BRIEF SUMMARIES

of

MEDICARE & MEDICAID

Title XVIII and Title XIX of

The Social Security Act

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NOTE: The following are brief summaries of complex subjects. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (DHHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.

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Introduction

Since early in this century, health insurance coverage has been an important issue in the United States. The first coordinated efforts to establish government health insurance were initiated at the State level between 1915 and 1920. However, these efforts came to naught. Renewed interest in government health insurance surfaced at the Federal level during the 1930s, but nothing concrete resulted beyond the limited provisions in the Social Security Act that supported State activities relating to public health and health care services for mothers and children.

From the late 1930s on, most people desired some form of health insurance to provide protection against unpredictable and potentially catastrophic medical costs. The main issue was whether health insurance should be privately or publicly financed. Private health insurance, mostly group insurance financed through the employment relationship, ultimately prevailed for the great majority of the population.

Private health insurance coverage grew rapidly during World War II, as employee fringe benefits were expanded because the government limited direct wage increases. This trend continued after the war. Concurrently, numerous bills incorporating proposals for national health insurance, financed by payroll taxes, were introduced in Congress during the 1940s; however, none was ever brought to a vote.

Instead, Congress acted in 1950 to improve access to medical care for needy persons who were receiving public assistance. This action permitted, for the first time, Federal participation in the financing of State payments made directly to the providers of medical care for costs incurred by public assistance recipients.

Congress also perceived that aged individuals, like the needy, required improved access to medical care. Views differed, however, regarding the best method for achieving this goal. Pertinent legislative proposals in the 1950s and early 1960s reflected widely different approaches. When consensus proved elusive, Congress passed limited legislation in 1960, including legislation titled "Medical Assistance to the Aged," which provided medical assistance for aged persons who were less poor, yet still needed assistance with medical expenses.

After lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly, with coverage added in 1973 for certain disabled persons and certain persons with kidney disease. (The recent Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) introduced the most sweeping changes to the program since its enactment. The most significant change is that, beginning in 2006, the MMA establishes the new Medicare prescription drug benefit.) Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance.

Responsibility for administering the Medicare and Medicaid programs was entrusted to the Department of Health, Education, and Welfare—the forerunner of the current Department of Health and Human Services (DHHS). Until 1977, the Social Security Administration (SSA) managed the Medicare program, and the Social and Rehabilitation Service (SRS) managed the Medicaid program. The duties were then transferred from SSA and SRS to the newly formed Health Care Financing Administration (HCFA), renamed in 2001 to the Centers for Medicare & Medicaid Services (CMS).

National Health Care Expenditures

Historical Overview

Health spending in the United States has grown rapidly over the past few decades. From $27 billion in 1960, it grew to $888 billion in 1993, increasing at an average rate of more than 11 percent annually. This strong growth boosted health care's role in the overall economy, with health expenditures rising from 5.1 percent to 13.4 percent of the gross domestic product (GDP) between 1960 and 1993.

Between 1993 and 1999, however, strong growth trends in health care spending subsided. Over this period health spending rose at a 5-percent average annual rate to reach $1.2 trillion in 1999, and the share of GDP going to health care stabilized, with the 1999 share measured at 13.2 percent. This stabilization reflected the nexus of several factors: the movement of most workers insured for health care through employer-sponsored plans to lower-cost managed care; low general and medical-specific inflation; excess capacity among some health service providers, which boosted competition and drove down prices; and GDP growth that matched slow health spending growth.

Between 2000 and 2002, growth picked up again, increasing 7.1 percent in 2000, 8.5 percent in 2001, and 9.3 percent in 2002, reaching $1.5 trillion in 2002. Health spending as a share of GDP increased sharply from 13.3 percent in 2000 to 14.9 percent in 2002, as strong growth in health spending outpaced economy-wide growth. For the 286 million people residing in the United States, the average expenditure for health care in 2002 was $5,440 per person.

