Chapter 13

MEDICARE AND MEDICAID

Medicare protects about 27 million elderly and disabled Americans from some of the financial risk of accidents and ill health, and Medicaid does likewise for about 23 million low-income persons (including some also protected by Medicare). In fiscal year 1980, their combined costs was $64.7 billion.[1/] Since they were enacted over 15 years ago, these programs have changed very little in the benefits offered, in the way they are managed, and in the way they reimburse medical institutions and physicians. While the programs have proven their worth, experience has indicated the need for certain changes.[A/]

The National Commission has identified four areas where major change is necessary:

(1) Greater limitations, including a "catastrophic cap," should be placed on the share of the program expenses for which Medicare beneficiaries are responsible (see pages 265-267);

(2) In States and jurisdictions which participate in Medicaid, the program should be extended to all those whose incomes fall below 65

1/Because some people are eligible for both programs, the total number of different persons is less than the sum of the persons protected under each program. In FY 1980, Medicare had a cost of $37.1 billion and Medicaid had a cost of $27.6 billion ($15.6 billion in Federal funds and $12.0 billion in State funds).

A/See supplementary statement on Medicare/Medicaid by Ms. Duskin and Ms. Miller.

below 65 percent of the Federal poverty level[2/] (see pages 280-281); [B/]

(3) Reimbursement to physicians for services to Medicaid beneficiaries should be raised to the levels paid by Medicare (see page 294).

(4) A comprehensive long-term care program should be established to more effectively provide and coordinate long-term care (see pages 286-287).

The Commission is also making other recommendations covering specific aspects of the programs.

Purposes of the Programs

Medicare was created to add a necessary supplement to the Social Security cash benefit provisions. The support for Medicare arose from three principal premises:

(I) The cost of medical care was not something that could be budgeted in preparing for retirement, because it varied so greatly from time to time and from person to person. Insurance against this cost was necessary to retirement security.

(2) The premium cost of adequate health insurance was too high for those who were retired to pay out of retirement income or savings. A new prepayment approach and government aid were required to make health insurance in retirement feasible.

2/ In 1982, the official Federal poverty level will be $10,060 for a family of four; 65 percent of the level will be $6,539, according to an estimate by the Office of Research and Statistics, Social Security Administration (based on mid-year budget projections, July 1980).

B/See dissenting statement on the concept of poverty by Mr. Myers in the statements related to Chapter 12.

(3) Adequate and affordable private-sector health insurance was generally available only through group coverage. Retired people usually could not be brought together into groups suitable for such coverage.

While Medicare was originally considered to be as comprehensive in its coverage as the best private health insurance plans then available, private health insurance has since grown. Health costs have risen sharply, while Medicare's protection has not kept pace. In certain respects it has become less adequate. A major purpose of the Commission% recommendations is to remedy this defect.

Medicaid was directed to the medical care needs of the poor, as a supplement to cash assistance provided under the Federal grant-in-aid titles of the Social Security Act. Medicaid's costs have grown rapidly. Many of those who need medical care are still not covered, although the cost of Medicaid has become very burdensome in many States and constitutes a major item in the Federal budget.

In considering Medicare and Medicaid changes, the subject of the adoption of some type of national health insurance inevitably arises. Medicare and Medicaid are the major government ventures to date into the health insurance field. They were designed to supplement cash benefit programs, to protect the economic security primarily of a nonworking group, or to help to maintain those without funds. National health insurance would extend benefits to the middle and higher income groups,

including those who are employed and who may have health insurance today. While members of the Commission hold differing views on the need for national health insurance, the Commission decided not to include the subject on its agenda because the issues raised are so complex that to review them properly would have made it impossible for the Commission to deal adequately with the existing programs.

Medicare

The Medicare program, enacted in 1965, is a Federal health insurance program primarily for Social Security beneficiaries who are 65 and over, and for those who have been entitled to disability benefits for at least 24 months. Certain workers and their families with kidney disease also receive benefits.

The program consists of two parts. Hospital Insurance (HI), sometimes called part A, covers expenses for medical services furnished in an institutional setting, such as a hospital or skilled nursing facility, or provided by a home health agency. Supplementary Medical Insurance (SMI), sometimes called part B, covers physician services, other outpatient services, laboratory services, and certain medical equipment.

The Health Care Financing Administration(HCFA), an agency within the Department of Health and Human Services, contracts with private organizations (e. g . Blue Cross/Blue Shield) to reimburse the providers of Medicare services and the beneficiaries. These organizations are known as "intermediaries" under Hospital Insurance and as "carriers" under Supplementary Medical Insurance.

Approximately 27.4 million people are enrolled in HI and 27.1 million in SMI. in fiscal year 1980, about 6.7 million people received reimbursable services under HI at a cost of about $24 billion..' About 17.3 million

received reimbursable services under SMI, at a cost of about $10 billion. There is no income test for Medicare; unlike Medicaid, it is available to qualified persons without regard to their incomes or assets..

HI is financed almost exclusively by a payroll tax on employers, employees, and the self-employed. In 1981, each of these groups is taxed at 1.3 percent of the first $29,700 of annual earnings. Enrollment in SMI is voluntary. It is financed on a current basis from monthly premiums paid by enrollees and from general revenues. The current standard premium rate is $9.60 a month until July 1981, when it will rise to $11.00.[3/] A higher premium rate than the standard one is charged for persons who enroll at a later time than when first eligible to do so.

About 4 percent of the income to the HI program comes from general revenues.[4/] About 71 percent of the income to the SMI program comes from general revenues. When the two programs are considered together, about 23 percent of the income to Medicare comes from general revenues.

Cost-Sharing under Medicare

Patients covered by Medicare have always had to pay some of their health care costs. The Commission believes that the cost-sharing under present law is too great a financial burden on those who incur heavy

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3/ The law requires the Secretary of Health and Human Services to review SMI program costs each year and to determine the premium rate which will be actuarially adequate to meet one-half of program expenditures on behalf of enrollees aged 65 and older over the premium period. The same premium rate is applicable for both the aged and the disabled. However, in order to assure that premium rates will not become excessive when medical care costs increase at a higher rate than Social Security benefits, the law limits the rate of increase in any year to the percentage by which the Social Security cash benefits were increased in the previous year. The current actuarially adequate rate is $16.30 for the aged and $25.50 for the disabled.

