assure that access and quality of care are not compromised.

Nursing facilities and certain suppliers participating in the Medicaid (or Medicare) program are subject to at least annual survey and certification procedures. States are responsible for conducting inspections to determine whether providers can be certified as meeting the standards and conditions for Medicaid participation. The Federal matching rate to States for survey and certification activities is 75%. The Administration's FY1991 budget includes a proposal to create a HCFA Survey and Certification Revolving Fund. The fund would finance Medicaid survey and certification activities through annual fees assessed on providers and suppliers requesting certification. Fees deposited into the revolving fund account would be available to pay all Medicaid survey and certification activities and associated HCFA administrative expenses. This change would make survey and certification activities self-supporting in conformance with the precedence set by the Clinical Laboratory

Improvement Amendments of 1988. The Administration estimates that implementation of the revolving fund will reduce Federal Medicaid expenditures by $113.5 million in FY1991. Critics question whether any savings would be as high as the Administration estimates. As allowable costs, user fees would be reimbursable by Medicaid. In addition, to cover the increased expense, some payers may increase rates to all payers.

Maternal and Child Health

The last three Congresses have gradually expanded both mandatory and optional Medicaid coverage for pregnant women and children. At least two major factors have contributed to congressional interest in Medicaid expansion. The first is growing concern over the incidence of infant mortality and other unfavorable outcomes of pregnancy. The United States had an infant mortality rate in 1987 of 10.1 deaths per thousand live births, higher than that of many other major industrial nations. Rates are higher for minorities and residents of inner cities. Beyond the children who die, there are many more low birth-weight infants and others with preventable problems that are costly to treat and that can result in lifelong disabilities. There is evidence that access to prenatal and well baby care is an important factor in these outcomes.

A second source of interest in Medicaid expansion has been the growth in the number of Americans without health insurance coverage. The proportion of the population without insurance has been going up in this decade, from about 14.6% of the nonelderly in 1979 to 17.5% in 1986. In that year, 37 million persons lacked coverage; of these, 12 million were children under age 18. More than half of these children were in families with incomes below the Federal poverty level. In 1987, Medicaid covered only 53% of children in poverty. Many poor children were excluded because Medicaid maximum income standards in most States were well below the poverty level, while others were excluded on categorical grounds, such as restrictions on enrollment of two-parent families with an employed parent. Recent changes in Medicaid eligibility standards, both financial and categorical, are often spoken of as having severed the traditional link between Medicaid and the welfare programs. These changes are only beginning to be implemented, and their impact cannot yet be measured.

Other proposals considered in the 101st Congress provide for broader expansions affecting other Federal programs as well as Medicaid. H.R. 3299 as originally passed by the House would have expanded coverage beyond the measures enacted by P.L. 101-239. Medicaid expansion is facing increasing opposition from State governments. The National Governors' Association has called for a 2-year moratorium on Medicaid expansion, arguing that past expansions have strained State budgets and detracted from other priorities, such as education.

Eligibility for Pregnant Women and Children

Proposals in the 101st Congress would raise the optional or mandatory maximum income standards for pregnant women and children and would also address other potential barriers to Medicaid coverage for these groups, such as limits on

allowable assets, delays in the application and eligibility determination process, and discontinuous eligibility. OBRA 89 (P.L. 101-239), raises the mandatory maximum income standards for pregnant women and children and also provides for potential increases in the numbers of health care providers available to these groups.

Income Standards

Pregnant women and infants. Before the enactment of P.L. 101-239, States were required to cover pregnant women and infants under 1 year old with family incomes up to 100% of the Federal poverty level by July 1, 1990. P.L. 101-239 requires States to cover pregnant women and children up to age six in families with incomes up to 133% of the Federal poverty level beginning Apr. 1, 1990. States may, at their option, establish a higher maximum income standard for pregnant women and infants, up to 185% of the Federal poverty level. H.R. 3931 and S. 2198 would phase in mandatory coverage of pregnant women and infants up to 185% of the poverty level by July 1, 1993. A similar provision was included in H.R. 3299 as originally passed by the House.

Children over 1 year old. States have the option of providing Medicaid to children aged 1 through 7 who were born after Sept 30, 1983, and whose family incomes meet a State-established standard no higher than 100% of the Federal poverty level. H.R. 3932 would permit States to extend Medicaid to children up to age 6 with family incomes below 185% of the poverty level, beginning Jan. 1, 1991. S. 2198 would allow States to cover children up to age 6 with incomes below 185% of the poverty level beginning July 1, 1991. H.R. 3932 would mandate coverage of children to age 18 and born after Sept 30, 1983, with incomes up to 100% of the poverty level. H.R. 3299 as passed by the House, included a similar provision. S. 2198 would mandate coverage of such children up to age 19. H.R. 3932 would required Section 209(b) States, those that do not automatically provide Medicaid to all recipients of SSI benefits, to cover all children under age 18 who are SSI-eligible. H.R. 3299 as passed by the House, included a similar provision. H.R. 3932 would allow States to cover foster children and children in group homes or private institutions to age 18 with incomes below 100% of the poverty level. H.R. 3299, as passed by the House, would also have covered foster children.

One alternative that has been offered to expansion of Medicaid as an entitlement is a Medicaid "buy-in" program, under which individuals or families whose incomes exceed Medicaid eligibility levels could obtain coverage by paying a premium. To make the coverage affordable, the premium might be set below the actual cost of coverage, with the difference made up through a public subsidy. President Bush advanced this idea in the 1988 campaign, but the Administration has not offered a concrete buy-in proposal. P.L. 101-239 provides for three-year demonstration projects to study the effect of allowing States to extend coverage to pregnant women and children under age 20 who are not otherwise eligible for Medicaid and whose family incomes are below 185% of the poverty line. The Secretary of DHHS may enter into agreements with several States to test alternatives for Medicaid extension which could be enrollment under an employer plan, a State uninsured plan, an HMO or other arrangement. Individuals or families with incomes over 100% of the poverty level must be charged premiums according to a sliding scale. Federal funding for these projects is limited to $10 million for each of the fiscal years 1990, 1991, and 1992.

Other Eligibility Standards

In establishing Medicaid eligibility for pregnant women and children, a State must determine income using the same methodology used in the State's AFDC program. States have the option of applying a resource standard (a limit on allowable family assets), but are not required to do so. H.R. 3931 and S. 2198 would forbid the use of a resource standard for mandatory coverage groups of pregnant women and children. In calculations of income, both bills would disregard child-care costs necessary for the employment of the pregnant woman or the infant's caretaker.

Presumptive Eligibility

To insure early access to prenatal care, States have the option of establishing "presumptive eligibility" for low-income pregnant women. Qualified providers such as Federally funded clinics, may make a preliminary determination that a pregnant woman seeking treatment is potentially eligible for Medicaid. The woman may then receive ambulatory prenatal care for up to 45 days, or until the State completes an eligibility review, whichever is earlier. Even if the woman is ultimately found to be ineligible, the provider may be reimbursed for services furnished during the presumptive eligibility period. However, if the woman fails to apply for Medicaid within 14 days, presumptive eligibility ceases. As of January 1989, 20 States provided for a presumptive eligibility period. H.R. 3931 and S. 2198 would eliminate the 45-day limit and extend the time to apply for Medicaid to the last day of the month following the month during which the preliminary determination was made; eligibility would continue until the State had completed its review of the Medicaid application. S. 1201 would also provide 45 days of coverage even if the woman never applied for Medicaid. As passed by the House, H.R. 3299 would have left presumptive eligibility optional, but would have continued eligibility until the completion of State review. H.R. 2216/S. 902 would mandate presumptive eligibility and would extend eligibility for 60 days even if the woman is determined ineligible before that date. S. 440 and S. 949 would allow States to establish presumptive eligibility for children, through age 17 under S. 440 and through age 20 under S. 949.

Other Medicaid Child Health Proposals

Although congressional interest has centered on financial eligibility for medical care, there have been concerns that mere extension of Medicaid coverage may not ensure that all mothers and children will receive appropriate services. Low-income people may face other barriers to access. First, not all providers of care will accept Medicaid reimbursement, largely because of low Medicaid payment rates. Second, some low-income mothers may be unaware of the availability of Medicaid benefits or may need help in applying for them. Third, some women may need special services to keep appointments and reduce risks of poor outcomes. Provisions of OBRA 89 (P.L. 101-239) and proposals in the 101st Congress address these issues.

Medicaid Provider Participation

Low rates of provider participation, and especially physician participation, have been a historic problem under Medicaid. Surveys of physicians have generally found

that low Medicaid reimbursement, relative to the physicians' usual charges, is an important factor in the decision to refuse Medicaid patients.

Federal regulations require that a State's Medicaid payment rates "must be sufficient to enlist enough providers so that services under the [State Medicaid] plan are available to recipients at least to the extent that those services are available to the general public." (42 CFR 447.204.) P.L. 101-239 incorporates this rule in the Medicaid statute, requires DHHS to determine the adequacy of States' payment rates for obstetrical and/or pediatric services, and permits States to pay more for obstetrical and pediatric services furnished in rural areas than for services furnished in metropolitan areas.

P.L. 101-239 requires States to include in their Medicaid benefit packages ambulatory services provided in federally qualified health centers and to pay these providers 100% of their reasonable costs. In addition, the Act requires States to pay for the services of certified pediatric and family nurse practitioners regardless of whether they are under the supervision of or associated with a physician or other provider.

Some proposals would expand current provisions under which States are required to give special treatment to hospitals serving a disproportionate share of low-income patients. Currently, States must provide increased payment rates to such hospitals for all inpatient services, make extra payments for infants with very long stays or high costs and must waive any durational limits on covered services for infants. H.R. 3932 and S. 2198 would extend these provisions to all children under age 18. H.R. 3299 as passed by the House contained a similar provision.

Application Assistance and Home Visiting

Some mothers may find the Medicaid application process difficult, or may lack the transportation or child care necessary to get to benefits or services. Others may be unaware of the importance of prenatal and well baby care, or may need special counseling to reduce risks for themselves and their infants. Current proposals address these concerns. S. 2198 would require States to provide for receipt of applications at locations other than welfare offices, such as hospitals or clinics. S. 2198 and H.R. 3931 would give States the option of covering home visitation services, as prescribed by a physician, to high-risk pregnant and postpartum women and to infants under age one.

Maternal and Child Health Block Grant

The Maternal and Child Health (MCH) Block Grant program, authorized by Title V of the Social Security Act, provides grants to States for a variety of health programs, including direct provision of preventive and primary care services to mothers and children, health screening, immunizations, and rehabilitation services for children with special health care needs (formerly referred to as crippled children). The appropriation for FY1990 is $561 million. Of this amount, $470,582,950 (approximately 84%) is available for block grants. The rest is available for grants under the special projects of regional and national significance (SPRANS) set-aside authority. The Administration budget for FY1991 requests a total of $579 million which includes $554 million for the MCH Block Grant Program and an additional

$25 million for a "one-stop shopping" program to be administered in conjunction with the block grant.

P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989, substantially revamped the MCH program. The bill increased the permanent authorization from $561 million to $686 million and authorized an additional 12-3/4% set-aside whenever the amount appropriated for the fiscal year is over $600 million. The new Federal set-aside would be used for several initiatives including case management provided in the home by either professional or qualified nonprofessional workers; projects designed to increase the participation of obstetricians and pediatricians in both the MCH and the Medicaid programs; integrated delivery systems; rural or hospital-based MCH projects; and community-based programs including day care for children who usually receive services through inpatient care.

P.L. 101-239 requires that both the Secretary and the States set goals and carry out activities consistent with the goals and objectives established under the Public Health Service Act for the year 2000. The bill also tightens controls on the use of funds allotted to States while increasing the services States may provide.

To receive an MCH grant, States have to submit an application containing a statewide needs assessment, a plan for meeting the needs identified in the assessment and a description of how MCH grant funds would be used to meet the needs. States are required to use at least 30% of the funds for preventive and primary care services for pregnant women, mothers and infants up to age 1, 30% for services to children and 30% for services for children with special needs. Funds for administrative expenses are limited to 10% of the allotment. P.L. 101-239 also requires States to comply with new detailed reporting requirements related to the use of funds and the extent to which the State has met its goals and objectives and the national health objectives.

LEGISLATION

P.L. 101-239, H.R. 3299 (Panetta)

Omnibus Budget Reconciliation Act of 1989. Clean bill reported by the House Budget Committee Sept. 20, 1989. Passed House with amendments, Oct. 5, 1989. Passed Senate with amendments Oct. 13, 1989. Conference report filed in House, Nov. 21, 1989. Both House and Senate agreed to conference report Nov. 22, 1989. Mandates Medicaid expansion for pregnant women and children up to age 6 with family incomes up to 133% of poverty level by Apr. 1, 1990. Codifies current regulatory requirement that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent they are available to the general population in a particular area. Requires State Medicaid programs to cover services of certified pediatric or family nurse practitioners and ambulatory services in federally qualified health centers. Requires State Medicaid plans to provide for coordination between Medicaid and WIC programs. In the Maternal and Child Health Block Grant, P.L. 101-239 increases authorization of appropriations to $686 million per year; adds a new 12 3/4% set-aside to support infant mortality initiatives and community-based services for children; provides for demonstration projects to cover uninsurable children; and

requires both DHHS and States to set goals consistent with health objectives for the year 2000.

H.R. 3931 (Collins)

Medicaid Infant Mortality Amendments of 1990. Introduced Feb. 1, 1990; referred to Committee on Energy and Commerce. Mandates phased-in coverage of pregnant women and infants up to 185% of poverty; prohibits application of resource standard for this group and disregards child care costs in income calculations. For presumptive eligibility, removes 45-day limit and extends application period. Permits States to cover home visitation services for high-risk pregnant and postpartum women and infants.

H.R. 3932 (Slattery)

Medicaid Child Health Amendments of 1990. Introduced Feb. 1, 1990; referred to Committee on Energy and Commerce. Mandates phased-in coverage of individuals under age 18 with family incomes under 100% of poverty. Permits coverage of children up to age 6 with incomes under 185% of poverty. Requires increased payments to disproportionate share hospitals for services to children up to age 18. Requires States to provide Medicaid to disabled children who are SSI-eligible. Permits States to provide Medicaid for foster children up to 100% of poverty.

S. 2198 (Bradley)

Infant Mortality Amendments of 1990. Introduced Feb. 28, 1990; referred to Committee on Finance. Mandates phased-in coverage of pregnant women and infants up to 185% of poverty; prohibits application of resource standard for this group and disregards child care costs in income calculations. Permits coverage of children up to age 6 with incomes under 185% of poverty. Provides for phased-in mandatory coverage of children through age 18 with incomes up to 100% of poverty. For presumptive eligibility, removes 45-day limit and extends application period. Requires increased payments to disproportionate share hospitals for services to children up to age 18. Permits States to cover home visitation services for high-risk pregnant and postpartum women and infants.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. House. Committees on Education and Labor, and Energy and Commerce, and the Senate Special Committee on Aging. Insuring the uninsured: options and analysis. Oct. 1988. Education and Labor Serial No. 100-DD. Energy and Commerce Serial No. 100-BB. Special Committee on Aging Serial No. 100-O. 212 p.

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and Environment. Medicaid Source Book: Background Data and Analysis. November 1988. House Energy and Commerce Committee Print 100-AA. 501 p.

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Washington Post, May 7, 1988, p. A7

Old Age, Disability Fund Gets Clean Bill of Health

By Spencer Rich
Washington Post Staff Writer

The Social Security old age and disability system remains in good shape for at least the next six decades, while the Medicare hospital trust fund is in better shape than projected a year ago because of efforts to hold down outlays, the Social Security system trustees said yesterday.

Although Medicare is still in deep trouble because of rising health-care costs, the trustees said that it should have enough money to keep going 17 years, three years longer than estimated last year.