Health care is funded through a variety of private payers and public programs. Privately funded health care includes individuals' out-of-pocket expenditures, private health insurance, philanthropy, and non-patient revenues (such as revenue from gift shops and parking lots), as well as health services that are provided in industrial settings. For the years 1974-1992, these private funds paid for 57 to 60 percent of all health care costs. By 1996, however, the private share of health costs had declined to 54 percent of the country's total health care expenditures, due primarily to the falling share of out-of-pocket spending, and remained relatively stable at 54-55 percent between 1996 and 2002. The share of health care provided by public spending increased correspondingly during the 1992-1996 period, falling slightly during the period 1997-2002.

Public spending represents expenditures by Federal, State, and local governments. Of the publicly funded health care costs for the United States, each of the following accounts for a small percentage of the total: the Department of Defense health care program for military personnel, the Department of Veterans' Affairs health program, non-commercial medical research, payments for health care under Workers' Compensation programs, health programs under State-only general assistance programs, and the construction of public medical facilities. Other activities that are also publicly funded include maternal and child health services, school health programs, subsidies for public hospitals and clinics, Indian health care services, migrant health care services, substance abuse and mental health activities, and medically related vocational rehabilitation services. The largest shares of public health expenditures, however, are made by the programs run by the Centers for Medicare & Medicaid Services (CMS)—Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Together, Medicare, Medicaid, and SCHIP financed $522 billion in health care services in 2002—one-third of the country's total health care bill and almost three-fourths of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements in the provision of health care services to our nation's aged, disabled, and disadvantaged.

Projected Expenditures

The latest update of the annual projections of national health spending consists of projections from 2003 through 2013. These projections are made using National Health Expenditure (NHE) historical data through 2002, which were released by CMS in January 2004. The Medicare and Medicaid projections and economic and demographic assumptions are based on the 2003 Medicare Trustees Report and the 2003 Old-Age and Survivors Insurance and Disability Insurance Trustees Report, updated with available information through November 2003. These projections were completed before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) was signed into law. Therefore, the growth path expected for national health spending in these projections can serve as a baseline from which the impact of this legislation can be measured.

National health expenditures are projected to reach $3.4 trillion in 2013, up from $1.6 trillion in 2002. From 2002 through 2013, health care spending is projected to grow at an average annual rate of 7.3 percent, roughly 2.2 percentage points faster than the GDP rate. As a percentage of GDP, national health spending is projected to reach 18.4 percent by 2013, up from 14.9 percent in 2002. After increasing 9.3 percent in 2002, NHE growth is projected to be 7.8 percent in 2003 and 7.2 percent in 2004. This deceleration would follow 6 consecutive years of accelerating spending growth.

Private personal health care spending growth is expected to decelerate from 8.8 percent in 2002 to 7.2 percent in 2003, and to gradually fall to 6.7 percent in 2013. Much of the long-term deceleration is ascribed to slowing real per capita income growth, an increase in the uninsured population, and increased use of consumer cost sharing by insurers to help contain cost growth.

Growth in private health insurance premiums per enrollee is projected to peak at 11.4 percent in 2002, after increasing 10.9 percent in 2001. Private health insurance benefits per enrollee are projected to slow in 2003 to 8.9 percent, from 10.1 percent in 2002. This divergence is a sign of the current phase of the underwriting cycle, which is projected to reverse after 2003 and help slow overall private health insurance spending growth.

Out-of-pocket (OOP) spending is expected to grow more rapidly over the projection period in comparison to the previous decade because of efforts by employers and insurers to share costs with employees. However, the growth rate of total health spending is still expected to be higher than the growth rate of OOP spending, causing the OOP share of total health expenditures to fall from 13.7 percent in 2002 to 13.0 percent in 2013.

Growth in spending on hospital care, the largest health care sector in 2002, rose sharply from 3.0 percent in 1998 to 9.5 percent in 2002, driven by higher labor costs and increased hospital leverage in pricing. Hospital spending growth is projected to slow to 6.5 percent in 2003 and to 6.2 percent in 2005, as both use and price are anticipated to grow less rapidly than they did in 2002.