4/ This is primarily payment with regard to uninsured people who reached age 65 before 1968 and military wage credits for which no Social Security tax was paid.

medical costs. It is recommending three changes to reduce potential cost-sharing of most beneficiaries: a change in the benefit period, a change in hospital benefits to cover a maximum of 150 days per calendar year with changes in coinsurance rates, and a catastrophic cap on the patient's total out-of-pocket costs.

-- Hospital Benefit Period

Medicare benefits covering hospital care are now based on a concept known as a "spell of illness." Each spell of illness is a period of consecutive days that begins when a patient enters a hospital and ends 60 days after discharge from the last stay in a hospital or nursing home. If a Medicare patient is hospitalized longer than the 90 days of hospital services covered during the spell of illness, the patient may choose to use up to 60 days from what is termed his or her "lifetime reserve." As benefit days in the reserve are used, available reserve days are reduced. The spell of illness and lifetime reserve concepts are complex and difficult for beneficiaries to understand.

For long-time residents of nursing homes, the spell of illness provision poses an additional problem. If hospital patients leave a hospital and then enter a nursing home within 60 days, they remain in the same spell of illness. The nursing home stay may last many years, during which repeated hospitalization may be necessary. Yet because this is one spell of illness, hospital coverage is limited to 90 days plus whatever portion of the 60-day lifetime reserve remains. To solve the problems of beneficiary confusion and exhaustion of the hospital benefit during a long nursing home stay, the Commission recommends that Medicare benefits be calculated on a calendar vear basis rather than a spell of illness basis for hospital stays, but not for skilled nursing facility stays.

The major cost to Medicare of eliminating the spell of illness concept comes from lowering the number of initial deductibles for which a beneficiary may be liable for inpatient hospital care during the course of a year; under the recommendation, a beneficiary would pay, at most, only one deductible per calendar year.[5/] The recommendation includes a "carryover" provision, which allows any amounts paid toward the deductible in the last quarter of a calendar year to also apply to the deductible for the following year. The estimated cost of the annual deductible and the carryover provision is:

Calendar Year	Annual Deductible (millions)	Carryover Provision (millions)	Total HI Cost (millions)
1982	$250	--	$250
1983	300	$60	360
1984	340	70	410
1985	390	80	470
1986	440	90	530

The 75-year, long-range cost to the HI program is estimated to be .05 percent of taxable payroll.[6/]

5/ For an explanation of the Medicare deductibles, see p. 264.

6/ The estimates of the long-range costs for the various changes discussed hereafter are made on the basis of considering each change independently (i . e. , assuming that it is the only change made in the provisions of present law). The summary at the end of this chapter shows the combined effect of all recommended changes. Also, all of the estimates are based on the intermediate cost estimates. The Commission recognizes the significant range in possible costs under the pessimistic and optimistic estimates, as discussed in Chapter 4. However, for the purpose of this report, it seems reasonable to use only the intermediate cost estimates in presenting the proposed changes and in developing the necessary financing provisions for them.

-- Covered Days and Coinsurance

Under present law, hospital benefits extend for 90 days during a "spell of illness." In addition, each person has a lifetime reserve of 60 days of hospital care. For spells of illness that begin on or after January I, 1981, the patient must pay the initial deductible of $204 for hospital care, and coinsurance of $51 per day (25% of the initial deductible) for the 61st through 90th day of hospitalization. When any of the 60 lifetime reserve days is used, the patient must pay $102 per day (50% of the initial deductible).[7/] The Commission recommends that, beginning in 1982, Medicare hospital benefits be provided for up to 150 days a year; for the first 50 days of hospitalization, the beneficiary would be liable for no more than the initial deductible; for the second 50 days, the coinsurance would be IO percent of the initial deductible for each day of hospitalization, and 5 percent per day for the third 50-day period. Lifetime reserve days would be eliminated.

7/ Different deductible amounts and days of coverage apply to skilled nursing facility services. 100 days of skilled nursing facility care are covered per benefit period (spell of illness). The program pays the cost of services for the first 20 days of institutionalization, and the patient is liable for one-eighth of the initial deductible, or $25.50, per day from the 21 st to the 100th day.

For SMI services, the beneficiary pays an initial deductible of $60 per calendar year. (This deductible does not apply to inpatient services provided by pathologists and radiologists, or, to the services of home health agencies). After that, the program pays 80 percent of the charges deemed "reasonable" by the carrier which reimburses SMI services in that area. The patient pays 20 percent, plus (when the physician does not accept assignment) the difference, if any, between the "reasonable charge" and the actual charge by the provider of the service. Only the 20 percent of reasonable charges is cost-sharing for program services.

Although home health services can be reimbursed under both parts, the program pays 100 percent of the cost so the patient has no cost-sharing liability.

The following table shows Medicare cost-sharing for 1982 under present law and what it would be under the Commission recommendation (assuming that the initial deductible then is $228):

Days of Hospital Care[a]	Patient Cost-Sharing Under Present Law	Patient Cost-Sharing Under Commission Recommendation
30	$228	$228
50	228	228
60	228	456
90	1,938	1,140
100	3,078 [b]	1,368
120	5,358 [b]	1,596
150	8,778 [b]	1,938

[a] This comparison does not take into account whether the hospital benefit period is based on spell of illness or calendar year.

[b] This assumes availability of reserve days.

The estimated cost of this change is:

Calendar Year	HI Cost (millions)
1982	$165
1983	195
1984	225
1985	260
1986	305

The 75-year, long-range cost to the HI program is estimated to be .03 percent of taxable payroll.

-- Limit on Cost-Sharing Liability

In 1980, the average out-of-pocket payment for covered services by individuals who received some reimbursement for services under HI or SMI was about $85. Approximately 550,000 beneficiaries, however, incurred cost-sharing expenses in excess of $2,000. Many of these expenses were incurred in the last year of the beneficiary's iife.