The old age and disability fund is in much better shape than Medicare because of steps taken to revise the system in 1983. Without additional changes, that fund should avoid bankruptcy through at least 2048, the trustees said.

Of the 7.51 percent Social Security payroll tax, levied on the first $45,000 of annual wages, 6.06 percentage points go to old age and disability pensions, and 1.45 percentage points to Medicare hospital payments. Employers pay a like amount for each worker.

For years, the Medicare hospital trust fund has been projected to go broke within a relatively short time because of rises in health-care costs throughout the economy—not just in Medicare—far exceeding the general rate of inflation. That forecast is not essentialy changed in the latest report on the financial soundness of the system.

But steps to hold down outlays under the Medicare hospital program taken in recent years, plus general economic recovery, have somewhat improved the day of reckoning, yesterday's report indicated.

Under the "intermediate" economic and demographic forecasts by the system's actuaries—the one considered most likely to occur—the trustees said the hospital trust fund should remain in sound financial shape until 2005, three years longer than estimated last year.

Under a somewhat more pessimistic set of assumptions, it could go belly-up by 1999, the trustees said. Under the most optimistic scenario, it could last until 2044 with no changes in financing.

"In order to produce long-term solvency over the next 25 years for the hospital insurance trust fund," Secretary of Health and Human Services Otis R. Bowen said in a statement, the report calculates that "either benefits would have to be reduced 14 percent or Medicare contributions increased 16 percent."

The report warned that because the baby-boom generation will begin retiring in the first quarter of the next century, Medicare long-term burdens could be increased further and that the trust fund faces huge deficits in the long term.

The report said the doctor-insurance part of Medicare (Part B), which is not a true trust fund and which is financed three-quarters from Treasury general revenue rather than from the Medicare portion of the Social Security tax, also faces large increases in costs.

The old age and disability fund should avoid bankruptcy through at least 2048, the trustees said.

The report said the Social Security old age and disability system is in much better shape than Medicare because of the 1983 financial rescue package that Congress and the president put together.

Under the "intermediate scenario," the combined old age and disability trust fund reserves are expected to build up enormously in the next few decades to a level five times as high as needed to pay a year's benefits by 2010 to 2020.

But then as the baby-boom generation retires, the fund will decline rapidly and become insolvent by 2048 unless economic and demographic conditions prove better than projected or Social Security taxes are increased somewhat.

Under a more pessimistic scenario, the combined trust funds would face insolvency in 2026.

The system's trustees are the secretaries of HHS, Labor and the Treasury, plus several public members.

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CRS Issue Brief

Medicare: Physician Fee Schedule

Updated May 7, 1990

by
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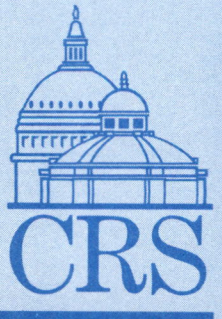
Education and Public Welfare Division



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Medicare: Physician Fee Schedule

SUMMARY

Medicare is a nationwide health insurance program for 31 million aged and 3 million disabled persons. The program consists of two parts. Part A, the Hospital Insurance program, provides protection against the costs of inpatient hospital and related services. Part B, the Supplementary Medical Insurance program, provides protection against the costs of physicians' and other medical services. Medicare spending for physician services is estimated at $30 billion in FY1990. Between FY1984 and FY1990, Medicare spending for physicians' services increased at an average annual rate of 12%. About 40% of the increase is attributable to increases in the price per unit of service, 15% to the increase in the number of beneficiaries, and 45% to increases in the volume and intensity of services.

From 1984-87 Congress, as part of the budget reconciliation process, approved a number of amendments to Medicare's physician payment provisions which were designed to stem these expenditure increases. Despite these legislative changes, Medicare's basic payment system remained relatively unchanged. Payments have been made, subject to certain limitations, for each service rendered. Many analysts have suggested that both the individual prices and the unit of payment (i.e., the individual service) are inflationary and permit certain price distortions. Some believe that these imbalances have created financial incentives that inappropriately influence physicians' decisions about what services to provide, location of their practices, and specialty choice.

On Dec. 19, 1989, the President signed into law P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This measure provides for the establishment of a new payment system for physicians services paid for by Medicare. Payments are to be made under a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. Implementation of an RVS system alone would not result in a decrease in the volume of services. Thus, the legislation also provides for the establishment of annual volume performance standards which are target rates of increase in physician expenditures. The relationship of actual expenditures to the volume performance standards is one factor that will be considered by the Congress in determining the annual update for the fee schedule.

ISSUE DEFINITION

Between FY1984 and FY1990, Medicare spending for physicians' services increased at an average annual rate of 12%. Spending for such services is estimated to exceed $30 billion in FY1990. About 40% of the increase is attributable to increases in the price per unit of service, 15% to the increase in the number of beneficiaries, and 45% to increases in the volume and intensity of services. From 1984-1987, Congress, as part of the budget reconciliation process, approved a number of amendments to Medicare's physician payment rules which were designed to stem these expenditure increases. Despite these changes, Medicare's basic payment system remained relatively unchanged.

On Dec. 19, 1989, the President signed into law P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This measure provides for the establishment of a new payment system for physicians services paid for by Medicare. Payments are to be made under a fee schedule based on a resource-based relative value scale (RBRVS). The legislation provides for the establishment of annual volume performance standards. The relationship of actual expenditures to the volume performance standards is one factor which will be considered by the Congress in determining the annual update for the fee schedule.

BACKGROUND AND ANALYSIS

Current Payment Rules

Medicare pays for physicians services on the basis of **reasonable charges**. A reasonable charge for a service cannot exceed (1) the physician's **actual charge** for the service; (2) the physician's **customary charge** for the service; or (3) the **prevailing charge** for the service in the locality. (There are approximately 240 prevailing charge localities nationwide.) Medicare generally pays 80% of the reasonable charge after the beneficiary has met the $75 deductible. The beneficiary is responsible for the remaining 20%, known as the coinsurance.

Customary and prevailing charge fee screens (i.e., benchmarks against which individual charges are compared) are updated annually. The increase in the prevailing charge screen is subject to a limitation known as the **Medicare Economic Index (MEI)**. The MEI is a limit on the cumulative changes in prevailing charges since 1973. Prior to 1984 (when fees were temporarily frozen) the MEI was based on changes in operating expenses of physicians and in earnings levels. Recently, Congress has specified the allowable increases in the MEI. Congress has also placed limits on prevailing charges for certain "overpriced procedures" such as cataract surgery.

Medicare payments are made directly to the physician or the patient, depending on whether the physician has accepted **assignment** for the claim. In the case of assigned claims, the physician bills the program directly and is paid an amount equal to 80% of the reasonable charge (less any deductible where applicable). The patient is liable for the 20% coinsurance. The physician may not charge the beneficiary more than the applicable deductible and coinsurance amounts. In the case of nonassigned

claims, Medicare payment is made to the beneficiary. The beneficiary pays the physician's bill. In addition to the deductible and coinsurance amounts, the beneficiary is liable for the difference between the physicians's actual charge and Medicare's approved charge; this is known as the **balance billed** amount.

A physician may become a **participating physician**. A participating physician is one who voluntarily enters an agreement with the Secretary of the Department of Health and Human Services (DHHS) to accept assignment on all claims for the forthcoming year. The law includes a number of incentives to encourage physicians to participate. For example, the difference between the MEI-adjusted prevailing charges for participating and nonparticipating physicians is 5%.

The program specifies a limit on actual charges of nonparticipating physicians. This is referred to as the **maximum allowable actual charge** or **MAAC**. Nonparticipating physicians whose actual charge for a service in the preceding year equals or exceeds 115% of the current year's prevailing charge, may increase their actual charges by no more than one percent. Nonparticipating physicians whose actual charge for the preceding year is below 115% of the current year's prevailing charge may increase their actual charges over a 4-year period (1987 - 1990), such that in 1990 their MAAC for the service equals 115% of the 1990 prevailing charge.

In 1988, 76.3% of claims (representing 79.4% of charges) were paid on an assigned basis. In 1989, 40.7% of physicians have signed participation agreements, which will account for over 60% of covered charges.

Medicare is administered by the Health Care Financing Administration (HCFA) within DHHS. The day-to-day functions of reviewing Part B claims and paying benefits are performed by entities known as carriers; these are generally Blue Shield plans or commercial insurance companies. Carriers are also responsible for delineating prevailing charge localities.

Current System Issues

From 1984-87 Congress, as part of the budget reconciliation process, approved a number of amendments to Medicare's physician payment provisions. These included placing a temporary freeze on and subsequently limiting allowable increases in physician payment rates, establishing the participating physician program, limiting balance billing charges on unassigned claims, and placing limits on prevailing charges for specified "overpriced procedures." Taken together these provisions were intended to achieve two main purposes: (1) stemming the annual increases in Medicare payments; and (2) protecting beneficiaries from a substantial increase in liability on nonassigned claims which might result if physicians balance billed for all charges not paid by Medicare. Congress also established a Physician Payment Review Commission (PPRC) to advise it on reforms of the methods used to pay physicians for services to Medicare beneficiaries.

Despite legislative changes, Medicare's basic payment system remained relatively unchanged. Payments have been made, subject to certain limitations, for each service rendered. Many analysts have suggested that both individual prices and the unit

of payment (i.e., the individual service) are inflationary and permit certain price distortions. With respect to the pricing system itself, analysts have cited the wide variations that exist by geographic region in physicians fees; they also note that while there is no uniform policy, physicians in different specialties may receive different payments for the same service. The system has also been criticized for the fact that while a high price may initially be justified for a new procedure, prices do not generally decline over time even when the procedure becomes part of the usual pattern of care. Further, it has been suggested that the differentials between recognized charges for physicians visits and similar services versus those for surgical and procedural services may be in excess of those justified by the resources used.

Increases in the price per service is only one component of overall price increases. The other major component is increases in **volume**. This service growth may reflect a number of factors. It can represent a *greater intensity of care* provided per enrollee, i.e., using a greater number of services and/or using more costly treatment modes. It may also reflect *unbundling*, i.e., billing separately for services previously consolidated into a larger payment unit. Further, it may reflect *upcoding*, i.e., describing a service by a procedure code with a higher allowable charge (e.g., a "brief visit" may become an "intermediate visit"). While some increase in volume may be appropriate, it has been argued that the current system provides no incentive to use alternative less costly treatment patterns. Previous efforts to control Medicare spending focused on controlling prices for individual services, not volume.

Initial Development of Relative Value Scale (RVS)

For several years, Congress and the Administration explored a number of options for reforming the physician payment mechanism under Medicare. The approach selected is that which bases physician payments on a relative value scale (RVS). An RVS is intended to establish "fairer" relative prices for individual services, thereby lessening the financial incentives that may inappropriately influence physician decisions. A relative value scale is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index number or weight. If one service has an assigned value of 1.2 and a second service has an assigned value of 2.4, the second service is considered to have twice the value of the first. An RVS scale is **not** a fee schedule. It is converted to fee schedule by use of a "conversion factor" or multiplier. For example, if the conversion factor is $10, a service with an RVS value of 2.4 would be priced at $24. The conversion factor is selected so as to achieve a particular level of total physician spending.

Hsiao Report. In 1986, legislation was enacted that required the Secretary, with the advice of the newly established PPRC to develop a RVS. As the first step, HHS entered into a cooperative agreement with the Harvard School of Public Health to develop a resource-based RVS (RBRVS). William Hsiao was the principle investigator, and the American Medical Association (AMA) was a subcontractor. With the assistance of the AMA and 30 specialty societies, 100 physicians were appointed to technical consulting groups. The "**Hsiao report**," representing Phase I of the study, was released in September 1988.

1989 PPRC Report. The 1989 PPRC report contained a package of recommended physician payment reforms. The first key recommendation was for the establishment of a Medicare fee schedule based on an RVS. The recommendations for an RVS built on those contained in the Hsiao report, though a number of modifications were suggested. The PPRC shared the concern of others, including the Administration, that the use of an RVS approach by itself would not control physician expenditures. This is because an RVS alone does not include limitations on the volume of services. PPRC therefore recommended use of a national expenditure target (ET). If total physician expenditures in a year exceeded the ET, a reduction would be made in the conversion factor in the subsequent year. The PPRC plan also included several additional policies to slow increases in expenditures. These included increased Federal support for building knowledge of effectiveness and appropriateness of medical practices and development and dissemination of practice guidelines.

Development of OBRA 1989 Provisions. Many groups supported the basic outlines of the RVS portion of the PPRC proposal. However, a number of conceptual and methodological issues were raised regarding the actual construct of the fee schedule. For example, one concern was the appropriate way to reflect in the fee schedule geographic variations in practice costs. However, the most controversial aspect of the PPRC proposal was that calling for an expenditure target. As noted, PPRC viewed the target as a means to control overall expenditures. It was characterized as a means of encouraging the physician community to respond with practice guidelines and other mechanisms to encourage appropriate delivery patterns. Further, proponents of the ET approach stated an overall Medicare spending limit was needed given the uncertainty surrounding what changes in volume and mix of services might occur with implementation of an RVS. Opponents of the expenditure target approach saw it solely as a means of limiting Medicare expenditures. They suggested that a target level set in this fashion might not fully cover those costs that they feel are reasonable and necessary to meet the elderly's health care needs. Some contended that physicians might respond to these economic incentives by rationing care, i.e., by limiting, postponing, or restricting access to care. OBRA 1989 provides for use of volume performance standards rather than expenditure targets.

OBRA 1989

Overview

On Dec. 19, 1989, the President signed into law P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This measure provides for the establishment of a new payment system for physicians' services paid for by Medicare. Payments are to be made under a fee schedule. The schedule will apply to all physicians service including diagnostic tests and X-ray services furnished in connection with physicians services. It will not apply to clinical diagnostic laboratory tests and other items and services the Secretary may chose to exclude.

The legislation also provides for the establishment of annual volume performance standards. The relationship of actual expenditures to the volume performance

standards is one factor which will be considered by Congress in determining the annual update for the fee schedule.

Fee Schedule. The fee schedule amount for a service is equal to the product of: (1) the relative value for the service; (2) the conversion factor for the year; and (3) the geographic adjustment factor for the service for the fee schedule area. The relative value for a procedure is made up of three components: a work component, practice expense component and a malpractice component. The proportions that each component consists of the total relative value varies by service based on a weighted-average of specialty specific practice expense and malpractice data. The conversion factor is expected to be set by the Congress. (See update discussion below.)

The geographic adjustment factor is intended to account for cost differentials in various areas. Geographic adjustments are to be made to the practice expense and malpractice components and 1/4 of the work component. Together the practice expense and malpractice components represent about 46% of the average fee while the work component represents about 54%. Thus, about 60% of the fee will be adjusted. Current prevailing charge localities are retained; they are the basis for the adjustment.

Medicare payments will equal 80% of the fee schedule amount with beneficiaries responsible for the 20% coinsurance. The fee schedule amount for nonparticipating physicians equals 95% of such amount for participating physicians. A 10% bonus is added to payments for services provided in health manpower shortage areas.

Phase-In. The fee schedule is phased in over the 1992-96 period. Prior to this time, certain transition policies are implemented. Payments are reduced for certain services, so-called "overvalued procedures", which have been identified as being overpriced. The list of overvalued procedures is substantially expanded in 1990. The legislation also requires publication of a model fee schedule in 1990.

Limits on Beneficiary Liability. New limits on actual charges of non-participating physicians are phased in beginning in 1991. For 1993 and subsequent years the limiting charge is 115% of the recognized payment amount for non-participating physicians for the year.