Spending on prescription drugs—still the fastest growing sector, at 13.4 percent, in 2003—is expected to continue its recent deceleration, partly due to increasingly broad use of tiered copayments and fewer drug introductions. By 2013, prescription drug spending is expected to account for 15.5 percent of total health expenditures, up from 10.5 percent in 2002.

Medicare: A Brief Summary

Overview of Medicare

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

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554) allowed persons with Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) to waive the 24-month waiting period.

Medicare has traditionally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. A third part of Medicare, sometimes known as Part C, is the Medicare Advantage program, which was established as the Medicare+Choice program by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries' options for participation in private-sector health care plans.

The MMA also established a fourth part of Medicare: a new prescription drug benefit, also known as Part D, beginning in 2004. Part D activities are handled within the SMI trust fund, but in an account separate from Part B. It should thus be noted that the traditional treatment of "SMI" and "Part B" as synonymous is no longer accurate, since SMI now consists of both Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other.

When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2004, almost 42 million people are enrolled in one or both of Parts A and B of the Medicare program, and about 5 million of them have chosen to participate in a Medicare Advantage plan.

Coverage

Part A is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in Federal, State, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. Part A coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 2003, Part A provided protection against the costs of hospital and specific other medical care to about

41 million people (35 million aged and 6 million disabled enrollees). Part A benefit payments totaled $152.1 billion in 2003.

The following health care services are covered under Part A:

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

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

- *Home health agency* (HHA) care is covered by both Parts A and B. The BBA transferred from Part A to Part B those home health services furnished on or after January 1, 1998 that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Part A and Part B has no copayment and no deductible.

  HHA care, including care provided by a home health aide, may be furnished part-time by a HHA in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment (DME) may also be provided, though beneficiaries must pay a 20-percent coinsurance for DME, as required under Part B of Medicare. There must be a plan of treatment and periodical review by a physician. Full-time nursing care, food, blood, and drugs are not provided as HHA services.

- *Hospice* care is a service provided to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program, but does pay small coinsurance amounts for drugs and inpatient respite care.

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

All citizens (and certain legal aliens) age 65 or over, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2003, Part B provided protection against the costs of physician and other medical services to about 38 million people (33 million aged and 5 million disabled). Part B benefits totaled $123.8 billion in 2003.

Part B covers the following services and supplies:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists. Also covered are the services provided by these Medicare-approved practitioners who are not physicians: certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician.

- Services in an emergency room or outpatient clinic, including same-day surgery, and ambulance services.

- Home health care not covered under Part A.

- Laboratory tests, X-rays, and other diagnostic radiology services, as well as certain preventive care screening tests.

- Ambulatory surgical center services in a Medicare-approved facility.

- Most physical and occupational therapy and speech pathology services.

- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.

- Radiation therapy, renal (kidney) dialysis and transplants, heart, lung, heart-lung, liver, pancreas, and bone marrow transplants, and, as of April 2001, intestinal transplants.

- Approved DME for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, and casts.

- Drugs and biologicals that cannot be self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered).

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

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

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

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

These Medicare Advantage plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan.

Beginning in 2006, a new regional Medicare Advantage plan program is established that allows regional coordinated care plans to participate in the Medicare Advantage program. Between 10 and 50 regions will be established, and plans wishing to participate must serve an entire region. There are provisions to encourage plan participation, and a fund will be established that can be used to encourage plan entry and limit plan withdrawals.

For individuals entitled to Part A or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provides access to prescription drug discount cards, at a cost of no more than $30 annually. For low-income beneficiaries, Part D initially provides transitional financial assistance (of up to $600 per year) for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and will phase out in 2006.

Beginning in 2006, Part D will provide subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. (Late enrollment penalties may apply under certain circumstances.)

Part D coverage includes most FDA-approved prescription drugs and biologicals. (The specific drugs currently covered in Parts A and B will remain covered there.) Part D coverage can consist of either standard coverage (defined later) or an alternative design that provides the same actuarial value. (However, the specific actuarial equivalence test leaves very little flexibility for plans to design alternative coverage.) For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

To encourage employer and union plans to continue to offer prescription drug coverage to Medicare retirees, Part D also provides for certain subsidies to those plans that meet specific criteria.