In order to relieve those beneficiaries and their families of some of the high cost of acute health care, the Commission recommends that, beginning in 1982, there should be an annual limit on cost-sharing liability for Medicare benefits--a catastrophic cap--which would be $2,000, to be indexed in later years by the annual change in the Consumer Price Index. The cap will apply to a beneficiary's total cost-sharing for covered services under HI and SMI .[8/]

The estimated cost of this change is:

Calendar Year	HI (millions)	SMI (millions)	Total Cost (millions)
1982	$330	$210	$540
1983	390	250	640
1984	470	300	770
1985	560	360	920
1986	660	425	1,085

8/ For example, if in 1982 an individual were in a hospital for 160 days and had $5,000 of charges for physician services, of which $4,500 was recognized for reimbursement under SMI, the cost-sharing payments without the catastrophic cap, but with the other changes in the cost-sharing provisions recommended, would have been $2,886. Of this total, $1,938 is for the first 150 days of hospitalization, assuming that the initial inpatient deductible is $228 for 1982. The remaining $948 is for physician services--the $60 initial deductible, plus 20 percent of the excess of $4,500 over the $60 initial deductible). Under such circumstances, the effect of the catastrophic cap would be to give the individual additional benefits of $886, although he or she would still have to pay the $2,000 of cost-sharing payments, the cost of the 151st to 160th days of hospitalization, and the $500 of physician charges not recognized by the program.

Program costs in excess of the annual limit would be apportioned between the H I and SMI programs, depending on whether the beneficiary's expenses are incurred for HI or SMI covered services.

The 75-year, long-range cost to the HI program is estimated to be .06 percent of taxable payroll.

-- Combined Cost

The combined estimated cost of establishing a catastrophic cap on cost-sharing to begin at $2,000 per year, of calculating hospital benefits on a calendar-year basis, and changing the hospital benefit to cover 150 days of care per calendar year with changes in coinsurance, is:

Calendar Year	HI (millions)	SMI (millions)	Total Cost (millions)
1982	$540	$210	$750
1983	700	250	950
1984	805	300	1,105
1985	940	360	1,300
1986	1,075	425	1,500

The 75-year, long-range cost to the HI program is estimated to be .10 percent of taxable payroll.9/

9/ It should be noted that this cost is less than the sum of the the costs of the three changes involved individually; this results from the fact that the cost of the catastrophic cap would be much higher if the present provisions (possibly paying more than one initial deductible in a year and very high coinsurance for long hospital stays) remained, than if changes in them were made to require less cost-sharing. So the cost of the catastrophic cap in the combined estimate is offset by the first two changes which reduce the out-of-pocket expenses of beneficiaries.

Hospital Coverage Outside of the United States

Medicare covers only services provided in the United States, with minor exceptions. 10/ There has been considerable reluctance to extend coverage to services rendered outside the United States because of difficulties in verifying the need for the services, the qualifications of the providers, and the appropriateness of the billings. Because a large number of beneficiaries live or travel outside the United States, the Commission considered a limited plan, which it believes to be administratively feasible, for some coverage of foreign hospital services.

Because hospital services are somewhat easier to verify, the Commission recommends that coverage be extended only to hospital inpatient services provided outside the United States. The amount of reimbursement should be limited to a daily rate of 50 percent of the initial deductible (estimated to be $228 in 1982), but not more than the rate the patient is charged. For example, under the recommended changes in the hospital benefit period and coinsurance rates discussed above, the 50 percent daily rate, less the initial deductible, could be paid for the first 50 days of care. For subsequent days, reimbursement would be at the same daily rate, subject to the cost-sharing provisions for hospital costs.

This recommendation, together with the Commission's recommendations on hospital cost-sharing, could provide the following reimbursement to a person hospitalized for 100 days outside the United States in 1982.

10/If beneficiaries become ill in the United States and require emergency hospitalization, they may be reimbursed for hospital care, related physician services, and ambulance services incurred in Canada and Mexico if the most accessible facility is in one of those countries. A beneficiary may also be reimbursed for expenses incurred in case of emergency hospital treatment that is required while traveling between the lower 48 States and Alaska. Certain border residents, where the hospital is closer to or more accessible from their residence than the nearest adequately-equipped U.S. hospital, may also receive covered care in a Canadian or Mexican hospital. In the case of border residents, care need not be of an emergency nature.

100 days at $114 per day (50% of the $228 initial deductible)	$11,400 *
less initial deductible	-228
less 10% of $228 for 51st through 100th day	1,140
Reimbursement for the patient	$10,032

* If the beneficiary's total expenditures were less than this, then that figure would be used.

The recommended catastrophic cap on Medicare cost-sharing by the beneficiary would not apply to any cost-sharing payments applied to services outside the United States.

The estimated cost of this change is:

Calendar Year	HI Cost (millions)
1982	$120
1983	140
1984	150
1985	170
1986	200

The 75-year, long-range cost to the HI program is estimated to be .02 percent of taxable payroll.

Hospital-based Physicians

Medicare's physician reimbursement policies are particularly inadequate when applied to certain hospital-based physicians. Patients generally cannot negotiate ahead of time for their services or fees. Services are provided under arrangements made by the physician and the hospital; patients, who have no part in the arrangement, are responsible for the fee.

Another problem arises in the case of services rendered by a laboratory which are charged to the patient as an SMI service. Unlike HI, they are subject to coinsurance and the $60 deductible. The Commission recommends that if a hospital does not wish to operate its own laboratory, it should contract to have the service performed for, and charged to, the hospital. The hospital should then be reimbursed by Medicare under the HI system.

The Health Care Financing Administration informed the Commission that this recommendation would have no net cost because it would shift a portion of SMI independent laboratory services to HI. The estimate assumed that hospitals will purchase these same services at a discount from the independent laboratories in much the same manner as physicians receive a discount for the laboratory services they purchase, so that the hospitals' reasonable costs for these services will approximately match the current SMI reimbursement. The estimated cost of requiring that the services to inpatients by independent laboratories be billed to the HI program is:

Calendar Year	HI (millions)	SMI (millions)	Total Cost (millions)
1982	$26	-$26	$0
1983	38	-38	0
1984	45	-45	0
1985	53	-53	0
1986	63	-63	0

The 75-year, long-range cost to the HI program is estimated to be .01 percent of taxable payroll.