Volume Performance Standards/Update. Each year a **volume performance standard** rate of growth is established for physicians services under Medicare; services included in the standard are all physicians services, other items and services commonly furnished in physicians offices such as clinical diagnostic laboratory tests, or services commonly performed by physicians. The law specifies the factors that must be included in the calculation of the standard for FY1990; these include inflation, growth in the beneficiary population, historical changes in the volume and intensity of services; and a performance standard. In subsequent years, the Secretary is to recommend a standard to Congress, and the PPRC is to comment on such recommendation. Generally, Congress is expected to specify the standard. In the absence of congressional action, the default performance standard for FY1991 and subsequent years is similar to the one established for FY1990.

Each year (beginning in 1991), the Secretary is required to recommend to Congress, the **update to the conversion factor** that will apply for the following

year. In making the recommendation, the Secretary is required to consider inflation, growth in the beneficiary population, growth in actual expenditures in the previous fiscal year compared to the performance standard for that year; and changes in volume and intensity of services. PPRC is required to comment on the recommendation. Congress is generally expected to specify the update. In the absence of congressional action a uniform update is to be applied for all services. The update is equal to the MEI increased or decreased by the percentage difference between the increase in actual expenditures and the performance standard for the second preceding fiscal year. However, the law specifies a lower limit on this default update.

The following sections provide a detailed explanation of the new law.

Fee Schedule

Establishment of Fee Schedule. The Secretary is required to establish a fee schedule before January 1 of each year (beginning in 1992), which establishes payment amounts for all physicians services furnished in all fee schedule areas for the year. **The fee schedule amount for a service is equal to the product of (1) the relative value for the service; (2) the conversion factor for the year and (3) the geographic adjustment factor for the service for the fee schedule area.**

Phase-In. The law provides for a transition to the fee schedule over the 1992-1996 period. If the adjusted historical payment basis is less than 15% over or under the fee schedule amount, payment is to be made on the basis of the fee schedule beginning in 1992. The adjusted historical payment basis is defined as the weighted average prevailing charge applied in the locality in 1991, adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations. The historical payment basis is determined without regard to physician specialty.

A transition is provided in the case of differences larger than 15% over or under the fee schedule. In 1992, the adjusted historical payment basis amounts are increased or decreased by 15% of the fee schedule amount, whichever is appropriate. For 1993-95, payment is based on a blended amount. In 1993, 75% is based on the previous year's amount adjusted by the update factor specified for the fee schedule for that year and 25% is based on the fee schedule amount for the year. The percentage attributable to the previous year's fee is reduced to 67% in 1994 and 50% in 1995. All fees are paid on the basis of the fee schedule beginning in 1996.

Determination of Relative Values for Physicians Services. The relative value for each service has three components:

- **Work Component**: the portion of the resources used that reflects physician time and intensity including activities before and after patient contact. For surgical procedures the term is to reflect a global definition including pre- and post-operative services.
- **Practice Expense Component**: the portion of the resources used in furnishing the service that reflects the general categories of practice expenses, such as office rent and wages of personnel. The term includes all expenses, excluding malpractice expenses, physician compensation, and physician fringe benefits.

- **Malpractice Component:** the portion of resources used reflecting malpractice expenses.

The Secretary is to develop a method for combining the relative values determined for each component for each service in order to produce a single relative value for the service. Where specific data are not available, the Secretary may use extrapolation and other techniques to determine relative values. The Secretary is to consider the recommendations of the PPRC and physician organizations when determining relative values this way.

The Secretary is required to update the relative values at least every five years to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is to publish an explanation of the basis for any adjustments. Any adjustments for a year may not cause expenditures to differ by more than $20 million from what would otherwise have been expended. The Secretary is required to consult with the PPRC and physician organizations in making these adjustments.

Calculation of Relative Value Units for Components. The proportion that the work, practice expense, and malpractice components represent of the total relative value varies between services. These proportions are based on a weighted average of specialty-specific practice expense and malpractice data. The weights reflect the proportion of each procedure provided by each specialty to Medicare patients. The following is an explanation of how this calculation is made.

The Secretary is required to determine the number of relative value units for each component. The number of work relative value units is based on the relative resources used reflecting physician time and intensity. The number of practice expense relative value units is the product of:

- the base allowed charges for the service (national average allowed charges for the service in 1991), and
- the practice expense percentage for the service.

Similarly, the number of malpractice value units is equal to the product of the base allowed charges for the service and the malpractice percentage for the service.

The Secretary is required to determine a work percentage, a practice expense percentage, and a malpractice percentage as follows.

- First, determine the average percentage of each service or class of services performed nationwide by physicians in each specialty.
- Second, for each service or class of service, determine the average percentage division of resources among each of the three components which are used by physicians in each specialty. The percentages are to be based on national data that describe the elements of physician practice costs and revenues by physician specialty. Extrapolation may be used when adequate data are not available.
- Third, determine the work percentage for the service which is the sum (for all physician specialties) of the average percentage for the work component for each physician specialty multiplied by the proportion of such service (or services) performed by physicians in that specialty. A similar calculation is made for the practice expense percentage and the malpractice percentage.

These percentages may be recomputed from time to time.

Specialties. The Secretary may not vary the number of relative value units or the conversion factor for a service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

Radiology and Anesthesiology Services. The Secretary is required to base relative values for radiology services on the relative value scale developed pursuant to the OBRA 1987 fee schedule with appropriate modifications to assure that relative values are consistent with those established for similar or related services. For anesthesia services, the Secretary is to use, to the extent practicable, the relative value guide required by OBRA 1987, with appropriate adjustment of the conversion factor to assure that the fee schedule amount for anesthesia services are consistent with fee schedule amounts for other comparable services. The Secretary is to adjust the conversion factor by geographic adjustment factors in the same manner such adjustments are made for other services. The Secretary is to consult with the PPRC and physician organizations in making these calculations.

Coding. The Secretary is required to establish a uniform coding system for all physicians. The Secretary is to provide for an appropriate coding structure for visits and consultations. However, the use of time may not be incorporated in the coding for such services until after Jan. 1, 1993. The Secretary is required to consult with the PPRC and physician organizations in establishing the coding system.

Conversion Factor. As noted above, physician fees under the fee schedule equal the product of the relative value for the service, the conversion factor, and the geographic adjustment factor for the service for the area. The conversion factor for each year is the previous year's conversion factor adjusted by the **update** for the year involved. For purposes of 1992 only, the conversion factor used for the calculation is that which if it had applied in 1991 would have been budget neutral. During the last 15 days of October 1991, the Secretary is required to publish the conversion factor and update for 1992. The Secretary is required to publish the applicable update during the last 15 days of October in each succeeding year.

By April 15 each year (beginning in 1991), the Secretary is required to report recommendations to the Congress on the appropriate update (or updates) in the conversion factor (or factors) for all physicians services for the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. The Secretary is required to consider the following in making the recommendations:

- the increase in the MEI for the year;
- the percentage change in actual physician expenditures in the preceding fiscal year;
- this percentage change in expenditures compared to the volume performance standard for the fiscal year;
- changes in volume and intensity of services;
- access to services; and
- other factors that may contribute to changes in volume or access.

For the 1992 recommendation, the Secretary is required to make a separate calculation for surgical services of the increase in expenditures and a comparison of such increase to the volume performance standard.

The Secretary may also consider unexpected changes by physicians in response to implementation of the fee schedule, unexpected changes in outlay projections, changes in quality or appropriateness of care and other relevant factors not reflected in the resource-based payment methodology.

The Secretary's required annual update report is to include the update recommended for each category of physicians services. A category of services is defined as surgical services, all other physicians services other than surgical services, and such other category or categories as the Secretary may from time to time define. The report is also to include the recommended update for each of the following groups of services: nonsurgical services, visits, consultations and emergency room services. The report is also to include the rationale for the recommended update for each of these categories and the underlying data and analyses for the recommendations.

The Secretary is required to include in the annual update report a budget neutral adjustment which is a statement of the percentage by which actual expenditures in the previous fiscal year differed from projected expenditures. Projected expenditures for that year are defined as the previous year's actual expenditures (1) increased by the weighted average percentage increase permitted for physicians services in the fiscal year, (2) adjusted to reflect population changes, (3) adjusted to reflect volume and intensity changes over the five fiscal-year period ending in the previous fiscal year, and (4) adjusted to reflect changes in laws or regulations.

PPRC review and recommendations are required by May 15 each year.

Congress is generally expected to specify the update. In the absence of Congressional action, a **uniform default update** is to be applied for all services. This update is equal to the Secretary's estimate of the MEI increased or decreased by the percentage difference between the increase in actual expenditures and the volume performance standard for the second previous fiscal year. The law specifies a lower limit on this default update. It is the MEI minus 2 percentage points in 1992 and 1993, MEI minus 2 1/2 percentage points in 1994 and 1995, and MEI minus 3 percentage points in subsequent years.

Geographic Adjustment Factor. As noted, physician fees under the fee schedule equal the product of the relative value for the service, the conversion factor, and the geographic adjustment factor for the service for the area. The Secretary is required to establish a geographic adjustment factor for all physicians services for each fee schedule area. This geographic adjustment factor is equal to the *sum* of the following:

- **Geographic Cost of Practice Adjustment Factor**. This is the *product* of:
  - the proportion of total relative value units for the service reflecting the practice expense component, and
  - the geographic cost-of practice index value for the area for the service. This index reflects the relative costs of the mix of goods and services comprising practice expenses in the different fee schedule areas compared to the national average. The Secretary may establish class-specific indices if the application of a single index would be substantially inequitable.

- **Geographic Malpractice Adjustment Factor**. This is the *product* of:
  - the proportion of total relative value units for the service reflecting the malpractice component, and
  - the geographic malpractice index value for the area. This index reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average.
- **Geographic Physician Work Adjustment Factor**. This is the *product* of:
  - the proportion of total relative value units for the service reflecting the work component, and
  - the geographic physician work index value for the area. This index reflects *1/4 of the difference* between the relative value of physicians work effort in each of the different fee schedule areas compared to the national average.

Medicare Volume Performance Standard Rates of Increase

In General. The law provides for the establishment of volume performance standard rate of increase beginning for FY1990. The Secretary is required to publish the FY1990 performance standard by Jan. 1, 1990. The law provides that the standard for FY1990 is the sum, reduced by 1/2 percent, of the Secretary's estimate of (a) the weighted average percentage increase in reasonable charges for physicians services in 1989 and 1990; (b) percentage change in Part B enrollees; (c) average annual percentage growth in volume and intensity of services for FY1985 - FY1989; and (d) percentage change in physician expenditures from FY1989 -FY1990 (not taken into account in (a)) resulting from changes in laws or regulations.

By April 15 of each year (beginning in 1990) the Secretary is required to recommend for the upcoming fiscal year an overall performance standard and separate standards for the categories of surgical services and such other categories of services the Secretary may establish by regulation. In making recommendations, the Secretary is required to confer with physician groups. The Secretary is to consider inflation, changes in the number of Part B enrollees, changes in the age composition of enrollees, changes in technology, evidence of inappropriate utilization of services, evidence of lack of access to necessary physicians services, and such other factors as the Secretary considers appropriate. PPRC is required to review the Secretary's recommendation and submit its recommendation to Congress by May 15. The Secretary must publish the performance standard during the last 15 days of October.

Default Volume Performance Standard. Generally, the Congress is expected to specify the performance standard. In the absence of Congressional action, the default standard for FY1991 and subsequent fiscal years is similar to the one established for FY1990. This performance standard is the *sum* of the:

- Secretary's estimate of the weighted average percentage increase in fees for physicians services in the calendar years included in the fiscal year involved;
- Secretary's estimate of the percentage change in Part B enrollees;
- Secretary's estimate of the average annual percentage growth in volume and intensity of services for the five fiscal year period ending with the preceding fiscal year;

- Secretary's estimate of the percentage change in physician expenditures in the fiscal year (not taken into account above) which will result from changes in laws or regulations; and
- the *performance standard factor*. This factor is *minus* one percentage point in FY1991, *minus* 1 1/2 percentage point in FY1992, and *minus* 2 percentage points for subsequent years.

The Secretary is required to establish procedures for reporting on a quarterly basis to PPRC, CBO, CRS, Committees on Ways and Means, Energy and Commerce, and Finance, on compliance with performance standards.

Group Specific Standards. The Secretary may establish separate group specific performance standards. However this may not be done before submission of the required Secretary's report on this issue (due July 1, 1990) nor before Oct. 1, 1991. Subsequently, the Secretary shall implement a plan under which qualified physicians groups could annually elect separate performance standard rates. The Secretary is required to develop criteria to determine which physician groups are eligible to elect to have separate performance rates applied and the methods by which such group specific rates would be accomplished. The Secretary is required to report on criteria and methods by Apr. 15, 1991. PPRC review and comments are required by May 15, 1991. Before implementing such standards, the Secretary is required to provide for notice in the Federal Register and to consult with physician groups. However, the plan may not be implemented unless specifically approved by Congress.

Limitation on Beneficiary Liability

Current law establishes limits, known as MAAC limits, on extra-billing charges by nonparticipating physicians. (See current law description.) MAAC limits are physician specific and are based on historical charging patterns. Beginning in 1991, new limits are phased in. These limiting charges are set at a maximum percentage above the recognized payment amount (i.e. prevailing charge in 1991 and fee schedule amount in future years) for nonparticipating physicians. Recognized payment amounts for nonparticipating physicians are 95% of such amounts for participating physicians. The limiting charges are therefore a percentage of this reduced amount.

In 1991, a physicians limiting charge is the same percentage (not to exceed 25%) above the 1991 recognized payment amount as their 1990 MAAC was above the 1990 recognized payment amount. This is referred to as the 125% limit. For 1992, a physicians limiting charge is the same percentage (not to exceed 20%) above the 1992 payment amount as their 1991 limiting charge was above the 1991 recognized payment amount. This is referred to as the 120% limit. For 1993, and subsequent years, the limiting charge for all physicians is 115% of the recognized payment amount for nonparticipating physicians for the year.

The law specifies that physicians are required, effective Apr. 1, 1990, to accept assignment on all claims for persons who are dually eligible for Medicare and Medicaid. This includes "qualified Medicare beneficiaries" (i.e. persons with incomes below poverty for whom Medicaid is required to pay Medicare premiums and cost-sharing charges.)

Other Provisions

Sending Information to Physicians. Before the beginning of each year (beginning for 1992), the Secretary is required to send to each physician furnishing Part B services information for commonly performed services on fee schedule amounts for participating and nonparticipating physicians in the area and information on the applicable limiting charge.

Physician Submission of Claims. Effective Sept. 1, 1990, physicians, suppliers, and other Part B providers are required to submit all claims, including nonassigned claims, on a standard claim form on behalf of beneficiaries. Further, claims are to be submitted within one year of the date of service.

Electronic Billing. The Secretary is required to encourage electronic billing and direct deposit of payments for participating physicians. The Secretary is required to submit a plan to Congress on these requirements by May 1, 1990.

Monitoring. The Secretary is required to monitor actual charges of nonparticipating physicians after Jan. 1, 1991. Further, the Secretary is to monitor changes (by specialty, type of service, and geographic area) in the proportion of services provided by participating physicians, the proportion of services paid on assignment, and the amounts charged above recognized payment amounts. The Secretary is required to report by April 15 each year (beginning in 1992) to Congress on such changes. If the Secretary finds that there has been a significant reduction in participation or assignment rates or an increase in balance billing charges, he is required to develop a plan to address the problem and submit recommendations to the Congress. The PPRC is required to review any such plan and submit its comments and recommendations to Congress.

The Secretary is also required to monitor: (1) changes in utilization and access within geographic, population and service related categories; (2) possible sources of inappropriate utilization which contribute to the overall expenditure level; and (3) factors underlying these changes and their interrelationship. The Secretary is required to report to Congress by April 15 (beginning in 1991) on utilization changes including an examination of factors which may contribute to such changes. The Secretary is to include recommendations concerning patterns of inappropriate utilization, utilization review, physician education or patient education, problems of beneficiary access to care identified in the monitoring process, and on such other matters the Secretary deems appropriate. The PPRC is required to comment on the Secretary's recommendations. In developing its recommendations, PPRC is to convene and consult a panel of physician experts to evaluate implications of medical utilization patterns on quality and access.