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

Program Financing, Beneficiary Liabilities, and Provider Payments

All financial operations for Medicare are handled through two trust funds, one for HI (Part A) and one for SMI (Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury

securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

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

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

The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. As previously noted, SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily financed by beneficiary premiums and contributions from the general fund of the U.S. Treasury.

Part B is financed through premium payments ($78.20 per beneficiary per month in 2005) and contributions from the general fund of the U.S. Treasury. (Penalties for late enrollment may apply.) Beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are the largest source of Part B income.

Similarly, Part D, once under way in 2006, will be financed primarily through premium payments and contributions from the general fund of the U. S. Treasury, with general fund contributions accounting for the largest source of Part D income, since beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage (as described in the next section). The premiums and general fund contributions for Part D will be determined separately from those for Part B. (In 2004 and 2005, the general fund of the U.S. Treasury will finance the transitional assistance benefit for low-income beneficiaries by providing funds to a Transitional Assistance account within the SMI trust fund. The proceeds will be transferred to the Part D account at the conclusion of the temporary program.)

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. For both Parts B and D separately, beneficiary premiums and general fund payments are redetermined annually, to match estimated program costs for the following year. (Beginning in 2007, the Part B premium will be increased for beneficiaries meeting certain income thresholds.)

Capitation payments to Medicare Advantage plans are financed from both the HI trust fund and the Part B account within the SMI trust fund in proportion to the relative weights of Part A and Part B benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

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

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

For hospital care covered under Part A, a fee-for-service beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($912 in 2005). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($228 per day in 2005) are required through the 90th day of a benefit period. Each Part A beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments ($456 per day in 2005) are required.

For skilled nursing care covered under Part A, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21-100, a copayment ($115 per day in 2005) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of his or her spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the 2005 Part A monthly premium rate is $375; for those with 30 to 39 quarters of coverage, the rate is reduced to $206. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom cash benefits have ceased due to earnings in excess of those allowed for receiving cash benefits. (Penalties for late enrollment may apply.)

For Part B, the beneficiary's payment share includes the following: one annual deductible ($110 in 2005); the monthly premiums; the coinsurance payments for Part B services (usually 20 percent of the medically allowed charges); a deductible for blood; certain charges above the Medicare-allowed charge (for claims

not on assignment); and payment for any services that are not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

For Part D, standard coverage is defined for 2006 as having a $250 deductible with 25 percent coinsurance (or other actuarially equivalent amounts) for drug costs above the deductible and below an initial coverage limit of $2,250. The beneficiary is then responsible for all costs until a $3,600 out-of-pocket limit is reached. For higher costs, there is catastrophic coverage that requires enrollees to pay the greater of 5 percent coinsurance or a small copay ($2 for generic or preferred brands and $5 for any other drug). After 2006, these benefit parameters are indexed to the growth in per capita spending in Part D. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted. The exception to this provision is cost-sharing assistance from Medicare's low-income subsidies and from State Pharmacy Assistance programs. The monthly premiums required for Part D coverage are described in the previous section.

Provider Payments

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

For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality. Beginning January 1992, allowed charges were defined as the lesser of (1) the submitted charges, or (2) the amount determined by a fee schedule based on a relative value scale (RVS). Payments for DME and clinical laboratory services are also based on a fee schedule. Most hospital outpatient services are reimbursed on a prospective payment system, and home health care is reimbursed under the same prospective payment system as Part A.

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

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

previously mentioned, the Medicare Advantage program will undergo changes beginning in 2006. Plan bids will be replacing the current payment structure for Medicare Advantage plans.

For Part D, in 2006 and later, PDPs (including the prescription drug portion of Medicare Advantage plans) will pay for most FDA-approved prescription drugs and biologicals under the benefit structure described in the previous section. Plans may set up formularies for their prescription drug coverage, subject to statutory standards.