Home Health Services

The Medicare program covers the services of participating home health agencies, which are private or public organizations that provide skilled nursing and other therapeutic services, generally in patients' homes. Beginning July 1, 1981, both HI and SMI will cover an unlimited number of home health visits.[11/]

The fact that home health visits can be reimbursed under either part of the program is confusing to beneficiaries. In addition, the benefits provided are not closely associated with hospital or skilled nursing facility care, the other two HI benefits. Home health services include physical therapy, speech therapy, occupational therapy, medical social services, medical supplies, and the use of some medical equipment.

The Commission recommends that the services of home health agencies be reimbursed only by the SMI program, except when a beneficiary is enrolled in HI only, in which case the services will be charged to HI.[12/] The estimated cost of making the SMI Trust Fund the payor of first resort for home health benefits is:

11/In 1978, the last year for which complete data are available, 71 percent of home health visits were billed to the HI program, and 29 percent to SMI . The percentage of visits reimbursed under HI is expected to increase because in 1980 Congress removed the requirement that visits billed to HI be limited to those for treatment of conditions for which the patient received inpatient hospital care. Almost all home health visits will be reimbursed under HI as a result of section 1833(d) of the Social Security Act.

12/The Commission contemplates no change in benefit administration. Under current procedures, reimbursement for home health visits is the responsibility of the HI intermediary.

Calendar Year	HI (millions)	SMI (millions)	Total Cost (millions)
1982	-$730	$730	0
1983	-1,290	1,290	0
1984	-1,520	1,520	0
1985	-1,710	1,710	0
1986	-1,920	1,920	0

The 75-year, long-range savings to the HI program is estimated to be .20 percent of taxable payroll.

Outpatient Mental Health Services

When Medicare was enacted, special limitations were included for outpatient treatment of mental disorders under SMI. Under present law, the outpatient psychiatric benefit is limited to 50% of $500 per year-- a maximum Medicare reimbursement of $250. To recognize cost increases since 1965, the Commission recommends raising the Medicare reimbursement to 50% of $750 per year, or a maximum reimbursement of $375. The estimated cost of this change is:

Calendar Year	SMI Cost (millions)
1982	$3
1983	5
1984	6
1985	8
1986	9

The 75-year, long-range cost to the HI program is estimated to be negligible (less than .005 percent of taxable payroll).

In view of the progress that has been made in establishing community mental health centers, the Commission supports covering under SMI the ambulatory services[13/] which they provide. Although there were

13/Services which are rendered outside a hospital or in a hospital outpatient department.

no community mental health centers before Medicare was enacted, there are now about 700 centers. At present, their services are reimbursed only when they are operated by hospitals. (The services of physicians, when delivered in a mental health center, are reimbursable under SMI the same as any other physician service.)

The Commission recommends that services provided by all community mental health centers be covered when provided under the supervision of any appropriate mental health professional, subject to the maximum annual limit of $375 for outpatient mental health services.

The estimated cost of this change is:

Calendar Year	SMI Cost (millions)
1982	$22
1983	25
1984	28
1985	31
1986	35

The 75-year, long-range cost to the HI program is estimated to be negligible (less than .005 percent of taxable payroll).

Eligibility

-- Eligibility Age for Medicare

As discussed in Chapter 5, the Commission has recommended that the age at which unreduced cash Old-Age and Survivors Insurance benefits for retired workers are paid be raised gradually, beginning in the year 2001, from 65 to 68. The Commission recommends that, as this is done, the eligibility age for Medicare should also rise gradually to 68.

With adequate prior notice, group and individual health insurance plans can adjust to the changed age of eligibility. C/

The cost savings of raising the Medicare eligibility age are estimated to be .38 percent of taxable payroll.[14/]

-- Medicare Waiting Period for Disabled Beneficiaries

An insured worker cannot become eligible for disability benefits until the sixth month after the month of onset of disability. The beneficiary must then wait an additional 24 months before becoming eligible for Medicare. There are valid reasons for some delay in Medicare coverage beyond the 5-month cash-benefits waiting period, since it often takes longer than 5 months to determine whether a person is disabled. However, 24 months, during a period when medical costs are presumably high, is a longer delay than necessary. The Commission recommends that the waiting period for Medicare benefits be reduced to 12 months after entitlement to disability cash benefits.

The estimated cost of this change is:

14/This estimate takes into account that Medicare benefits will be available for disabled beneficiaries over age 65, as the minimum age at which unreduced retirement benefits are available increases from 65 to 68.

C/See dissenting statement on raising the retirement age by Mr. Cohen, Ms. Duskin, and Ms. Miller in the statements related to Chapter 5.

Calendar Year	HI (millions)	SMI (millions)	Total Cost (millions)
1982	$510	$210	$720
1983	610	250	‘860
1984	720	300	1,020
1985	850	350	1,200
1986	1,000	400	1,400

The 75-year long-range cost to the HI program is estimated to be .IO percent of taxable payroll.

-- Universal Coverage

As discussed in Chapter 8, the Commission recommends that HI coverage be extended to all governmental employees and to employees of nonprofit organizations who are not now covered by Social Security and HI, effective in 1982.[15/] This proposal would result in a reduction in the average long-range cost of the HI program (under the provisions of present law) amounting to .41 percent of taxable payroll. This saving results because most of these workers will be eligible for HI benefits under present law without having made HI contributions over their entire working lifetimes. They would become insured on the basis of a few years’ earnings or on the basis of their spouse’s earnings record.

-- Cost Effect of Revised Earnings Bases

The Commission recommends that the maximum taxable earnings base applicable to the HI program be frozen for 1985-86 at the same level that

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15/This extension of HI coverage would be different as to effective date than that for Old-Age, Survivors, and Disability Insurance for some categories. Old-Age, Survivors, and Disability Insurance coverage on a compulsory basis would apply to governmental employees under a retirement system only for new entrants after 1984.

it will reach in 1984 (see Chapter 4). As a result, the HI Trust Fund will have somewhat reduced tax income after 1984 (but no decrease in benefit liabilities). Accordingly, the average long-range cost of the program, as it would be revised by the other recommendations of the Commission, will be increased by .17 percent of taxable payroll.