Carriers are required to monitor and profile physician billing patterns and provide comparative data to physicians whose utilization patterns differ significantly from other physicians in the same payment locality.

Studies. The legislation requires the following studies:

- GAO Study of Alternative Payment Methodology for Malpractice Component (due Apr. 1, 1991). Requires examination of alternative ways of paying for malpractice expenses (including no fault and mandatory arbitration).
- DHHS Study of Payments to Risk-Contracting Plans (due Apr. 1, 1990). Requires an examination of how physician payment reform will affect payments to risk-contracting plans.
- DHHS Study of Volume Performance Standard Rates of Increase by Geography, Specialty, and Type of Service (due July 1, 1990). Requires a study of the feasibility of establishing separate volume performance standards by geographic area, specialty, type of service, or combinations of these. Also required is a study of services included in or excluded from volume performance standards.
- DHHS Visit Code Modification Study (due July 1, 1991). Requires a study of the desirability of including time as a factor in visit codes.
- PPRC Study of Practice Expenses (due July 1, 1991). Requires a study of extent to which practice expenses and malpractice costs vary by geographic locality, extent to which available indices accurately reflect costs in rural areas, which geographic units would be most appropriate in measuring and adjusting these costs, appropriate methods for allocating malpractice expenses to particular procedures, the effect of alternative methods of allocating malpractice expenses on Medicare expenditures, and special circumstances of rural independent laboratories.
- PPRC of Geographic Payment Areas (due July 1, 1991). Requires a study of the appropriateness of using Metropolitan Statistical Areas or other payment areas for purposes of physician payment.
- PPRC Study of Payment for Non-Physician Providers of Medicare Services (due July 1, 1991). Requires study of the implications of using a resource-based fee schedule for non-physician practitioners (such as physician assistants, clinical psychologists, and nurse midwives) whose services can be billed on a fee-for-service basis under Medicare.
- PPRC Study of Physician Fees Under Medicaid (due July 1, 1991). Requires a study of Medicaid physician fees to determine adequacy, physician participation, and beneficiary access to care.
- GAO Study of Beneficiary Anti-Trust Issues (due July 1, 1991). Requires a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers. Also, the study is to address anti-trust issues as they relate to adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases.

Medical Care Outcomes and Effectiveness Research. OBRA 1989 creates a new agency, the Agency for Health Care Policy and Research under the Public Health Service Act. One function of this agency is to coordinate and expand the outcomes and effectiveness research program. This program promotes research with respect to patient outcomes for selected medical treatments and surgical procedures for purposes of assessing their appropriateness, necessity, and effectiveness.

OBRA 1989 Implementation

OBRA 1989 required DHHS to set the volume performance standard (VPS) rate of increase for 1990 using the formula discussed above. The Department set the level at 9.1% for FY1990. The law also required the Secretary to recommend a rate of increase in the level for future years. For FY1991, DHHS recommended a VPS rate of increase of 8.7% for surgery, 10.5% for nonsurgical services, and 9.9 percent for all services together. In its required comments on the DHHS recommendation, the PPRC recommended a slightly larger FY1991 increase. Specifically it recommended an overall increase of 11.2%, with a 9.3% increase for surgical services and 12.1% for nonsurgical services. The overall figures compare to a projected rate of increase of 13.2%. The reduction proposed by the Commission is less than that proposed by DHHS primarily due to a lower allowance by the Department for growth in the volume and intensity of services. The PPRC feels that it may not be realistic for the medical profession to meet the DHHS level. The recommendations are currently under review by the Congress which is expected to set the FY1991 VPS rate of increase. (Otherwise the default standard would kick in, as described above.)

Potential Impact

The PPRC 1990 annual report to Congress provides an estimate of the impact of OBRA 1989 on physicians and beneficiaries. PPRC simulations suggest that if the fee schedule had been in effect in 1989, payments for primary care services would have been 30% higher, while payments for surgical procedures generally would have been lower. Overall payments for medical specialists (internists and family practitioners) would have increased by 20%. Overall, payments to surgical specialists would have decreased by 11%, though payments for some specialties, such as ophthalmologists and thoracic surgeons, would decrease by a substantially larger amount. The substantial variation in the magnitude of the change for different surgical specialists partly reflects the difference in the mix of services they provide.

The PPRC simulations also show that with a 115% balance billing limit, beneficiary balance billing charges would decrease by 75%. Sixty-eight percent of beneficiaries would receive a reduction in the amount they spend for coinsurance and balance bills, while another 21% would have increases of no more than $10 per year.

The PPRC assumed no change in physician behavior, either in the mix of services or percentage of services provided on assignment. However, a change in physician behavior could modify these results, though the type of change is difficult to predict. Some suggest that there may be a shift from surgeries/procedures to evaluation and management services. Others suggest that while there may not be a reduction in the volume of surgeries, there may be an increase in the number of visits as surgeons attempt to offset lost revenues. There is also the possibility that physicians could alter their assignment policy. Previous experience with policies designed to limit Medicare expenditures per service have shown that physicians have responded by increasing volume to offset lost revenues. However, there is little experience with policies designed to realign the price structure as well as stem price increases.

Over time, implementation of volume performance standards will have the effect of stemming increases in Medicare expenditures. One goal of the VPS system is to encourage physicians to be more cost conscious in their provision of services. A number of specialty societies are developing practice guidelines to assist physicians in this effort.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. House. Committee of Conference. Omnibus Budget Reconciliation Act of 1989; conference report to accompany H.R. 3299. Nov. 21, 1989. Washington, U.S. Govt. Print. Off., 1989. (101st Congress, 1st session. H.Rept. no. 101-386)

FOR ADDITIONAL READING

Physician Payment Review Commission. Annual Report to Congress, 1990.

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[EXCERPT]

PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

MEDICARE PROSPECTIVE PAYMENT AND THE AMERICAN HEALTH CARE SYSTEM

REPORT TO THE CONGRESS

JUNE 1989

Executive Summary

The delivery and financing of health care services in the United States are undergoing significant changes. Medical advances, the growth of services outside the hospital, and attempts to control health care spending continue to affect health care delivery. Maintaining access to quality care at a cost the country can afford is still a major challenge facing the American health care system.

The Medicare prospective payment system (PPS), implemented in 1983, contributed to changing the health care system. The complex and poorly understood interactions between payment policy and service delivery frequently make it impossible to identify causal relationships. Therefore, five years after the introduction of PPS, many questions concerning its impact remain unanswered.

In this report, the Prospective Payment Assessment Commission (ProPAC) describes and comments on the major changes in the American health care system. The Commission especially wishes to note the following findings.

- The growth of total health care expenditures for the nation has not slowed despite the cost containment efforts of the government and the private sector. While Medicare inpatient hospital expenditure growth has declined since PPS, primarily because of dramatic declines in hospital admissions, Medicare admissions appear to be increasing again. Spending for non-inpatient hospital services, however, has grown continuously and rapidly. Other payers have experienced similar patterns.

- The recent declines in overall hospital financial status appear to be leveling off. Total margins reported by the American Hospital Association (AHA) averaged 4.8 percent in 1988, compared with 4.7 percent in 1987. PPS operating margins, however, are projected to continue declining through the sixth year of PPS. There continues to be wide variation in PPS operating margins across hospitals, and the number of hospitals with negative PPS margins is growing.

- Growth in hospital capital costs has stabilized at a rate lower than that of the past decade. While the industry has become increasingly capital-intensive in the 1980s, capital's share of total costs has recently leveled off. In 1988, capital costs grew at the same rate as total costs; capital accounts for 8.5 percent of total costs.

- Again this year, ProPAC has identified no systemic problems associated with quality of care. Studies of hospital readmissions and transfers and of targeted population groups at special risk do not indicate the existence of quality problems. There is evidence of substantial growth in the number of specialized procedures. Greater concentration of these procedures, in general, would be desirable in view of the finding that concentration promotes both better health outcomes and lower costs. However, ProPAC's study of concentration of services indicated that there has been little consolidation of procedures in high-volume centers.

- Rural hospitals, which make up almost half of all of the hospitals in the United States, have fared poorly under PPS. Because PPS is a per-case payment system, the most serious problem facing rural hospitals is the declining rate of admissions; total admissions have decreased almost 5 percent annually, on average, since 1981. Although recent policy changes have helped, a high and growing proportion of rural hospitals have negative PPS margins.

- A re-examination of traditional approaches to the financing of care is needed. The Commission believes that the challenges facing the American health care system may require a new set of organizational and financing arrangements. The traditional definition of hospitals and the requirements placed on these institutions should be re-examined.

HOSPITAL PERFORMANCE

The implementation of PPS represented a major change in the way hospitals were paid for a large portion of their inpatient admissions. Hospitals could make a profit or lose money treating individual Medicare patients.

Financial pressures on hospitals are also related to the slow growth of total revenue, especially inpatient revenue, primarily because of decreased admissions and length of stay (LOS) for all age groups. At the same time, Medicare and other payers have restricted the growth of per-case payments.

Some cost reduction efforts have taken place, such as the reduction of LOS, movement of services to other settings, and group purchasing of supplies. Other factors continue to increase costs. Hospitals have added information systems and associated personnel to analyze costs and market new services to deal with PPS and the so-called competitive environment. Additional costs have also been incurred to expand medical records, quality assurance, and discharge planning activities.

While hospital labor productivity improved in the early years of PPS, it has recently declined despite continued incentives to reduce costs. During 1984 and 1985, total labor hours per discharge decreased due to reductions in services per discharge, or intensity. Intensity declines resulted primarily from reductions in LOS. Since 1985, intensity levels have not changed, while labor hours per service have increased. This has resulted in increases in total labor hours per discharge and a productivity level roughly equal to the level in 1983.

Although capital costs are a larger percentage of total costs than before PPS, growth in capital costs has slowed in recent years. In 1988, capital costs grew at the same rate as total costs. This was the first year since 1980 that capital expenses did not grow relative to total costs. Medicare capital payment policy continues to provide incentives for some hospitals to favor capital over operating expenses, even if it is not the most efficient mix of resources. It also encourages hospitals to turn over capital assets earlier.

Hospitals have also pursued strategies to increase or replace revenues. Most hospitals turned to outpatient services, such as ambulatory surgery and special diagnostic clinics. The number of exempt psychiatric and rehabilitation units has also grown rapidly since PPS was implemented. While some of these activities were designed to reduce inpatient costs, others created new opportunities to provide services to patients who might otherwise have foregone care.

Studies of concentration of services and marketing strategies conducted by ProPAC point to another revenue increasing strategy: the addition of new, usually technology-intensive services to enhance competitive position and attract physicians and patients. Some hospitals have dropped unprofitable services, but many more have added services they perceive necessary to increase revenues.

Since the implementation of PPS, hospital efforts to reduce costs and generate revenue interacted with Medicare and other third-party payment to produce a rapid increase in margins initially, which was followed by a decline in margins. During the first year of PPS, hospitals engaged in extensive cost containment activities. As a result, a relatively small increase in costs per case occurred in 1984. Revenue per case increased 50 percent faster than costs, resulting in historically high margins.

During the next three years, hospitals did not control costs to the same degree as they did in the first year of PPS. It is possible that cost reductions with the greatest impact were made in the first year or that higher margins removed some of the cost-saving incentives. Over the same period, growth in revenues per case was much slower than in 1984. Consequently, margins declined over these three years. In 1988, costs per case rose at the slowest rate since 1984, and revenue per case rose at about the same rate. Total hospital margins in 1988 remained at the same level as in 1987. It appears that uncertainty about revenues and declining margins may again be affecting the growth of costs per case.

Data from the AHA show that the hospital industry as a whole had a patient margin of about zero and a total margin of just under 5 percent in 1988. In addition, the PPS margin is estimated to

have been approximately zero. These aggregate statistics fail to show the variability of hospital financial performance, however. For example, 10 percent of hospitals had PPS margins of −24 percent or lower in the fourth year of PPS, while another 10 percent had margins of 18 percent or higher. This variation, while not fully understood, is in part due to changes in Medicare and other third-party payment practices that allow hospitals to realize a profit or risk a loss.

Admission and LOS decreases have exacerbated the problem of overcapacity in the industry, and hospitals have been slow to reduce unused capacity. In 1986, average occupancy was at its lowest in ten years (63.4 percent). By 1988, the occupancy rate had increased only slightly, to 64.5 percent.

While the total number of hospital closures has increased during the past few years, many hospitals have opened or converted to other uses. As a result, the total number of hospital beds has not been reduced substantially. Hospitals that closed tended to be smaller and have both lower occupancy rates and higher costs than open hospitals of comparable size. Over time, more hospital closures have occurred in rural areas. Admission declines began in rural hospitals in 1981 but did not begin in urban hospitals until 1984. Since 1984, admissions have fallen much more rapidly for rural than for urban hospitals. PPS may have influenced the pattern of admissions. Urban hospitals, eager to increase admissions and revenue, have tried marketing their services to physicians and patients in rural areas. Moreover, physicians seeking to provide the latest technology to their patients may send them to rural referral centers or urban hospitals.

QUALITY AND ACCESS

The recent declining financial performance of many hospitals and the increasing number of hospital closures are raising new questions about the quality of and access to health care services. Individual occurrences of quality of care problems continue to be reported as they were before PPS. In some cases, these problems could be attributed to PPS incentives, but they may also be due to many other factors. The Commission has not found evidence of systematic quality problems with inpatient care since the implementation of PPS. The use of ambulatory and other alternative sites to substitute for part or all of a hospital inpatient stay and the inadequate quality measures in these sites, however, have raised new concerns.

The Commission is aware that the ability to define, identify, and measure quality is not well developed, and it is important to consider many aspects of this issue. The increased use of outpatient settings and alternative sites like ambulatory surgery centers and rehabilitation units may be appropriate and consistent with PPS incentives. Measurement and monitoring systems are not as extensive for these services, however. Consequently, it is difficult to draw conclusions about how quality might have changed given the movement of services out of the traditional inpatient setting. Improvements in the quality assurance mechanisms used in these sites are necessary.

Changes in readmission and transfer rates and patterns could indicate quality problems. Results of a ProPAC analysis of this subject do not provide any evidence that should cause concern. Rates of readmission and transfer from 1984 to 1986 have not changed substantially from the pre-PPS period. The pattern of transfers and readmissions appears to be appropriate. Patients are transferred from smaller rural and urban hospitals to larger urban ones, as might be expected. If patients are readmitted, they are generally readmitted to a larger hospital.

It also appears that access to services involving new technologies has not been reduced. In fact, while PPS was expected to prompt hospitals to specialize in certain services, this has not happened. ProPAC's study of concentration of services shows that the volume of services has increased across-the-board, without the consolidation of procedures in a few high-volume facilities. This suggests that access has not been impeded. As volumes increase, costs are lowered and mortality decreases. This means that cost and quality might be improved if more concentration occurred.

In addition to the analyses described above, ProPAC has studied groups particularly at risk of lower quality care related to the incentives of PPS. No problems were identified in this study. The work of the Peer Review Organizations (PROs) has been examined; a low percentage of cases screened

out by the PROs actually have quality of care problems.