Medicare Claims Processing

Medicare's Part A and Part B fee-for-service claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal Government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for Part B. Examples of intermediaries are Blue Cross and Blue Shield (which utilize their plans in various States) and other commercial insurance companies. Intermediaries' responsibilities include the following:

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

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a State, and various commercial insurance companies. Carriers' responsibilities include the following:

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

Claims for services provided by Medicare Advantage plans (that is, claims under Part C) are processed by the plans themselves.

Once Part D begins in earnest in 2006, plans will be responsible for claims processing, as is the case under Part C. However, there are a number of complex Part D claims processing provisions, and the administration of some of these provisions is not yet fully resolved. Future versions of this article will address these issues as they unfold.

Quality improvement organizations (QIOs; formerly called peer review organizations, or PROs) are groups of practicing health care professionals who are paid by the Federal Government to generally oversee the care provided to Medicare beneficiaries in each State and to improve the quality of services. QIOs educate other health care professionals and assist in the effective, efficient, and economical delivery of health care services to the Medicare population. The ongoing effort to combat monetary fraud and abuse in the Medicare program was intensified after enactment of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), which created the Medicare Integrity Program. Prior to this 1996 legislation, the Centers for Medicare & Medicaid Services (CMS) was limited by law to contracting with its current carriers and fiscal intermediaries to perform payment safeguard activities. The Medicare Integrity Program provided CMS with stable, increasing funding for payment safeguard activities, as well as new authorities to contract with entities to perform specific payment safeguard functions.

Administration

The Department of Health and Human Services (DHHS) has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with CMS. SSA assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums (and, once applicable beginning in 2006, Part D premiums) from the Social Security benefit checks of beneficiaries, and by maintaining Medicare data on the master beneficiary record, which is SSA's primary record of beneficiaries. The Internal Revenue Service in the Department of the Treasury collects the Part A payroll taxes from workers and their employers.

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

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

Data Summary

The Medicare program covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. In 2003, Part A covered about 41 million enrollees with benefit payments of $152.1 billion, and Part B covered about 38 million enrollees with benefit payments of $123.8 billion. Administrative costs for both Parts A and B were under 2 percent of disbursements in 2003. Total disbursements for Medicare in 2003 were $280.8 billion.

Medicaid: A Brief Summary

Overview of Medicaid

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

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

Basis of Eligibility and Maintenance Assistance Status

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

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

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996.

- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL).

- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).

- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries (described later).

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

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each State).
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their State on July 16, 1996.
- Institutionalized individuals eligible under a "special income level" (the amount is set by each State—up to 300 percent of the SSI Federal benefit rate).
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Recipients of State supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.
- "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33).
- "Medically needy" persons (described below).

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

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. As of August 2002, thirty-five States plus the District of Columbia have elected to have a MN program and are providing at least some MN services to at least some MN beneficiaries. All remaining States utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

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

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

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

Medicaid coverage may begin as early as the third month prior to application—if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The

BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Those with higher incomes may pay a sliding scale premium based on income.

Scope of Medicaid Services

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

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

States may also receive Federal matching funds to provide certain optional services. Following are the most common of the thirty-four currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).

- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Home and community-based care to certain persons with chronic impairments.

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

Amount and Duration of Medicaid Services

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

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

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology

and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. Under legislation passed in 1991, 1993, and again within the BBA of 1997, the Federal share of payments to DSH hospitals was somewhat limited. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) increased DSH allotments for 2001 and 2002 and made other changes to DSH provisions that resulted in increased costs to the Medicaid program.

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

The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In fiscal year (FY) 2004, the FMAPs varied from 50 percent in twelve States to 77.08 percent in Mississippi, and averaged 60.2 percent overall. The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent and raised the FMAP for Alaska from 50 percent to 59.8 percent through 2000. The BIPA of 2000 further adjusted Alaska's FMAP to a higher level for FY 2001-2005. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108-27), in order to bring about State fiscal relief in the current troubled economy, has made three temporary modifications to the States' FMAP calculation: (1) the FMAP for the last two quarters of 2003 will equal the greater of the current law FMAPs for 2002 or 2003; (2) the FMAP for the first three quarters of 2004 will equal the greater of the current law FMAPs for 2003 or 2004; and (3) for the last two quarters of 2003 and first three quarters of 2004, the newly calculated (under 1 and 2 above) FMAP will increase by 2.95 percentage points. The Federal Government pays States a higher share for children covered through the SCHIP program. This "enhanced" FMAP averages about 70 percent for all States, compared to the general Medicaid average of 60.2 percent.