Selection of H I Intermediaries

When Medicare and Medicaid were enacted, the legislation gave the Secretary of HEW (now HHS) substantial discretion in selecting and supervising the contractors who administer the Medicare program. The Department received additional authority over them in 1977, when the Secretary was authorized to assign and reassign HI providers to available intermediaries when it is in the best interest of the administration of the program, and also to designate regional or national intermediaries to reimburse particular classes of providers.

When Medicare was enacted, HI providers were given the right to nominate the intermediary through which they would be reimbursed. However, the Secretary was instructed not to enter into an agreement with the intermediary unless to do so was consistent with effective and efficient administration. At first, HI intermediaries were selected through the nomination process alone. Recently, the Department has sought authority to end the HI providers' role in naming the intermediaries. Instead, it wishes to select them on the basis of competitive bids, to be given authority to pay some contractors on a basis other than their incurred cost, and to reduce the number of contractors overall.

The Commission recommends against suspension of the hospitals' rights of nomination. Effective cost and utilization controls will come about only if the contractor and the provider communicate in a cooperative way. This relationship is important not only for HI but also for SMI, where the level of acceptance of assignment by physicians is, in part, a reflection on the relationship between physicians and the carrier.

Experimentation with competition among intermediaries for selection by the Secretary and incentive-based reimbursement are attractive proposals, but the Commission believes that a further period of experimentation is needed to identify the best ways to achieve them. In establishing a bid procedure, it is quite easy to devise ways to measure administrative costs, but it is difficult to know how to measure the quality of services. A bid procedure developed at this time is just as likely to result in poor service at an excessive price as it is to result in quality service at reasonable cost.

To avoid the risks of proceeding prematurely, the Commission urges that more be learned about measurement methods and effects. In the meantime, the authority under present law is adequate to improve the effectiveness of the administrative process.

Appeals of SMI Claims

The SMI appeal procedures differ significantly from Social Security, SSI, and HI hearings.[16/] Initial determinations on claims, reviews, and

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16/ See Chapter 10 for a discussion of OASDI and SSI appeals. This description of SMI appeals does not apply to those conducted through the Professional Standards Review Organizations system, or to appeals of eligibility determinations.

hearings are conducted by employees of the insurance carrier, and there is no judicial review.

If the amount at issue in an entitlement claim is at least $100; a beneficiary dissatisfied with the carrier's award may request a hearing by an officer appointed by the carrier. Hearing officers may be disqualified upon a showing of prejudice, partiality, or interest in the matter. Although HCFA sets out very general selection criteria for these hearing officers, it does not review their qualifications. There is no nationwide uniformity in selection and training procedures.

Final decisionmaking authority should not be given to an individual whose impartiality could be compromised because of association with the carrier whose decision is being appealed.[17/] The Commission recommends that hearings involving coverage of services under the SMI program be conducted by employees of the Federal government, under rules to be established by the Secretary.

Medicaid

The Medicaid program is a Federal grant-in-aid program under which States may enter into agreements with the Secretary of Health and Human Services to finance health care services for public assistance recipients and certain other low-income individuals and families. The

17/ McClure v. Harris, No. C-79-0201 D.C.N.D.Cal. (1980) found that SMI hearings procedures are a violation of claimants' due process rights insofar as the final unappealable decision regarding claims disputes is made by carrier appointees whose impartiality is subject to doubt. The decision would apply to all SMI beneficiaries whose claims for benefits have been denied since 1978, or will be denied, by carrier-appointed hearing officers. As of December 31, 1980, the district court judge had not issued a final order in the case.

proportion of State to Federal funding of the program is determined by a formula based on each State's per capita income.

About 23 million people were eligible for Medicaid services in FY 1980. Medicaid expenditures in FY 1980 were approximately $27.6 billion, of which $15.6 billion were Federal funds and $12.0 billion were State funds.

The States determine the scope of services to be offered and the reimbursement rate for these services, subject to Federal law and guidelines which include a minimum required "package" of medical services.[18/] The States determine the income eligibility for Medicaid. All of these variations mean that Medicaid programs differ greatly from State to State.

A State which chooses to participate in the Medicaid program must have a State plan approved by the Secretary of Health and Human Services. As of December 31, 1980, all States except Arizona were participating in the program. In addition, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, and the Virgin Islands participate in the program.

18/ For people who become eligible for Medicaid because of their eligibility under cash assistance programs, States must provide at least the following services but may limit their scope:

(1) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases.
(2) (a) Outpatient hospital services;
(b) Rural health clinic services (consistent with State law permitting such services).
(3) Other laboratory and X-ray services.
(4) (a) Skilled nursing facility services for people 21 and over;
(b) Early and periodic screening, diagnosis and treatment of physical and mental defects for eligible people under 21; and
(c) Family planning services and supplies.
(5) Physician services.
(6) Home health services for people eligible for skilled nursing facility services.

Medicaid Eligibility

The variation in the eligibility, benefits, and reimbursement rules for Medicaid, with its 54 separate and different programs, raises the . question of whether the current structure should be replaced by a more uniform program.

Eligibility is limited to specific categories of needy people: the aged, the blind, the disabled, and members of single-parent families. (or families in which one parent is incapacitated) with dependent children.[19/] Needy people who do not meet one of these categories are not eligible. Among them are single people who are neither aged nor disabled, couples without children, and in many States, two-parent families with children.

-- A National Minimum Eligibility Standard

In order to achieve a measure of national uniformity in the Medicaid program, and to assure that persons in like financial circumstances receive similar benefits regardless of their State of residence, the Commission recommends broadening the Medicaid program to provide that States and jurisdictions which participate in Medicaid include in their programs all individuals and families who meet a Federal minimum eligibility standard set at 65

19/ **Additionally, States may, at their option, cover children in families which meet AFDC income standards and parents and children where one parent is unemployed.**

percent of the national bovertv level. States would be precluded from reducing services currently available under their Medicaid plans.[20] States would be permitted to provide a more liberal eligibility standard. D/

The estimated cost of using the 65 percent eligibility standard, assuming no other change in State or Federal law, is:

Calendar Year	Total Cost (millions)	Federal Cost (millions)
1982	$4,400	$2,400
1983	4,900	2,700
1984	5,500	3,000
1985	6,200	3,400
1986	6,900	3,800

-- National Coverage of the Medically Needy

In 21 States and jurisdictions, Medicaid benefits are provided only to those who receive cash assistance under the Aid to Families with Dependent Children (AFDC) program or the SSI program.[21] The remaining 33 States and jurisdictions also provide Medicaid benefits to some people who meet the categorical requirements, but do not qualify for public assistance because of excess income and resources. They are called the "medically needy." These people can "spend down" to Medicaid eligibility by incurring medical expenses which,

20/In 1982, the official Federal poverty level will be $10,060 for a family of four; 65 percent of the level will be $6,539, according to an estimate by the Office of Research and Statistics, Social Security- Administration (based on mid-year budget projections, July 1980).