Concern about access to care in rural areas has grown as the number of rural hospital closures has increased. Developing an appropriate policy to deal with rural hospitals presents special problems. Attracting and retaining physicians, nurses, and other hospital staff in rural areas is difficult. In some areas, distances between facilities require the availability of sophisticated equipment even though patient volumes do not cover expenses; even a minimum level of capacity entails large expenses. Admissions of all patients, not just Medicare patients, have been declining faster in rural than in urban hospitals. This is a particularly serious problem because PPS is a case-based payment system; declines in admissions lead directly to decreased revenues. Maintaining access to care for Medicare beneficiaries is a concern. ProPAC has supported several mechanisms for providing increased payments to rural hospitals under PPS. Increasing payment for the care furnished to Medicare patients, however, will not by itself solve the problems of all rural hospitals.

Finally, efforts to evaluate the appropriateness and effectiveness of care have recently been initiated by a variety of organizations. The goal of these new efforts is to develop practice standards or guidelines. Too often procedures and treatments have been adopted without vigorous testing to identify the patients and situations most likely to benefit from the new practices. This new information should allow providers to determine which course of treatment will be most beneficial for their patients. The development and use of such guidelines should represent a major improvement in quality of care.

SPENDING ON HEALTH CARE

The United States spends over $500 billion a year and an increasing portion of its gross national product (GNP) on health care. In 1987, more than 11 percent of GNP was spent on health care. Health care expenditures in 1989 are expected to reach $600 billion, and by the mid-1990s are likely to represent more than 12 percent of GNP. On a per capita basis, the U.S. spends more than any other country, 41 percent more than Canada, which spends the next greatest amount. The reasons for the higher rates of spending in the U.S. are uncertain. In addition, whether Americans are receiving value commensurate with the greater spending levels is unclear.

Reimbursement changes and cost control efforts have apparently reallocated health care spending rather than slowed its growth. While Medicare inpatient expenditures slowed after 1983 due to decreases in admissions and constraints on payment, outpatient and physician costs have been growing at about 16 percent annually. Although the decreases in LOS can be attributed to the incentives of PPS, the decreases in admissions cannot. Private payers have reported similar growth in non-inpatient expenses. The growth rate in private spending for health care was greater in 1986 and 1987 than the growth in government spending. The percentage of health care spending paid by private sources has grown from 59.8 percent in 1985 to 60.4 percent in 1987.

Congress has recently begun to deal with Medicare non-inpatient hospital expenditures. It has legislated a number of changes in outpatient payment policy that limit reimbursement for some of these services. The Physician Payment Review Commission (PPRC) recently proposed a fundamental change in the way Medicare pays physicians. PPRC is recommending a relative value scale as part of a national fee schedule and expenditure targets.

In addition, Congress has expressed interest in changing the system of paying for hospital outpatient services. As a first step toward this goal, payment for hospital ambulatory surgery has been changed. Congress has asked ProPAC to provide its views on this subject to the Secretary of the Department of Health and Human Services. ProPAC's report on ambulatory surgery was submitted on April 1, 1989.

The Medicare program and some other third-party payers have been constraining hospital reimbursement to encourage efficiency and limit the cost of treatment. Many hospitals contend, however, that they are unable to provide high-quality services for all patients at current payment levels.

To ensure that all patient care and other expenses are covered, hospitals try to make up for

perceived shortfalls in revenues from some payers by maximizing payments from others. This behavior is usually called "cost shifting." The Commission believes that "revenue shifting" is a more appropriate term because it focuses on hospital behavior aimed at obtaining revenues adequate to cover total expenses. Those hospitals experiencing losses under PPS, for example, may attempt to recoup them through other revenue sources. Hospitals earning profits from one payer, however, may use surpluses to maintain lower prices to other payers. Thus, hospitals may shift revenues to government payers from private payers and vice versa.

The Commission believes that more research is necessary to determine the costs of providing an efficient level of care and the reasons for variations in costs. Better understanding of the relationship between costs and revenues becomes even more critical as larger variations in hospital financial performance emerge. Such information is necessary for both payers and hospitals to ensure that hospital revenues from all sources appropriately reflect hospital expenses associated with efficient provision of care.

The Medicare program provides 40 percent of hospital inpatient revenues; no other individual payer controls nearly this amount of hospital payments. Hospitals do not have the opportunity to negotiate prices with Medicare as they do with some other payers. The legislative process is used to set Medicare prices. It is appropriate that the Federal government continue to establish tight limits on what it pays hospitals for Medicare patients. The Commission believes, however, that the government should take into consideration the overall financial circumstances of hospitals. This is especially true as the traditional mechanisms for financing uncompensated care and other activities are being limited.

Despite continued constraints on PPS rates, various factors will probably increase the growth of Medicare expenditures. After several years of decreases in admissions for those over age 65, admissions for this group grew by almost 2 percent in 1988; this growth rate is almost equal to the growth of the beneficiary population. Furthermore, Medicare costs per case grew 10 percent annually through 1987.

An aging and expanding beneficiary population will also require greater resources from all Medicare programs. Over the next 30 years, the over 65 population, especially those over 85, is projected to grow faster than the rest of the population. This older population will have many more chronic diseases, requiring a variety of medical and other services.

The continued growth in health spending also affects beneficiaries' liabilities. Of the $150 billion spent on health care for the elderly in 1986, 25 percent was paid for by the elderly themselves or by their families. Medicare paid about 45 percent of the costs, while Medicaid paid 20 percent and private sources paid for the remaining 10 percent. The largest out-of-pocket expense for the elderly was nursing home care. The elderly paid 50 percent of nursing home costs, or $16 billion a year.

The substitution of services for all or part of a hospital admission influences the amount beneficiaries must pay for health care. While substituting ambulatory surgery for an inpatient stay reduces beneficiary liability in many cases, skilled nursing care or rehabilitation services following an inpatient stay probably increase out-of-pocket costs.

THE HEALTH CARE SYSTEM IN 1990 AND BEYOND

The health care system in the United States continues to adopt many remarkable scientific and medical advances. At the same time, however, the public has voiced concern about increasing costs and dissatisfaction with the existing system. The present organization and financing of the health care system have failed to fulfill society's expectations. Improving the system, given the demands that will be placed on it, is the challenge of the future.

The forces that have contributed to increased medical spending will continue. New medical capabilities will become available, new sites of service will be developed, and people will be living longer and require more care. Dealing with these forces while limiting the growth of health care spending will be difficult.

When the present system of health insurance was established, health care was provided primarily by hospitals and physicians. Medicare was patterned after these existing private insurance plans. Over time, the health care system has evolved to include home health care, freestanding ambulatory surgery centers, and specialized outpatient clinics. Health insurance plans, including Medicare, have changed incrementally to take these new providers into account. As the government and private insurers have seen expenditures increase for all types of care, they have instituted financing changes that limit reimbursement to the cost of care for their beneficiaries.

These cost containment efforts and incremental changes, while dealing with specific issues, highlight important deficiencies in the present system that need to be addressed. First, although the United States spends more money per capita than any other developed country, 15 percent of the population, or approximately 37 million people, lack health insurance and thus have limited access to health care. Other issues include who should pay and how to pay for medical education and clinical research and what funding levels are sufficient for these activities. In addition, present policies do not adequately recognize changes in health care delivery. The incentives of current policies are often conflicting or inappropriate. Finally, increases in health care expenditures have not been slowed by the approaches that have been tried so far.

Given the inadequacies of the current system, it is time to consider alternative organizational and financial arrangements in this country. These efforts should include an examination of the role of the hospital and other providers in the delivery of health care. The structure of health care benefits, including Medicare, also should be reviewed.

Difficult decisions have to be made that will shape the health care system of the 1990s and beyond. The Federal government, as a major payer of health care services, will play a vital role. It has been suggested that limited increases in Medicare and Medicaid budgets will restrict access to care for the elderly, the poor, and those in rural areas. Questions concerning access will have to be balanced with economic considerations. Public policy debate on this and other issues related to the health care system is essential and should include a discussion of the role of the government, other third-party payers, and the general public. This debate should help identify solutions that will provide everyone with quality care at a cost that the public views as acceptable.

Medicare Incentives to Go Low-Tech

New Fee Scale Would Reward Doctors for 'Hands-On' Medicine

By Spencer Rich
Washington Post Staff Writer

Today, a doctor treating a Medicare patient can use all the costly high-tech machines he wants for diagnosis and treatment, charge his customary fee, and, within limits, the government will pay the bill, even if it is markedly different from the fee being paid to a colleague down the hall treating the same illness.

That is now changing. Under legislation passed by Congress in the final hours of the session that ended early yesterday, the government would impose a uniform national fee scale setting the payments doctors receive and would provide incentives for doctors who practice "hands-on" medicine that does not rely on expensive technology. These would be two of the biggest changes ever imposed by the government on the practice of medicine in this country.

One major goal of the changes is to help solve the national problem of soaring health-care costs. Medicare outlays to doctors have been increasing at 16 percent to 17 percent annually for a decade, triple the typical consumer price index.

"This is the first major change in the way physicians are paid since they stopped accepting chickens and pigs in payment," said Rep. Fortney H. "Pete" Stark (D-Calif.), one of the lawmakers behind the overhaul of the nation's biggest health insurance system.

"It will make reimbursement to physicians far more fair and workable," said Sen. John D. "Jay" Rockefeller IV (D-W.Va.). The overhaul will shift rewards to "tough primary diagnostic care" instead of "high-tech," said Sen. Dave Durenberger (R-Minn.).

Under the measure, included in the budget-reconciliation bill that President Bush is expected to sign:

■ Medicare would create a uniform national fee scale for each of 7,000 different types of doctor services, so that with minor regional variations every doctor will receive the same fee for any specific service. A major benefit would be to reward doctors in rural areas more highly than now so that they would be less likely to move out and leave the area with no doctor.

SEN. DAVE DURENBERGER
. . . would reward "primary" care

■ The fee for any given service would not be based on reimbursement rules that tend to reward high technology and surgery at rates that many experts consider excessive. Instead, fees would be based on a new "relative value scale" measuring how much time, effort, physical labor, overhead and the like go into providing a given service.

This scale, under development, would reward surgery and high-tech doctoring relatively less well than now and family practice or hands-on medicine more.

A recent study by the government's Physician Payment Review Commission found that under one version of the new scale, internal medicine generally would go up 17 percent and family practice up 38 percent, but surgery would would drop 11 percent.

■ Congress each year would specify an aggregate amount that it wants to spend on outlays for Medicare doctor services in the coming year, taking into account population growth, increases in the costs of supplies and devices that doctors must buy and similar factors. If the amount subsequently paid in that year exceeded the target, Congress could retard the growth of Medicare fes in the next year to make up for part of the excess.

Paul Ginsburg, director of the Physician Payment Review Commission, said he expects that government goals would eventually be met as doctors, aware of Medicare priorities, began acting through their professional organizations to try to hold down unnecessary costs—primarily through development of practice codes and medical effectiveness research.

At the urging Rep. Bill Gradison (R-Ohio), the measure contains funding for studies on the effectiveness of different treatment strategies.

■ In a provision to be phased in by 1993, doctors would be forbidden to charge a Medicare patient more than 15 percent over the amount allowed by Medicare for a specific service. This would place a cap on "balance billing," instances where the doctor charges the patient more than Medicare will help pay and the patient is forced to pay the extra amount out of pocket.

The changes constitute a major step by Congress toward bringing Medicare outlays under control. There were clear signals during bargaining on the bill, which the American Medical Association has endorsed, that tougher steps will be considered down the road if the new program doesn't work. They could include flat annual outlay targets with mandatory fee cuts large enough to recapture the amount by which actual outlays exceeded the target.

"Health-care costs are out of control—for the family and, obviously, for the family that's uninsured," said Rockefeller, chairman of the Senate Finance Committee's Medicare subcommittee. "Health-care costs have spread fear in the American people."

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Health Care Access: Federal Policy Issues IP 421H

There has been increasing public and congressional concern over access to health care in the United States. Health care costs continue to rise while an estimated 37 million Americans under age 65 are uninsured. Developments in health care services, such as new hospital reimbursement policies which make it more difficult to shift the costs of the uninsured and the large percentage of poor not covered by Medicaid, have led to recent reports by private organizations calling for reexamination of the Nation's health care delivery system.

This Info Pack contains background material on the current health care delivery system and recent proposals for change. Also included are articles on the systems of health care in Great Britain and Canada, which are often proposed as models for this country. In addition, the enclosed CRS reports discuss current Congressional proposals to expand health care coverage to certain populations.

Other Info Packs on related topics are: "Catastrophic Health Insurance" (IP 370C), "Health Care Costs" (IP 223H), "Health Insurance: Employer Benefits Required Under COBRA and Pending Proposals" (IP 389H), and "Health: Long-Term Care" (IP 402H).

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Health Insurance," "Medical Economics," and "Medicare and Medicaid" and in the latest *Update* under "Health."

Constituents may find additional information on this topic in a local library through the use of *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), and various newspaper indexes. Books on this subject may be identified through the library's catalog or the most recent edition of *Subject Guide to Books in Print.*

We hope this information will be helpful.

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89-682 L

CRS Report for Congress

Access to Health Care: Selected References, 1988-1989

Charles P. Dove
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Library Services Division

December 1989

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ACCESS TO HEALTH CARE: SELECTED REFERENCES, 1988-1989

SUMMARY

This bibliography contains references from the Public Policy Literature Data Base of the Library of Congress. The focus of the selected references is on the accessibility of all Americans to adequate medical care regardless of the individual ability to pay. The groups that require improved access include the homeless, the aged, children, and minorities. In addressing the issue of access the material included in this bibliography discuss private health insurance, national health insurance, patient dumping, indigent care, and closing of hospitals.

ACCESS TO HEALTH CARE: SELECTED REFERENCES, 1988-1989

Access to medical care for Black and white Americans. JAMA [Journal of the American Medical Association], v. 261, Jan. 13, 1989: 278-281. LRS89-2506

"A 1986 national survey of use of health services shows a significant deficit in access to health care among black compared with white Americans. This gap was experienced by all income levels of black Americans. In addition, the study points to significant underuse by blacks of needed medical care."

Battistella, Roger M. Weil, Thomas P.
National health insurance reconsidered: dilemmas and opportunities. Hospital & health services administration, v. 34, summer 1989: 139-165. LRS89-3500

"The authors conclude that government intervention in the health sector is bound to expand rather than contract because centralization is the key to reconciling otherwise divergent political demands for spending controls and greater equality of access to quality care for the increasing number of uninsured or underinsured persons."

Bishirjian, Terry.
Rural health care in the 1990s: decade of decision and change. Appalachia, v. 22, spring 1989: 31-37. LRS89-5321

Addresses the challenges facing Appalachian health care in the near future: costs, competitiveness, accessibility, affordable insurance, skilled medical professionals, geographical barriers.

Cancer and the poor: a report to the nation; findings of regional hearings conducted by American Cancer Society. Atlanta, American Cancer Society [1989] 33, 52 p. LRS89-6564

Reports findings from May-June 1989 hearings in Georgia, Mississippi, New Jersey, Missouri, Texas, California, and Arizona in which people from 47 States and territories testified about high mortality rates and access to health care for poor persons who develop cancer.

Cleeton, David L.

The medical uninsured. Public finance quarterly, v. 17, Jan. 1989: 55-83. LRS89-743

Argues "that the present design of public asistance programs creates a market failure by ruling out limited ceiling coverage for individuals who consider public assistance programs to provide at least partial coverage against losses. This is particularly relevant to the state Medicaid needy programs and their spend-down provisions."

Cost and effects of extending health insurance coverage. Washington, G.P.O., 1989. 176 p. LRS89-3043

At head of title: Committee print.

"Education and Labor serial no. 100-EE; Energy and Commerce serial no. 100-CC; Special Committee on Aging serial no. 100-P"

"Prepared for the Subcommittee on Labor-Management Relations and the Subcommittee on Labor Standards of the Committee on Education and Labor and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives and the Special Committee on Aging, United States Senate by the Congressional Research Service, Library of Congress."