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

Except for the SCHIP program, the Qualifying Individuals (QI) program (described later), and DSH payments, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into Public Law 106-113, the

appropriations bill for the District of Columbia for FY 2000) increased the amount that certain States and the territories can spend on DSH and SCHIP payments, respectively. The BIPA set upper payment limits for inpatient and outpatient services provided by certain types of facilities.

Medicaid Summary and Trends

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

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and economic recessions.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2001, for example, indicate that Medicaid payments for services for 23.3 million children, who constitute 50 percent of all Medicaid beneficiaries, average about $1,305 per child (a relatively small average expenditure per person). Similarly, for 11.6 million adults, who comprise 25 percent of beneficiaries, payments average about $1,725 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4.4 million aged, constituting 9 percent of all Medicaid beneficiaries, average about $10,965 per person; for 7.7 million disabled, who comprise 16 percent of beneficiaries, payments average about $10,455 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2001 payments to health care vendors for 47.0 million Medicaid beneficiaries average $3,965 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2001show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled $37.2 billion for more than 1.7 million beneficiaries of these services—an average expenditure of $21,890 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled $3.5 billion for more than 1.0 million beneficiaries—an average expenditure of $3,475 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow Statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided States a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 59 percent in 2003.

More than 46.0 million persons received health care services through the Medicaid program in FY 2001 (the last year for which beneficiary data are available). In FY 2003, total outlays for the Medicaid program (Federal and State) were $278.3 billion, including direct payment to providers of $197.3 billion, payments for various premiums (for HMOs, Medicare, etc.) of $52.1 billion, payments to disproportionate share hospitals of $12.9 billion, and administrative costs of $16.0 billion. Outlays under the SCHIP program in FY 2003 were $6.1 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach $445 billion and $7.5 billion, respectively, by FY 2009.

The Medicaid-Medicare Relationship

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

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still

less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes a capped allocation to States, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100 percent federally funded, up to the State’s allocation.

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

Starting January 2006, the new Medicare prescription drug benefit will provide drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for both Medicare and Medicaid will also receive the low-income subsidy for both the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid will no longer provide drug benefits for Medicare beneficiaries.

Since the Medicare drug benefit and low-income subsidy will replace a portion of State Medicaid expenditures for drugs, States would see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) requires each State to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006 this payment is 90 percent of the projected 2006 reduction in State spending. After 2006 the percentage decreases by 1-2/3 percent per year to 75 percent for 2014 and later.

NOTES:

National Health Expenditure (NHE) historical estimates and projections are from the National Health Statistics Group in the Office of the Actuary (OACT), the Centers for Medicare & Medicaid Services (CMS). Refer also to:

Articles	**Also available on the Internet at**
"Health Spending Rebound Continues in 2002," by Katharine Levit *et al*., Health Affairs, January/February 2004, Volume 23, Number 1, pages 147-159.	www.healthaffairs.org/
"Health Spending Projections through 2013," by Stephen Heffler *et al.*, Health Affairs, Web Exclusive, February 11, 2004, pages W4-79 – W4-93.	content.healthaffairs.org/cgi/content/full/hlthaff.w4.79v1/DC1
"Health Accounts"	www.cms.hhs.gov/statistics/nhe/

Medicare enrollment data are based on estimates prepared for the 2004 annual report of the Medicare Board of Trustees to Congress (available on the Internet at www.cms.hhs.gov/publications/trusteesreport/). Medicare benefits, administrative costs, and total disbursements for 2003 are actual amounts for the calendar year, as reported by the Department of the Treasury.

Medicaid data are based on the projections of the Mid-Session Review of the President's Fiscal Year 2005 Budget and are consistent with data received from the States on the Forms CMS-2082, MSIS, CMS-37, and CMS-64.