21/ Sixteen States do not provide Medicaid coverage to all SSI recipients (see page 247).

D/By Mr. Laxson, Mr. MacNaughton, Mr. Myers, and Mr. Rodgers: Each State is in a better position than the Federal government to determine the level of benefits it can afford to provide.

when subtracted from income, reduce their available income to a State-established eligibility level. According to the law, a State's medically-needy Medicaid eligibility level may not exceed 133 1/3 percent of its AFDC payment level for that size family unit.22/

People who have demonstrated their need for medical services can now receive Medicaid benefits only in the 33 States which provide eligibility to the medically needy. The Commission recommends that, as a condition for approval of their State plans by the Secretary, all States be required to provide Medicaid coverage to the medically needy, and that States be precluded from reducing services currently available under their Medicaid plans. This would bar cutbacks in the eligibility and benefit provisions in effect prior to the addition of the new requirements. E/

The estimated cost of this change, assuming no other change in State or Federal law is:

Calendar year	Total Cost (millions)	Federal Cost (millions)
1982	$1,250	$ 780
1983	1,400	880
1984	1,570	980
1985	1,760	1,100
1986	1,970	1,230

22/ From available data, it appears that, of the 33 States which participate in the medically needy portion of the program, 14 have eligibility standards below 65 percent of the poverty index in 1980. Hence, it is expected that persons who meet categorical requirements in these States will often have been enrolled in Medicaid already, based on the Commission's recommendation for an income-related eligibility standard described above. This accounts for some of the overlap and consequent cost savings of the combined recommendations on page 284.

E/By Mr. Laxson, Mr. MacNaughton, Mr. Myers, and Mr. Rodgers: Each State is in a better position than the Federal government to determine the level of benefits it can afford to provide.

-- Medicaid Coverage of All SSI Recipients

Under present law, State Medicaid plans may exclude from eligibility some people who are entitled to SSI benefits. Sixteen States have taken advantage of this provision which permits States to limit coverage to people who would have been eligible under State Medicaid standards applicable in 1972, prior to the implementation of the SSI program. This allows States to exclude those who became eligible for cash assistance as a result of the more liberal SSI provisions. The law requires that the excluded group be allowed to meet the States' income requirement by spending down to the 1972 Medicaid- eligibility level; that is, by deducting their incurred medical expenses from their income. The Commission recommends that all States which participate in the Medicaid program be required to extend Medicaid eligibility to all SSI recipients, and that States be precluded from reducing services currently available under their Medicaid plans. F/

The estimated cost of this change, assuming no other change in State or Federal law is: 23/

Calendar Year	Total Cost (millions)	Federal Cost (millions)
1982	$380 to $ 700	$230 to $380
1983	430 to 780	250 to 420
1984	480 to 880	280 to 470
1985	540 to 980	320 to 530
1986	610 to 1,100	360 to 590

23/ This estimate does not take into account the Commission's recommendation to increase SSI benefit levels by 25 percent. (See Chapter 12.) The range in costs for the estimate is due to inadequate data furnished by New York State's program, which has the highest Medicaid expenditures of all States and jurisdictions. On August 29, 1980, New York invoked the 1972 option, thereby restricting Medicaid eligibility to people who would have met the eligibility level in 1972. The combined estimate for the Commission's three eligibility recommendations on page 284, as well as the estimate in Table 13-1, use mid-point figures.

F/By Mr. Laxson, Mr. MacNaughton, and Mr. Rodgers: Each State is in a better position than the Federal government to determine the level of benefits it can afford to provide.

A Separate Program for Long-Term Care

Long-term care refers to services required to maintain or to improve the health and functioning of those who have a chronic illness or disability. The services may range from intensive medical care delivered in institutions, such as nursing homes, to social services that promote personal independence and permit more people to remain in their homes and communities.

The Commission believes that noninstitutional alternatives to long-term care should be encouraged. Today, approximately 5 percent of those over 65 live in institutions. About 85 percent of the residents of nursing homes are over 65; 75% of these are over the age of 75. Not only will the proportion of the aged rise in relation to the rest of the population in the future but also a greater number of them will be living to older ages. Thus, the need for nursing home or similar institutional care will increase in the coming years. Many placements in institutions might be unnecessary, however, if alternative care were available.

Medicare and Medicaid emphasize institutional care rather than alternatives. For example, Medicaid now pays $10 billion per year, about 40 percent of its total budget, to nursing homes. This sum goes to support only IO percent of the program's beneficiaries.

Providing quality long-term care presents a combination of social, medical, and financial challenges. As presently constituted, Medicare and Medicaid alone cannot meet them satisfactorily. The Commission recommends that a seoarate title of the Social Security Act be created to provide services other than acute medical and hospital care to needv persons who require lonq-term care. This program would be operated by the States and financed with both Federal and State funds, much as Medicaid is today.

A broad range of services should be available to provide quality care in a way which will strengthen community-based and in-home services and reduce the need for long-term institutional care. Program benefits might include nursing home services; rehabilitation services; residential or boarding home care; home health, homemaker, and other in-home services; adult day care; and aid with minor home remodeling to adapt to handicaps.[26/] A State agency would be required to assess the need for long-term care in each case, establish criteria for what care is most appropriate, encourage the development and coordination of services and reimburse providers of care.

Paying for these services under a separate title would identify the range of needed long-term care services and their costs with greater precision and public concern than now exists. It would also create a better basis for future decisions with respect to local needs for services, whether different income and resource requirements should be established for long-term care than for acute care, and whether other changes in long-term care provisions will be needed to meet changing future needs. [H/]

Dealing with the Rising Costs of Health Care

In 1979, the cost of health care in the United States was $943 per person. By 1990, it could exceed $3,000 per person. Of the $212.2

26/ Some of these benefits are now available to some needy people under title XX of the Social Security Act, which provides grants to States for social services.