Crisis in the U.S. Health Care System: how should government and industry respond? Washington, MAPI, 1989. 31 p. (MAPI policy review PR-108) LRS89-6548

"Examines the current U.S. system of health care delivery and its problems. The mandated benefit proposal, as contained in S. 768, is then reviewed, and finally, alternative approaches to improving access to health care without further escalation of costs are discussed."

Davis, James E.

National initiatives for care of the medically needy. JAMA [Journal of the American Medical Association], v. 259, June 3, 1988: 3171-3173. LRS88-4839

"The provision of medical care to the underserved, the underprivileged, and the financially needy is a compelling concern of medicine, perhaps the most perplexing problem that confronts the medical profession today."

Duncan, R. Paul.

Inpatient transfers and uncompensated care. Hospital and health services administration, v. 33, summer 1988: 237-248. LRS88-5073

Differentiates between "the concepts of patient transfer and dumping and presents an empirical examination of a sample of inpatient transfers including descriptions of patient, hospital, episode, and compensation characteristics."

Enfield, Lisa M.

Patient dumping in the hospital emergency department: renewed interest in an old problem. American journal of law & medicine, v. 13, no. 4, 1988: 561-595. LRS88-14978

"We conclude that the currently proposed solutions to patient dumping will have limited effectiveness without more specific incentives for the provision of health care to the medically indigent."

Estes, Carroll L.

Aging, health, and social policy: crisis and crossroads. Journal of aging & social policy, v. 1, 1989: 17-32. LRS89-7783

"In the 1980s, significant and growing problems of uninsurance and underinsurance for health care have re-emerged. Simultaneously, state Medicaid programs are characterized by their increasing variation and inequities, while there has been a decline in access for the poor. The future of aging policy will be decided in the context of four socio-demographic realities: (1) population aging (2) trends in mortality and morbidity (3) the relationship between income and health, and (4) aging as a woman's issue."

Friedman, Emily.

Are risk pools being oversold as a solution? Hospitals, v. 62, Nov. 5, 1988: 100-104. LRS88-10248

Charts characteristics of current State health insurance risk pools. Assesses finance and feasibility of State plans to provide health insurance coverage to those unable to get access to other health insurance. Includes a report on public opinion of hospital responsibility for the care of the uninsured by Jane Edgar of the Arthur D. Little, inc.

Ginzberg, Eli.

Medical care for the poor: no magic bullets. JAMA [Journal of the American Medical Association], v. 259, June 10, 1988: 3309-3311. LRS88-5163

"The thrust of my analysis has been to highlight the inherent limitations in a nonegalitarian society of continental proportions to establishing a single acceptable level of care for all its population and the inability to achieve this goal by passing more laws and appropriating more money, although some new laws and more money are definitely needed."

Goodman, John C. Robbins, Gary. Robbins, Aldona.
Mandating health insurance. Dallas, National Center for Policy Analysis, 1989. 21, 14 p. LRS89-1542

Argues against proposals for mandated health insurance and concludes that "it would be far less expensive to subsidize unpaid hospital bills from public funds. And close inspection of the market for health insurance reveals that existing government regulation is a major cause of the rising number of people without health insurance. Before enacting new regulations, we should first repeal old ones and give market forces a chance to work."

Haislmaier, Edmund F.
The health care quagmire. Consumers' research, v. 72, Sept. 1989: 10-16. LRS89-7745

"There is a growing concern in America that the nation's health care system needs intensive care. The most obvious problems are the rapid escalation in the cost of medical care and, in part as a result of such high costs, the fact that many Americans effectively are denied access to necessary medical treatment."

Minimum Health Benefits Act: mandating new problems. Washington, Heritage Foundation, 1988. 15 p. (Issue bulletin no. 136) LRS88-3154

"There is a real danger, however, that this [minimum health benefits] legislation would do more harm than good. While these proposals might help some workers and employers, they still would leave many Americans unprotected and, at the same time, would destroy jobs and drive health care spending and costs even higher, to the detriment of all Americans and the U.S. economy."

Hansen, Karen.
A painful prescription. State legislatures, v. 14, Nov.-Dec. 1988: 20-21. LRS88-12431

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Health insurance and the uninsured: background data and analysis. Washington, G.P.O., 1988. 172 p. LRS88-14353

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"Education and Labor serial no. 100-Z; Energy and Commerce serial no. 100-X; Special Committee on Aging serial no. 100-1"

"Prepared for the Subcommittee on Labor-Management Relations and the Subcommittee on Labor Standards of the Committee on Education and Labor and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives and the Special Committee on the Aging, United States Senate by the Congressional Research Service, Library of Congress."

Healthy children: investing in the future. Washington, Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1988. 301 p. LRS88-5975

Partial contents.--Children's access to health care.--Prevention of childhood illness: selected topics.--Prenatal care.--Newborn screening.--Wellchild care.--Prevention of accidental childhood injuries.--Prevention of child maltreatment.

Hegarty, Stephen H. Kinzer, David M.

Mandated coverage: Massachusetts' ordeal. Hospitals, v. 62, July 20, 1988: 66-73. LRS88-6519

"A Massachusetts law, signed in April 1988, provides health coverage to all of that state's uninsured citizens. The law is a U.S. 'first' in the sense that it promises coverage to all citizens, regardless of their employment status. The law, which will not be fully phased in until 1992, is a complex one that not only addresses the uninsured issue but also redesigns a regulatory system that for some years has made the state's hospitals--voluntary and governmental--subject to overall revenue controls."

Hospital closures and access to medical care. Lexington, Ky., Council of State Governments, 1989. 11 p. (CSG backgrounder 078901) LRS89-7029

"There is much debate concerning the economics of our nation's health care system, and whether these hospital closings are the result of unfair regulation practices, the health industry's own glut, or poor fiscal management. The purpose of this paper is not to argue these points, but to address the occurrence of hospital closings as a concern for state and local officials who must deal with the consequences as they affect public access to medical care."

Inequities in health services among insured Americans: do working-age adults have less access to medical care than the elderly? New England journal of medicine, v. 318, June 9, 1988: 1507-1512. LRS88-5075

Concludes "that insured, working-age adults have less access to medical care than the elderly, and that poor, black, or Hispanic persons in this group are at risk for even greater problems with access to care."

Insuring the uninsured: options and analysis. Washington, G.P.O., 1988. 212 p. LRS88-14354

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"Prepared for the Subcommittee on Labor-Management Relations and the Subcommittee on Labor Standards of the Committee on Education and Labor and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives and the Special Committee on Aging, United States Senate by the Congressional Research Service, Library of Congress.

Jackson, Jesse L.

A prescription for America's health. State government news, v. 31, Dec. 1988: 6-8. LRS88-11806

Urges a national health program to support health care as a constitutional right. "A federally administered program is the only way to ensure adequate funding in poorer areas and to prevent regressive state governments from blocking access to care."

Koska, Mary T.

Alternate care: indigent care and overcrowding threaten EDs (emergency departments). Hospitals, v. 63, July 20, 1989: 66, 68, 70. LRS89-5934

Presents evidence that for a growing number of hospital emergency departments, "the constant flow of indigent patients and increasing instances of overcrowding," are straining the acute health care system.

Main, Karen.

1988 report on the medically indigent. Frankfort, Ky., Legislative Research Commission, 1988. 96 p. (Research report no. 236) LRS88-12401

Reports on Kentucky's problems involving "the uninsured and people whose insurance is insufficient for any reason, including exhausted benefits, exclusions on allowable procedures or types of care and pre-existing conditions." Includes reports on trends in other States' Medicaid programs for 1986 and 1987.

Man, Anthony.
Rural health care: closed hospitals only part of problem. Illinois issues, v. 15, May 1989: 12-15. LRS89-3490
"As the most visible symptoms of the ailments plaguing rural health in Illinois, hospital closings will continue to get lots of attention--the kind that spurs political and government activity."

Mueller, Keith J.
The role of policy analysis in agenda setting: applications to the problem of indigent health care in the United States. Policy studies journal, v. 16, spring 1988: 441-453. LRS88-6004
"This discussion of the shaping of policies concerning indigent health care is a call for more research concerning the shaping of state policies using the agenda setting approach to explain the roles played by various actors in shaping legislative suggestions. This approach can also explain the difficulty experienced in moving from general knowledge of a problem to actual policies."

Orr, Suezanne Tangerose. Charney, Evan. Straus, John.
Use of health services by Black children according to payment mechanism. Medical care, v. 26, Oct. 1988: 939-947. LRS88-11089
"The use patterns of approximately 2,600 black children, categorized according to type of insurance (Medicaid, private health insurance or no insurance), were analyzed. All children were enrolled in an urban pediatric primary care program that attempted to increase access to health care by poor children. Medicaid recipients used health-care services more than their counterparts who had private or no insurance. All groups received significant levels of preventive care."

Patricelli, Robert E.
Statement of the U.S. Chamber of Commerce on problems in access to affordable health insurance for small business. Washington, U.S. Chamber of Commerce, 1989. 7 p. LRS89-9164
Addresses the problem of rising costs of health care plans in the small business market.

Pincus, Carol R.
How your colleagues care for the uninsured. Medical economics, v. 65, Aug. 1, 1988: 60-65. LRS88-6439
A nationwide survey of doctors indicates that the uninsured can make up 15% of a physician's practice and in some depressed areas the numbers can be as high as 55%. Doctors cope by making special payment arrangements, offering credit, and referring patients to clinics. Some doctors require cash payments from uninsured patients.

Rosenbaum, Sara. Hughes, Dana C. Johnson, Kay.
Maternal and child health services for medically indigent children and pregnant women. Medical care, v. 26, Apr. 1988: 315-332. LRS88-2435

"Millions of low-income children and women of childbearing age are completely uninsured. Medicaid, the nation's largest public health financing program for the poor, is an inadequate resource for uninsured families with children. By 1984, the program served only 46% of the poor and near-poor, down from 65% in 1976."

Russell, Louise B.
Proposed: a comprehensive health care system for the poor. Brookings review, v. 7, summer 1989: 13-20. LRS89-5107

Outlines a program that would make health care available to the poor, even those not now covered by Medicaid.

Sager, Alan.
Prices of equitable access: the new Massachusetts health insurance law. Hastings center report, v. 18, June-July 1988: 21-25. LRS88-5805

"Massachusetts's new health insurance law has been shaped by much more than presidential politics. Ten years of evolving policy on health insurance and hospital finance have exerted powerful influences. Ironically, enacting universal access required paying hospitals much more money for their currently insured patients. This costly compromise may destabilize the law's implementation."

Thorpe, Kenneth E. Siegel, Joanna E. Dailey, Theresa.
Including the poor: the fiscal impacts of medicaid expansion. JAMA [Journal of the American Medical Association], v. 261, Feb. 17, 1989: 1003-1007. LRS89-1801

"We estimate that expanding Medicaid coverage to all currently uninsured nonelderly persons below the federal poverty line would cost approximately $9 billion."

U.S. Congress. House. Committee on Education and Labor.
Subcommittee on Labor-Management Relations.
Oversight hearing on access to health insurance. Hearing, 100th Congress, 2nd session. June 9, 1988. Washington, G.P.O., 1988. 367 p. LRS88-12396

"Serial no. 100-94"

U.S. Congress. House. Committee on Energy and Commerce.
Subcommittee on Health and the Environment.
Health insurance coverage and reform. Hearing, 101st Congress, 1st session. Mar. 9, 1989. Washington, G.P.O., 1989. 137 p.

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Minimum health benefits for all workers. Hearings, 100th Congress, 2nd session on H.R. 2508. Apr. 14 and 15, 1988. Washington, G.P.O., 1988. 345 p. LRS88-12106

"Serial no. 100-174"

Includes discussion of the impact of the proposed bill on employers and businesses.

U.S. Congress. House. Committee on Government Operations. Human Resources and Intergovernmental Relations Subcommittee.
Equal access to health care: patient dumping. Hearing, 100th Congress, 1st session. July 22, 1987. Washington, G.P.O., 1988. 463 p. LRS88-1973

U.S. General Accounting Office.
Health insurance: a profile of the uninsured in Ohio and the nation; report to the Honorable Howard M. Metzenbaum, U.S. Senate. Aug. 30, 1988. Washington, G.A.O., 1988. 66 p. LRS88-8683

"GAO/HRD-88-83, B-232117"

"Data compiled annually by the Bureau of the Census to identify characteristics of the uninsured and changes in the uninsured population since 1982."

Health insurance: an overview of the working uninsured; report to the chairman, Committee on Finance, U.S. Senate. Feb. 24, 1989. Washington, G.A.O., 1989. 54 p. LRS89-1515

"GAO/HRD-89-45, B-230452"

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Long-term care for the elderly: issues of need, access, and cost; report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. Nov. 28, 1988. Washington, G.A.O., 1988. 54 p. LRS88-14243

"GAO/HRD-89-4, B-226097"

Provides information on "(1) the number of elderly estimated to need long-term care now and in the next century, (2) the types of available long-term care services and access to them, and (3) public and private expenditures to finance and deliver long-term care."

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CRS Issue Brief

Medicaid: FY90 Budget and Child Health Initiatives

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by
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Medicaid: FY90 Budget and Child Health Initiatives

SUMMARY

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance to approximately 25 million low income persons who are aged, blind, disabled, or members of families with children. The Federal share of program expenditures for Medicaid is from general revenues. It is expected that the Federal share for FY89 will total $34 billion while the Federal share for FY90 is projected to reach over $37 billion. Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. The Federal share of expenditures for Medicaid services is tied to a formula inversely related to the square of a State's per capita income. For FY90, the Federal matching percentages range from 50% to 80.18%. Federal matching for State program administration is generally at 50%. However, current law provides higher matching rates for certain activities, such as operation of data systems and health care quality monitoring.

The Bush Administration's FY90 budget proposal included proposals for modest expansions of Medicaid services for pregnant women and children. The Federal share in the cost of these initiatives would be offset by a reduction in Federal contributions to State administrative costs. The FY90 budget resolution approved by the Congress provided a $200 million increase in Federal Medicaid funding over FY89 law levels, and permitted further expansions if offsetting savings could be found in other programs. The 101st Congress is considering a variety of Medicaid changes, including expansion of community services for the frail elderly and the developmentally disabled. However, options for improving coverage for low-income mothers and children are receiving the greatest attention, because of concerns about the Nation's infant mortality rate and the problem of access to care for children without health insurance coverage. H.R. 3299, the Omnibus Budget Reconciliation Act of 1989, was enacted by Congress Nov. 22, 1989 and is currently awaiting presidential action. The Act includes expansion of eligibility for pregnant women and infants, and increases the availability of providers for them.

Many proposals in the 101st Congress focus on Medicaid eligibility. They would permit or mandate coverage of individuals at higher income levels and would remove other barriers to coverage, such as assets tests, and delays in eligibility determination. Other bills address issues beyond basic eligibility for benefits. There are proposals to increase provider participation in Medicaid, to improve coordination between Medicaid and other programs, and to provide outreach, education, and social services to pregnant women and children. Some of these proposals would also expand another major Federal health program targeted at mothers and children, the Maternal and Child Health Block Grant program.

ISSUE DEFINITION

Medicaid is a Federal-State matching program providing medical assistance to approximately 25 million low income persons in FY89, at an expected total Federal cost of $34.5 billion. The FY90 budget resolution approved by the Congress provided for a $200 million increase in Federal Medicaid funding over FY89 law levels, and permitted further expansions if offsetting savings could be found in other programs. H.R. 3299, the budget reconciliation agreement recently enacted by the Congress but not yet presented for presidential action, extended Medicaid eligibility to larger numbers of pregnant women and children and took other measures to improve access to prenatal and early childhood health care.

BACKGROUND AND ANALYSIS

Description of Medicaid

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance to a projected 25 million low income persons in FY89. FY90 program expenditures are expected to reach $67 billion, of which the Federal share will be $38 billion. Although Federal funds account for 56% of total program expenditures, each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. Thus, there is considerable variation among the States in terms of eligibility requirements, range of services offered, limitations placed on those services, and reimbursement policies.