H/By Mr. Laxson, Mr. MacNaughton, Mr. Myers, and Mr. Rodgers: The subject of long-term care is complex. We do not necessarily disagree with the Commission's recommendation, but believe much more study is needed before enactment.

billion the Nation spent on health care last year, about one-quarter was paid through Medicare and Medicaid.

The Commission recommends that Medicare and Medicaid not be used as instruments to control health care costs. They must pay their fair share of the cost of institutional, physician, and related services to their beneficiaries, without shifting costs to the private sector in the form of higher insurance premiums and out-of-pocket expenses for all Americans. The market share held by national health programs, however, requires the Federal and State governments to participate in efforts to slow the rate of increase in medical costs.

The costs must be faced squarely, and responsibly, with a national commitment to provide adequate health care to the elderly, the disabled and the needy. The Commission recommends that public policymakers encourage competition in the' delivery of health care services where competition can help to restrain cost increases. One way is to encourage the availability of organizations such as health maintenance organizations (HMO's), which provide comprehensive health care for groups of enrollees for a fixed periodic payment. Such organizations focus on the need for preventive care as an alternative to costly institutionalization.

The Commission recommends that the Medicare and Medicaid programs encourage further experimentation in organizations such as health maintenance orqanizations, with the goal of restraining medical care cost increases. 1/

Health Care Reimbursement

Medicare reimburses providers of health care at a level designed to approximate the reasonable cost of institutional services to beneficiaries (under HI), and 80 percent of the reasonable charges of physician and related services (under SMI). As a general rule, the program's reasonable cost levels are comparable to those paid by private insurers and by patients who must pay their own expenses out-of-pocket.

Under the Medicaid program, State plans are required to provide for reimbursement of the reasonable cost of hospital services; with respect to hospital and other services, reimbursement must not exceed the amount which would be determined to be the reasonable cost under Medicare.

1/See dissenting statement on the role of HMOs by Mr. Laxson, Mr. MacNaughton, Mr. Myers, and Mr. Rodgers; and also by Mr. Cohen and Ms. Duskin.

The program's reimbursement levels vary significantly from State to State; on the whole, they are much lower than those that prevail in the market.[27/]

Experiments with Prospective Reimbursement

Hospital care accounted for $85.3 billion in national health expenditures in 1979; the cost increased 12.5 percent from 1978. The magnitude of hospital expenses, and their dominant role in the Medicare and Medicaid programs, makes it imperative that the Nation use available means to limit the rate of future increases.

One development in this area is the evolution of State and community programs of prospective reimbursement to hospitals. In prospective reimbursement, rates are set so that hospitals know in advance what they will be paid regardless of the costs they actually incur. It contrasts with the general current practice of retrospective reimbursement under which payment is based on cost. The amount or rate to be paid may be fixed through a number of methods, such as prospective budget review and approval, rate review or rate setting, or the use of formulas to determine rates of payment. When a hospital knows what it will be paid before it renders its services, it may provide them more efficiently. The Federal government is authorized to promote broad experimental programs in prospective reimbursement and other alternative reimbursement and rate-setting methods.

27/ For example, HCFA has estimated that if Medicaid reimbursed physicians at the Medicare rate (without the limits that many States place on the number of covered visits), then Medicaid reimbursement would be 45 percent higher than at present.

Under this authority, HCFA has evaluated existing State and local prospective reimbursement systems and is funding a number of demonstration and developmental activities to gather further information on rate-setting systems.

The Commission reviewed these experiments and believes the evidence shows that moves away from cost-based reimbursement have promise. So far, however, the results have not demonstrated that any particular new approach should be adopted. It is important for these experiments to continue. At present, no matter how successful an experiment may be, when the data from it have been obtained, it must be terminated. The Commission recommends that when a hospital reimbursement experiment has succeeded, it be permitted to continue without time limit, and that the area to which it applies, when appropriate, be expanded.

Physician Reimbursement

While physicians themselves account for only 20 percent of health care spending, physician decisions on behalf of their patients affect over 70 percent of health spending. In 1980, as a result of these decisions, physicians were responsible for $110 billion in expenditures, in addition to the $45 billion spent on physician services. The issue of physician reimbursement is complicated by the fact that there are over 400,000 physicians compared to 7,000 hospitals.

Federal and State leverage on physicians is limited because Medicare accounts for only 16 percent of national expenditures on physician

care, and Medicaid for 6 percent. To the extent that reimbursement levels are lower than private market rates, physicians are less likely to participate in the National health programs.

Medicare reimburses through its carriers on the basis of customary, prevailing, and reasonable charges. Medicaid has no uniform national reimbursement method; States must assure only that reimbursement levels not exceed Medicare's, Of the 49 States and the District of Columbia which have a Medicaid program, thirteen use the customary, prevailing, and reasonable Medicare system, 11 use variations of it, and 26 use fee schedules.

Medicare reimburses physicians primarily on the basis of the charge they customarily make for the service involved, but not to exceed the level of charges prevailing among all physicians who perform that service. Whether or not a charge is reasonable is determined by measuring the charge against charges which prevailed in the locality about 18 months earlier. Thus, in times of inflation, these so-called "reasonable charges" may lag considerably behind current charges.

Since July 1975, the annual increase in prevailing fees has been limited by statute to an index related to physician practice costs and wage levels . The use of this index has held the increase in prevailing charges substantially below the level it would otherwise have reached, resulting in increasingly large numbers of payments to physicians being determined solely by the level of the so-called prevailing charge.

Some have proposed that physicians be reimbursed under a fee schedule, negotiated between the government and the physician. Physician fee schedules are simpler for providers and beneficiaries to understand, and simpler to administer. They may remove some of the reimbursement differentials that favor expensive methods of treatment. The Secretary of Health and Human Services has authority to experiment with negotiated fee schedules as a basis for physician reimbursement.

The Commission recommends that, if the Secretary enters into experimental agreeements with local medical societies regarding the voluntary use of fee schedules for Medicare and Medicaid. the societies be able to use the same schedules for other payors. The use of fee schedules by physician organizations should be exempt from the antitrust laws. In other areas, the present approach to setting reimbursable charges would continue.J/

Medicare Reasonable Charge Terminology

The Commission also notes that the present system of establishing reimbursable fee levels does not always yield a fee that is necessarily "reasonable" in the sense that word is generally used. The Commission recommends that Medicare use a term that is more understandable to beneficiaries and descriptive of its reimbursement process. For instance, "billed charge" could be used for the physician's fee, and "approved" charge for the amount determined by the carrier, and "reimbursable" charge for the amount to be paid by the program. This would distinguish among the three different elements in the reimbursement process.

J/See dissenting statement on physician assignment by Mr. Dillman, Mr. Myers, and Mr. Rodgers.

Medicaid Physician Fee Levels

Because of the program's low reimbursement levels, some physicians are reluctant to treat Medicaid patients. Medicaid's reimbursement rates must be set high enough to encourage the participation of physicians. The program's goal of assuring access to care for needy people is jeopardized when providers are unwilling to treat the poor in the same manner as they treat those whose expenses are reimbursed from other governmental and private sources.

The Commission recommends that Medicaid physician fees be increased to levels paid by Medicare. The fees of both programs will ultimately have to be reasonably equivalent to those paid for privately-purchased services, or patients under both programs will be denied access to medical services. K/

The estimated cost of raising Medicaid physician fees fully to Medicare levels, assuming no other change in State or Federal law, is: 28/

Calendar Year	Total Cost (millions)	Federal Cost (millions)
1982	$1,150	$610
1983	1,290	680
1984	1,440	760
1985	1,610	850
1986	1,810	950

28/ **HCFA has found that as the level of Medicaid reimbursement to physicians increases to levels more nearly in line with Medicare payments, the number of Medicaid physician visits increases. Costs to the Medicaid program in this estimate reflect expected increases in physician participation as a result of higher reimbursement levels.**

K/**By Mr. Cohen and Mr. Dillman: We believe that this recommendation should be phased in over a period of years in order that the States can make budget plans for the additional State expenditures involved.**

Cost of Commission Recommendations

The total combined cost of the Commission's recommendations in the health care area is shown in Table 13-I for the Medicaid program (for calendar years 1982-86) and in Tables 13-2 and 13-3 for the Medicare program.

The Medicaid cost estimates shown here take into account the Commission proposals with regard to changing the Supplemental Security Income program (by increasing the payment level and by eliminating the assets test) and the Disability insurance program (by reducing the waiting period for Medicare benefits for disabled beneficiaries from 24 months to 12 months).

Table 13-2 presents the estimated dollar costs of the benefit changes in calendar years 1982-86, separately for HI and SMI (including the additional benefits payable because of the extension of coverage to all employees of nonprofit organizations and to all governmental employees). Table 13-3 gives the 75-year, long-range costs for the HI program separately by type of change and also for the entire package combined, taking into account the cost interaction among the various changes. The effects of the changes in the HI program on its long-range financing are discussed in Chapter 4. As can be seen from Table 13-3, the HI program, as it would be modified by the National Commission's proposals, would have a positive actuarial balance of .23 percent of taxable payroll. It should be noted that this positive actuarial balance does not represent a real surplus, but rather it is needed to build up and maintain the trust-fund balance at a level of about one year's outgo.

Table 13-1

INCREASES IN COST OF MEDICAID PROGRAM UNDER . NATIONAL COMMISSION RECOMMENDATIONS, 1982-86
(in millions)

Calendar Year	Federal cost	State cost	Total cost
1982	$3,495	$2,935	$6,430
1983	3,920	3,220	7,140
1984	4,350	3,655	8,005
1985	4,905	4,070	8,975
1986	5,470	4,530	10,000

Table 13-2

INCREASES IN COST OF MEDICARE PROGRAM UNDER NATIONAL COMMISSION RECOMMENDATIONS, 1982-86 (in millions)

Calendar Year	HI	SMI
1982	$300	$1,160
1983	130	1,810
1984	150	1,140
1985	170	1,440
1986	420	2,760

Table 13-3

ESTIMATED CHANGES IN LONG-RANGE COST AND IN ACTUARIAL BALANCE OF HI PROGRAM UNDER NATIONAL COMMISSION PROPOSALS (as percent of taxable payroll)

	75-Year Period (1980-2054)
Under Present Law 1/	
Estimated Average-Expenditures 2/	6.36
Average Scheduled Tax Rate	2.87
Actuarial Balance	**-3.49**
Estimated Change in Average Expenditures for Recommended Proposals, Each With Respect to Present Law 1/:	
A Increase Normal Retirement Age Gradually to Age 68	-.38
B Hospital Coverage on a Calendar-Year Basis	+.05
C Change in Cost-Sharing Structure	+.03
D Catastrophic Cap	+.06
E Shifting Home Health Services to SMI	-.20
F Reduced Waiting Period for Disabled Beneficiaries	+.10
G Broadened Coverage Outside of United States	+.02
H Hospital-Based Physicians	+.01
I Universal Coverage	-.41
Total Change in Average Cost of Expenditures for Above Proposals, with Interaction Reflected	-.67
Change in Average Cost of Expenditures for Modifying Earnings Base After Adopting Above Proposals	+.17
Total Change in Average Cost of Expenditures for Above Proposals (Including Modifying Earnings Base), with Interaction Reflected	-.50
Total Average Cost of Expenditures for System as Modified by Above Proposals	5.86
Average Tax Rate Under Proposed Schedule	**6.09**
Actuarial Balance 3/	+.23

1/ Present Law Expenditures and Tax Rates are based on OMB Mid-Session Review assumptions blended into the intermediate assumptions of the 1980 Trustees Report, modified to include the effects of P. L. 96-499.

2/ Traditionally, Estimated Average Cost of Expenditures has included an allowance for trust-fund building and maintenance. However, Present-Law Expenditures shown do not include this allowance.

3/ The 75-year actuarial balance of +.23 percent of taxable payroll is sufficient to build the HI Trust Fund to the level of one year's outgo by the year 2000 and to maintain it at that level for the remainder of the 75-year period.