Every State except Arizona participates in the Medicaid program, as do the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. (Arizona currently provides federally funded medical assistance through a demonstration program that has received waivers of certain Medicaid requirements.) At the State level, Medicaid is administered by a designated single State agency. Federal oversight of the Medicaid program is the responsibility of the Health Care Financing Administration (HCFA) within DHHS.

The Federal share of expenditures for Medicaid services is tied to a formula inversely related to the square of a State's per capita income. For FY90, the Federal matching percentages range from 50% to 80.18%. The matching rate for administrative costs is generally 50% for all States. Higher matching, at levels ranging from 75% to 90%, is available for certain management and control activities. The remaining costs of the program are paid by the State; in some States local governments may also contribute.

Eligibility

Eligibility for Medicaid benefits has traditionally been linked to actual or potential receipt of cash assistance under either of two programs: Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI) for the aged, blind, and disabled. Recently States have been given the option to extend

Medicaid to other low-income groups. Coverage of some of these new populations was made mandatory by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). Although H.R. 3607 repealed the Medicare provisions of the Act, Medicaid provisions were left intact.

All States must cover the **categorically needy**. These include all persons receiving AFDC and, in most States, persons receiving SSI. States have the option of limiting Medicaid coverage of SSI beneficiaries by using more restrictive standards for Medicaid, if those standards were in effect on Jan. 1, 1972 (before implementation of SSI). Fourteen States continue to use more restrictive standards. States must also cover as categorically needy a number of groups that are not receiving AFDC or SSI. The following are among the more important of these groups:

-- Certain persons whose family income and resources are below AFDC standards but who fail to qualify for AFDC for other reasons, such as family structure. These include pregnant women, as well as children born on or after Oct. 1, 1983, to age 7.

-- Families losing AFDC benefits as a result of increased employment income or working hours or increased child or spousal support payments. States must continue coverage for these families for various periods, depending on the reason for the loss of AFDC benefits.

-- Persons who have been receiving both Social Security and SSI benefits and who become ineligible for SSI because of increases in their Social Security payments.

-- Certain disabled people who lose SSI after returning to work but who remain disabled and who could not continue working if their Medicaid benefits were terminated.

In addition to the mandatory groups, there are several optional groups that States may elect to treat as categorically needy for Medicaid purposes. These include families with unemployed parents and "Ribicoff children" in families with income below AFDC standards; these are children whom the State is not required to cover but who are under a maximum age set by the State, which may be 18, 19, 20, or 21. States may also cover persons in institutions who meet a special institutional financial standard set by the State; this standard may not exceed 300% of the SSI payment level. Finally, States may cover disabled children who are not in an institution but who would be eligible if they were in an institution.

Thirty-nine States and other jurisdictions also provide Medicaid to the **medically needy**. These are persons whose income or resources exceed the standards for the cash assistance programs but who meet a separate medically needy financial standard established by the State and also meet the non-financial standards for categorical eligibility (such as age, disability, or being a member of a family with dependent children). The separate medically needy income standard may not exceed 133.3% of the maximum AFDC payment for a household of similar size. Persons may qualify as medically needy after their incurred medical expenses are deducted from their income or resources. This process known as "spenddown" is a frequent route to Medicaid eligibility for persons in nursing facilities.

Beginning with the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Congress has permitted States to extend Medicaid coverage to certain **target populations**, using eligibility standards which are not directly linked to those used in the cash assistance programs. The Act allowed States the option of covering pregnant women and young children and/or aged and disabled persons meeting State-established income standards as high as 100% of the Federal poverty level.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) converted the options to mandates for several of the target groups. States were required to phase in coverage of pregnant women and infants under 1 year old, and aged and disabled persons eligible for Medicare with family incomes below 100% of poverty. Coverage for the aged and disabled may be restricted to Medicare premiums and cost-sharing amounts. States may choose to cover older children with family incomes below 100% of poverty. This option permits States to cover children through age 7 beginning Oct. 1, 1990.

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) further expanded States' options by allowing coverage, beginning July 1, 1988, of pregnant women and children up to age 1 with incomes less than 185% of the Federal poverty level. The State may impose a premium for this coverage, equal to no more than 10% of the amount by which the family's income exceeds 150% of the poverty level.

H.R. 3299, as enacted by Congress, mandates coverage of pregnant women and infants with family incomes up to 133% of the Federal poverty level by Apr. 1, 1990.

Services

All States must cover a minimum set of services under Medicaid and may at their option offer additional services. The minimum service requirements differ for the categorically needy and the medically needy. For the categorically needy, the State must provide inpatient and outpatient hospital services, physician services, laboratory and x-ray, family planning, skilled nursing facility (SNF) services for those over age 21, and home health care for persons entitled to SNF care. The State must also provide early and periodic screening, diagnosis, and treatment (EPSDT), a preventive health program for persons under 21. H.R. 3299 as enacted, adds ambulatory services provided by federally qualified health centers, defined as community or migrant health centers or health care for the homeless programs. If the State covers the medically needy it must provide, at a minimum, ambulatory care for children and prenatal and delivery services for pregnant women. States may limit coverage for the mandatory services in a variety of ways. They may impose ceilings on the number of inpatient days or physician visits that will be reimbursed, require prior authorization or second surgical opinions, and deny coverage for services deemed to be experimental.

Among the additional services that States may choose to provide are prescription drugs, dental care (some dental coverage is mandatory for children under EPSDT), eyeglasses, and care in inpatient psychiatric facilities for persons under 21 or over 65. In terms of overall expenditures, the most important optional Medicaid service is care

in intermediate care facilities (ICFs). All of the States and the District of Columbia cover ICF services, and every State except Wyoming also covers services in an ICF for the mentally retarded, or ICF-MR.

Whatever services the State chooses to cover, it must offer them uniformly throughout the State and must, with minor exceptions, offer comparable coverage to all persons in the categorically needy groups. Finally, beneficiaries must generally be allowed to obtain services from any qualified provider. All three of these requirements -- statewideness, comparability, and freedom of choice -- may be waived under circumstances to be described below.

Payment for Services

States are generally free to develop their own reimbursement methodologies and levels for covered services. There are statutory guidelines for certain services, with only three rules applicable to every service type. First, providers must accept Medicaid payment as payment in full and may not seek to collect from beneficiaries. Second, Medicaid pays only after any other insurance or third party payment source available to the beneficiary has been exhausted. In particular, when beneficiaries are eligible for both Medicaid and Medicare, Medicare pays first for the services it covers. Medicaid pays what would ordinarily be the beneficiary's share (deductible or coinsurance) and covers services not available under Medicare. Finally, H.R. 3299 as enacted, requires that payments be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent they are available to the general population in a geographic area.

States use two basic payment methodologies for institutional care: retrospective and prospective. In a retrospective system, payment amounts are determined after services are rendered and are based on the actual costs incurred by the provider in furnishing those services. In a fully prospective system, payment amounts are determined in advance. The provider receives a specified rate for each defined unit of service, such as a day of care or a total hospital stay, regardless of whether the provider's actual costs are more or less than that rate. States are increasingly shifting towards prospective systems for both hospital and nursing facility care.

For services of physicians or other individual practitioners, payment amounts are usually the lesser of the provider's actual charge for the service and a maximum allowable charge established by the State. In setting these maximums, some States use methods comparable to those used by Medicare in establishing reasonable charges for physician services. Other States have developed fixed fee schedules, specifying a flat maximum payment amount for each type of service; the maximum may be unrelated to actual provider charges.

Alternative Delivery Systems

States are permitted to develop alternative ways of providing Medicaid benefits, through a variety of structured systems. Use of some of these alternatives is wholly at the State's option; others require waivers of Federal requirements approved by the Secretary.

First, States may contract with health maintenance organizations (HMOs), or other prepaid health plans for the enrollment of Medicaid beneficiaries. For each beneficiary enrolled in a plan, the State issues a fixed monthly premium payment, out of which the plan provides all covered services.

Second, States may obtain waivers to restrict the providers from whom beneficiaries may obtain services. Some States have used this option, established by Section 2175 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35, OBRA 81), to enter into selective contracting arrangements. The State may, for example, choose participating hospitals through a system of competitive negotiation. The more common use of the 2175 waiver authority is to establish primary care case management programs. Beneficiaries are required to select a single primary care provider. Except in an emergency, care from other providers must be authorized by the primary care physician.

Finally, States may obtain waivers, authorized by Section 2176 of OBRA 81, to provide home and community-based services to persons who would otherwise require continuing care in hospitals or nursing homes. The waivers allow the State to design a comprehensive package of medical and social services to allow a target population, such as the frail elderly or the mentally retarded, to remain in the community.

FY90 Budget

Each of the last four budget reconciliation acts has provided for expansions of the Medicaid program, chiefly by providing for optional or mandatory coverage of additional groups of women and children. Partly as a result of these expansions, Medicaid expenditures have recently been growing more rapidly than anticipated. In its FY88 budget, the Administration projected that Federal outlays would grow from $25 billion in FY86 to $28.2 billion in FY88, for a 2-year growth rate of about 13%. Instead, FY88 outlays rose to $30.4 billion, nearly 22% above the FY86 level. The Administration's original FY89 projections assumed further growth, under then current policy, of 6.5%. However, later projections set FY89 Federal expenditures at $34.3 billion, 12.8% above the FY88 level. Projections for FY90 under H.R. 3299, as enacted by the Congress, stand at over $37 billion.

President Reagan's FY90 budget included legislative and regulatory proposals intended to reduce Federal Medicaid outlays from a projected $37.6 billion to $36.0 billion. President Bush's revised proposal, presented to Congress on Feb. 9, 1989, retained only one of the proposed legislative changes, a reduction in Federal funds for State administrative costs. Savings would have been used to finance the Federal share of costs for expanded services to pregnant women and children. The net effect of this proposal was to maintain FY90 Federal spending at current law levels, with costs for Medicaid eligibility and service expansions to be borne by the States.

The Bipartisan Budget Agreement accepted by the President and congressional leadership in April 1989 provided for FY90 Medicaid funding at current law levels. As passed by the House, H. Con. Res. 106, the FY90 budget resolution, provided for a $200 million increase to be used to fund new initiatives in the area of infant mortality and child health, expanded community services for the frail elderly and the mentally retarded, as well as to make coverage of hospice services mandatory. As

amended by the Senate, the budget resolution provided for Medicaid funding at current law levels, with any program expansions to be funded through offsetting savings in Medicaid or other programs. The budget conference agreement followed the House provision, allowing a $200 million increase for program expansion. It also permitted further expansion if the committees of jurisdiction could achieve offsetting savings in other programs.

Both the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) estimate that the expansion provisions of H.R. 3299 as enacted by the Congress and currently awaiting presidential action, will cost $150 million in FY90. The bill contains technical amendments which CBO estimates at no cost and OMB estimates at up to $650 million. The difference is due to differences in the methods used by the two agencies to compute their baseline costs for Medicaid.

Maternal and Child Health

The last three Congresses have gradually expanded both mandatory and optional Medicaid coverage for pregnant women and children. At least two major factors have contributed to congressional interest in Medicaid expansion. The first is growing concern over the incidence of infant mortality and other unfavorable outcomes of pregnancy. The United States had an infant mortality rate in 1987 of 10.1 deaths per thousand live births, higher than that of many other major industrial nations. Rates are higher for minorities and residents of inner cities. Beyond the children who die, there are many more low birth-weight infants and others with preventable problems that are costly to treat and that can result in lifelong disabilities. There is evidence that access to prenatal and well baby care is an important factor in these outcomes.

A second source of interest in Medicaid expansion has been the growth in the number of Americans without health insurance coverage. The proportion of the population without insurance has been going up in this decade, from about 14.6% of the non-elderly in 1979 to 17.5% in 1986. In that year, 37 million persons lacked coverage; of these, 12 million were children under age 18. More than half of these children were in families with incomes below the Federal poverty level. In 1987, Medicaid covered only 53% of children in poverty. Many poor children were excluded because Medicaid maximum income standards in most States were well below the poverty level, while others were excluded on categorical grounds, such as restrictions on enrollment of two-parent families with an employed parent. Recent changes in Medicaid eligibility standards, both financial and categorical, are often spoken of as having severed the traditional link between Medicaid and the welfare programs. These changes are only beginning to be implemented, and their impact cannot yet be measured. However, they are expected to reach only a fraction of uninsured children.

The Bush Administration proposal to finance expanded coverage through a reduction in Federal matching for administrative costs was introduced as H.R. 2216/S 902. Other proposals considered in the first session of the 101st Congress provide for broader expansions affecting other Federal programs as well as Medicaid. H.R. 3299, as passed by the House, would have expanded coverage beyond the measures

adopted by the conference agreement. Medicaid expansion is facing increasing opposition from State governments. The National Governors' Association has called for a 2-year moratorium on Medicaid expansion, arguing that past expansions have strained State budgets and detracted from other priorities, such as education.

Eligibility for Pregnant Women and Children

Proposals in the 101st Congress would raise the optional or mandatory maximum income standards for pregnant women and children and would also address other potential barriers to Medicaid coverage for these groups, such as limits on allowable assets, delays in the application and eligibility determination process, and discontinuous eligibility. H.R. 3299, as enacted, raises the mandatory maximum income standards for pregnant women and children and also provides for potential increases in the numbers of health care providers available to these groups.

Income Standards

Pregnant women and infants. Before the enactment of H.R. 3299, States were required to cover pregnant women and infants under 1 year old with family incomes up to 75% of the Federal poverty level by July 1, 1989, and up to 100% of the Federal poverty level by July 1, 1990. As enacted, H.R. 3299 requires States to cover pregnant women and children up to age six in families with incomes up to 133% of the Federal poverty level by Apr. 1, 1990. States may, at their option, establish a higher maximum income standard for pregnant women and infants, up to 185% of the Federal poverty level. S. 1201 would mandate a 185% standard for pregnant women and children under age 6 by Jan. 1, 1991. S. 339 would phase in mandatory coverage of pregnant women and infants up to 185% of the poverty level by July 1, 1993. A similar provision was included in H.R. 3299 as passed by the House; however, the provision was not included in the conference agreement. H.R. 1573 would phase in mandatory coverage up to 200% of the poverty level by July 1, 1993, and would permit States to raise their standards to 200% of poverty beginning in July 1990.

Children over 1 year old. States have the option of providing Medicaid to children aged 1 through 7 who were born after Sept. 30, 1983, and whose family incomes meet a State-established standard no higher than 100% of the Federal poverty level. S. 339 would mandate coverage of children under age 18 and born after Sept. 30, 1983, with incomes up to 100% of the poverty level. H.R. 3299, as passed by the House, included the same provision; however, the provision is not included in OBRA 89. S. 949 would leave coverage optional, but would allow States to cover 8-year-olds and would raise the maximum permissible income standard for 1 through 8-year-olds to 185% of the Federal poverty level. S. 949 would also allow States to cover foster children and children in group homes through age 20 with incomes below 100% of the poverty level. H. R. 3299, as passed by the House, would have covered foster children up to age 18. S. 1201 would allow coverage of children under age 19 with family incomes below 100% of poverty. S. 1201 and H.R. 3299, as passed by the House, would require Section 209(b) States, those that do not automatically provide Medicaid to all recipients of SSI benefits, to cover all children under age 18 who are SSI-eligible.

One alternative that has been offered to expansion of Medicaid as an entitlement is a Medicaid "buy-in" program, under which individuals or families whose incomes exceed Medicaid eligibility levels could obtain coverage by paying a premium. To make the coverage affordable, the premium might be set below the actual cost of coverage, with the difference made up through a public subsidy. President Bush advanced this idea in the 1988 campaign, but the Administration has not yet offered a concrete buy-in proposal. H.R. 3299, as enacted by the Congress, provides for three-year demonstration projects to study the effect of allowing States to extend coverage to pregnant women and children under age 20 who are not otherwise eligible for Medicaid and whose family incomes are below 185% of the poverty line. The Secretary of DHHS may enter into agreements with several States to test alternatives for Medicaid extension which could be enrollment under an employer plan, a State uninsured plan, an HMO or other arrangement. Individuals or families with incomes over 100% of the poverty level must be charged premiums according to a sliding scale. Federal funding for these projects is limited to $10 million for each of the fiscal years 1990, 1991 and 1992.

Other Eligibility Standards

In establishing Medicaid eligibility for pregnant women and children, a State must determine income using the same methodology used in the State's AFDC program. States have the option of applying a resource standard (a limit on allowable family assets), but are not required to do so. H.R. 1573 and S. 339 would allow States to use an income determination methodology less restrictive than that for AFDC. These bills, along with S. 440, would forbid the use of a resource standard for mandatory coverage groups of pregnant women and children. Under H.R. 1573 and S. 440, States could continue to apply a resource standard for optional coverage groups. S. 1201 would permit a resource standard for both mandatory and optional groups, but would exclude from consideration non-liquid assets, such as automobiles or insurance policies.

Presumptive Eligibility

To insure early access to prenatal care, States have the option of establishing "presumptive eligibility" for low-income pregnant women. Qualified providers such as Federally funded clinics, may make a preliminary determination that a pregnant woman seeking treatment is potentially eligible for Medicaid. The woman may then receive ambulatory prenatal care for up to 45 days, or until the State completes an eligibility review, whichever is earlier. Even if the woman is ultimately found to be ineligible, the provider may be reimbursed for services furnished during the presumptive eligibility period. However, if the woman fails to apply for Medicaid within 14 days, presumptive eligibility ceases. As of January 1989, 20 States provided for a presumptive eligibility period.

H.R. 1573, S. 339, and S. 1201 would require all States to implement the presumptive eligibility option, and would eliminate the 45 day limit; eligibility would continue until the State had completed its review of the Medicaid application. S. 1201 would also provide 45 days of coverage even if the woman never applied for Medicaid. As passed by the House, H.R. 3299 would have left presumptive eligibility optional, but would have continued eligibility until the completion of State review. The conference agreement, however, made no changes in current law. H.R. 2216/S.

902 would mandate presumptive eligibility and would extend eligibility for 60 days even if the woman is determined ineligible before that date. S. 440 and S. 949 would allow States to establish presumptive eligibility for children, through age 17 under S. 440 and through age 20 under S. 949.

Continuation of Coverage

Since July 1, 1989, States have had the option of continuing coverage for a pregnant woman through the end of the second full month beginning after the end of the pregnancy, even if the woman would otherwise become ineligible during that period. H.R. 1573 and S. 339 would change this option to a mandate, and would also require continued coverage of infants through the first year of life. S. 440 would mandate continuation of coverage for pregnant women only, while S. 1201 would continue coverage for infants only through the first 60 days of life. S. 339, S. 440, and S. 949 would also permit, but not require, extended coverage for older children. Eligibility could be deemed to continue for 1 year from the date of the last previous determination of eligibility. H.R. 3299 as passed by the House, would have required continued eligibility when a child ceased to qualify for Medicaid on one basis (such as receipt of AFDC) until the State had determined that the child was not eligible on any other basis (such as qualifying as medically needy). S. 1201 has a similar provision applicable to AFDC and SSI recipients only. For other children, it provides that eligibility must be established for 6 month periods, with no redetermination in the middle of a period. Continuation of coverage was not addressed in H.R. 3299, as enacted by Congress.

Other Medicaid Child Health Proposals

Although congressional interest has centered on financial eligibility for medical care, there are concerns that mere extension of Medicaid coverage may not ensure that all mothers and children will receive appropriate services. Low-income people may face other barriers to access. First, not all providers of care will accept Medicaid reimbursement, largely because of low Medicaid payment rates. Second, some low-income mothers may be unaware of the availability of Medicaid benefits or may need help in applying for them. Third, there may sometimes be insufficient coordination between the Medicaid program and other medical and social services available to mothers and children. Medicaid proposals in the 101st Congress seek to address each of these problems. There are also proposals to modify Medicaid to address another child health concern, declining rates of immunization for certain diseases.

Medicaid Provider Participation

Low rates of provider participation, and especially physician participation, have been a historic problem under Medicaid. Surveys of physicians have generally found that low Medicaid reimbursement, relative to the physicians' usual charges, is an important factor in the decision to refuse Medicaid patients.

Federal regulations require that a State's Medicaid payment rates "must be sufficient to enlist enough providers so that services under the [State Medicaid] plan are available to recipients at least to the extent that those services are available to the general population." (42 CFR 447.204.) H.R. 3299 incorporates this rule in the Medicaid statute and requires DHHS to determine the adequacy of States' payment

rates for obstetrical and/or pediatric services. S. 721 focusses on the availability of obstetrical care in rural areas and would raise the Federal matching rate to 90% for pregnancy related services in rural health manpower shortage areas if the State's Medicaid rates for these services were equal to at least 80% of the rates paid by the health insurance plan offered to State employees.

As enacted by the Congress, H.R. 3299 requires States to include in their Medicaid benefit packages ambulatory services provided in federally qualified health centers and to pay these providers 100% of their reasonable costs. In addition, H.R. 3299, as enacted, requires States to pay for the services of certified pediatric and family nurse practitioners regardless of whether they are under the supervision of or associated with a physician or other provider. Finally, H.R. 3299 as enacted, permits States to pay more for obstetrical and pediatric services furnished in rural areas than for services furnished in metropolitan statistical areas.

Several bills would expand current provisions under which States are required to give special treatment to hospitals serving a disproportionate share of low-income patients. Currently, States must provide increased payment rates to such hospitals for all inpatient services, make extra payments for infants with very long stays or high costs and must waive any durational limits on covered services for infants. S. 339 and S. 1201 would extend these provisions to all children under age 18. H.R. 3299, as passed by the House, contained a similar provision; however, the provision wa s not included in the conference agreement. S. 1201 would also prohibit annual dollar limits on inpatient coverage for children under 1 year old. Finally, S. 949 would require higher payment rates to disproportionate share hospitals for outpatient as well as inpatient care.

Some providers may be deterred from accepting Medicaid patients, not just by Medicaid payment rates, but because of problems in dealing with State Medicaid agencies and delays in receiving Medicaid payment, or because of concerns about potential malpractice liability. S. 339 and S. 949 would provide grants to States for demonstration projects to test innovative ways of overcoming barriers to provider participation, such as expedited reimbursement, changes in burdensome administrative requirements, or sharing in the cost of malpractice insurance. Federal funding for the projects would be available at enhanced matching rates. S. 1201 would require States to furnish providers with assistance with billing and other paperwork.

Outreach and Application Assistance

Some mothers may be unaware of the importance of prenatal and well baby care or the availability of Medicaid to pay for that care; others may find the application process difficult. Some proposals would provide for outreach services, to locate potentially eligible mothers or families, educate them about available benefits, and/or assist in filing applications. H.R. 2216/S. 902 would require outreach activities, while S. 430 would merely permit States to claim Federal matching for such activities. There are also proposals to simplify the process of applying for Medicaid. S. 339 and H.R. 1573 would require States to process applications at sites other than welfare offices, such as hospitals or clinics. "Outstationing" of eligibility workers could be included as an optional outreach service under S. 430. H.R. 1573, and S. 1201 would also require DHHS to develop a uniform application for programs

serving children under 6, including Medicaid, the MCH block grant, Head Start, and the supplemental food program for women, infants, and children (WIC). The requirement for a uniform application form is included in the conference agreement on H.R. 3299, in amendments to the Maternal and Child Health Block Grant.

Coordination with Other Programs

Several proposals seek to improve the coordination between Medicaid and other programs, such as the supplemental food program for women, infants, and children (WIC), which is designed to prevent medical problems due to inadequate nutrition. The conference agreement on H.R. 3299 requires States to make information about WIC available to all eligible Medicaid beneficiaries. S. 949 would fund State demonstration projects to improve the coordination of Medicaid, WIC, the MCH block grant program, and other services. The Administration has proposed similar demonstrations, to be funded at $40 million over a 2-year period.

Childhood Immunizations

Overall immunization rates for children have improved in recent years as a result of requirements that children be immunized for certain diseases before entering elementary school. However, immunization rates in the pre-school population have declined for certain diseases, such as polio and diphtheria/tetanus/pertussis. The Administration's Medicaid proposal (H.R. 2216/S. 902) would require States to cover immunizations for children under age 6 who are receiving food stamps, regardless of whether these children were otherwise eligible for Medicaid. The maximum income standard for food stamps is 130% of the poverty level. With mandatory Medicaid coverage of children under age 6 up to 133% of the poverty level, H.R. 3299, enacted by the Congress, but not yet acted upon by the President, covers the children who would have been affected by the Administration proposal.

Maternal and Child Health Block Grant

In addition to proposals for changes in Medicaid, several bills would expand the current Maternal and Child Health (MCH) Block Grant program authorized by Title V of the Social Security Act. This program provides grants to States for a variety of health programs, including direct provision of preventive and primary care services to mothers and children, health screenings, immunizations, and rehabilitation services for children with special health care needs (formerly referred to as crippled children). The appropriation for FY89 was $554 million. Of this amount, approximately 84% was allocated to States; the rest was retained by DHHS to support "special projects of regional and national significance" and to conduct research, training, and genetic disease screening programs. The FY90 DHHS appropriations bill (P.L. 101-166) provides for $561 million, the maximum authorized for MCH funding at the time of its passage.

As enacted by the Congress, H.R. 3299 would substantially revamp the MCH program, while increasing the permanent authorization to $686 million. Both the Secretary and the States would be required to set goals and carry out activities consistent with the goals and objectives established under the Public Health Service Act for the year 2000. The Federal set-aside for special projects would remain at

15%, and there would be an additional 12-3/4% set-aside whenever the amount appropriated for the fiscal year is over $600 million. The bill would also tighten controls on the use of funds allotted to States while increasing the services States may provide.

The new Federal set-aside would be used for several initiatives including case management provided in the home by either professional or qualified non-professional workers; projects designed to increase the participation of obstetricians and pediatricians in both the MCH and the Medicaid programs; integrated delivery systems; rural or hospital-based MCH projects; and community-based programs including day care for children who usually receive services through inpatient care. The set-aside authorized by H.R. 3299 as enacted is 12 3/4% of the appropriated amounts that exceed $600 million.

To receive an MCH grant, States would have to submit an application containing a statewide needs assessment, a plan for meeting the needs identified in the assessment and a description of how MCH grant funds would be used to meet the needs. States would be required to use at least 30% of the funds for preventive and primary care services for pregnant women, mothers and infants up to age one, 30% for services to children and 30% for services for children with special needs. Funds for administrative expenses would be limited to 10% of the allotment. H.R. 3299 as enacted by the Congress would also require States to comply with new detailed reporting requirements related to the use of funds and the extent to which the State has met its goals and objectives and the national health objectives.

Various other provisions of H.R. 3299, as enacted, would increase access to health services. The bill provides for a maternal and child health handbook to be distributed to pregnant women and young families; a model application form that can be used to apply for several maternal and child assistance programs simultaneously; demonstration projects to provide insurance coverage to medically uninsurable children up to age 19; and a national directory which lists the toll-free telephone numbers States are required to provide for access to information.

LEGISLATION

Note: The provisions of the following bills are discussed in detail in the preceding text. The following discussion includes only provisions not discussed above.

H.R. 1573 (George Miller)

Child Investment and Security Act of 1989. In addition to provisions relating to the Medicaid, MCH, and Community and Migrant Health Center programs, the bill includes expansions of the WIC and Head Start programs. Introduced Mar. 22, 1989; referred to Committees on Energy and Commerce and Education and Labor.

H.R. 2216 (Michel)/S. 902 (Dole)

Medicaid Pregnant Women, Infants, and Children Amendments of 1989. (Administration proposal.) Funds provisions relating to expanded Medicaid eligibility and childhood immunization programs by reducing Federal matching payments for administrative costs. Matching percentages for the following activities would be

reduced to 50% on a timetable ending Sept. 30, 1994: compensation or training of skilled professional medical staff, nursing home pre-admission screening and resident review, nursing home survey and certification, contracts with utilization and quality control peer review organizations (PROs) or similar entities, and immigration status verification. The current 90% matching rate for family planning services would be retained, but the rate for administrative costs associated with those services would be reduced to 50%. H.R. 2216 introduced May 3, 1989; referred to Committee on Energy and Commerce. S. 902 introduced May 3, 1989; referred to Committee on Finance.

H.R. 2924 (Waxman)

Omnibus Budget Reconciliation Act of 1989. Energy and Commerce Committee reconciliation package; also includes Medicare amendments and Medicaid amendments unrelated to maternal and child health. Introduced July 18, 1989; incorporated in H.R. 3299 as reported by the House Budget Committee.

H.R. 3299 (Panetta)

Omnibus Budget Reconciliation Act of 1989. Clean bill reported by the House Budget Committee Sept. 20, 1989. Passed House with amendments, Oct. 5, 1989. Passed Senate with amendments Oct. 13, 1989. Conference report filed in House, Nov. 21, 1989. Both House and Senate agreed to conference report Nov. 22, 1989, however, the bill as enacted has not yet been presented for presidential action. Mandates Medicaid expansion for pregnant women and children up to age 6 with family incomes up to 133% of poverty level by Apr. 1, 1990. Codifies current regulatory requirement that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent they are available to the general population in a particular area. Requires State Medicaid programs to cover services of certified pediatric or family nurse practitioners and ambulatory services in federally qualified health centers. Requires State Medicaid plans to provide for coordination between Medicaid and WIC programs. In the Maternal and Child Health Block Grant, H.R. 3299 as enacted increases authorization of appropriations to $686 million per year; adds a new 12 3/4% set-aside to support infant mortality initiatives and community-based services for children; provides for demonstration projects to cover uninsurable children; and requires both DHHS and States to set goals consistent with health objectives for the year 2000.

S. 339 (Bradley)

Infant Mortality and Children's Health Act of 1989. Medicaid expansions for pregnant women and children. Introduced Feb. 2, 1989; referred to the Committee on Finance.

S. 430 (Daschle)

Optional Medicaid coverage of outreach services. Introduced Feb. 22, 1989; referred to Committee on Finance.

S. 440 (Biden)

Health Care for Children Act of 1989. Medicaid expansions for children aged 1 through 18. Introduced Feb. 23, 1989; referred to Committee on Finance.

S. 721 (Baucus)

Rural Obstetrical Care Access Act of 1989. Medicaid reimbursement increases. Introduced Apr. 6, 1989. Referred to Committee on Finance.

S. 949 (Riegle)

Medicaid Children's Health Improvement Act of 1989. Medicaid expansion for children aged 1 through 20. Introduced May 9, 1989; referred to Committee on Finance.

S. 1201 (Bentsen)

Maternal and Child Health Act of 1989. Medicaid and MCH expansions. In addition to general maternal and child health provisions, includes provisions for increased flexibility in providing home and community-based care to children with special needs. Introduced June 19, 1989; referred to Committee on Finance.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. House. Committees on Education and Labor, and Energy and Commerce, and the Senate Special Committee on Aging. Insuring the uninsured: options and analysis. Oct. 1988. Education and Labor Serial No. 100-DD. Energy and Commerce Serial No. 100-BB. Special Committee on Aging Serial No. 100-O. 212 p.

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and Environment. Medicaid Source Book: Background Data and Analysis. Nov. 1988. House Energy and Commerce Committee Print 100-AA. 501 p.