Social Security

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Chapter 6
Basic Principles and Present Provisions of the Medicare System

The Medicare program, which was originally officially designated as Health Insurance for the Aged but is now called Health Insurance for the Aged and Disabled, consists of two separate plans—Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). In popular usage, these plans are often referred to as Part A and Part B. The Medicare portion of the Social Security Act (Title XVIII) is divided into three parts, the first dealing solely with HI, the second dealing solely with SMI, and the third dealing with provisions common to both.[1]

Just as was done in Chapter 2 in connection with the Old-Age, Survivors, and Disability Insurance (OASDI) system, this chapter considers the Medicare program under several broad headings: eligibility conditions, benefit provisions, reimbursement bases, and financing provisions. Not only are the provisions as of the beginning of 1993 described, but also the reasons why they were adopted are given.

The development of the Medicare system is discussed in Chapter 7, and its financing principles are examined in Chapter 8. Chapter 9 is devoted to the consideration of possible future changes in Medicare.

Appendix D shows various reporting dates applicable to promulgations and reports under Medicare. Appendix E presents in tabular form the elements of the several fund ratios (measuring trust-fund

1. For a more complete and detailed description of the Medicare program, and especially how it functions, see Robert J. Myers, *Medicare* (Homewood, Ill.: Richard D. Irwin, 1970). Although this book was published about 20 years ago, most of it is still currently applicable; the principal changes which occurred subsequently are the coverage of the disabled, the financing changes of both HI and SMI, the establishment of PSROs, and the method of reimbursement of hospital and physicians.

balances against annual outgo) which are used to trigger certain features of the HI program (such as loan repayments).

Basic Principles of the Medicare System

There are a number of basic principles of the Medicare system which more or less parallel those of the OASDI system, although there are important differences. Among those discussed are the following: (1) the basic nature of the program; (2) the benefits being based on presumptive need; (3) the relationship with the floor-of-protection concept; (4) the non-earnings-related nature of the benefits; (5) the relationship between individual equity and social adequacy; and (6) the self-supporting contributory nature. Just as was the case in connection with the OASDI system, there is not complete agreement by all persons with these principles.

Basic Nature of HI

The HI program clearly meets the usual definitions of social insurance (see Appendix A). HI can be characterized as a program that has the following characteristics:

1. Administered by a government agency.
2. Financed by compulsory contributions (taxes) from the protected persons and their employers (except for certain older persons at the start of the program whose benefits are financed from general revenues and a small number of persons aged 65 or over who can voluntarily buy into the program at self-supporting premium rates).
3. Provides benefits as a matter of right, without any means or needs test, on the basis of satisfying specified eligibility conditions as to age and length of coverage.

Basic Nature of SMI

On the other hand, SMI does not meet the usual definition of social insurance, although it may be so categorized by some individuals. A better way of designating the SMI program is as a voluntary individual insurance program with government subsidy that is underwritten and administered by the government, using private carriers to assist with the administration. SMI is a program under which eligible individuals, in effect, elect whether they wish to participate and pay a premium in partial financial support of the program. Upon such

election, the federal government pays a matching amount at least equal to the enrollee's premium. SMI has some characteristics of social insurance, such as a broad pooling of the risk, administration by a government agency, and establishment by legislative action, but it lacks the compulsory-participation basis that is one of the prime characteristics of social insurance. Some might argue that an element of compulsory coverage is present in the "actuarial-bargain" basis of the premium rate due to the government subsidization thereof.

SMI differs significantly from private individual insurance in that the premium payment with respect to the protected person is not the actuarial equivalent of the benefit protection. This is the reason for the matching government contribution, which meets at least half the cost. This basis balances out the different risk levels involved between the broad group of persons aged 65 and over, who have differing insurance costs because of their variations in age and state of health, but for virtually all of whom the actuarial value of the protection is more than half the total cost (i.e., more than the enrollee premium). Similarly, the matching government contribution with respect to the disabled who are protected by Medicare meets an even larger proportion of the cost; this is necessary because of the higher average cost for this group and its greater nonhomogeneity than that of the aged group.

It would not have been possible for this voluntary plan to be financed solely by a uniform premium from all participants (or even separate rates for the aged and the disabled), because then antiselection would have entered in—the highest-cost risks would have tended to participate, and the lowest-cost risks would have tended to stay out. If a self-supporting premium rate were desired, a snowballing effect would have occurred. With each increase in the rates, those in good health would consider dropping out, and many would do so. Accordingly, it is necessary to have some second-party financial participation. Because no employer contributions could be involved in a current-risk plan applicable to all aged persons, the only remaining course of action was for the government (i.e., the general taxpayers) to participate in the financing.

With the participants being required to pay no more than half the cost of the program, it is a good buy for even the lowest-cost risks involved—such as the person just beyond age 65 who is in good health. Under these circumstances, it is a good buy—not only when considered on a lifetime basis but also (and necessarily) when considered on a year-by-year term-insurance basis. From a purely practical approach, it would be unreasonable to establish a program like this that would provide lifetime protection at an attractive premium rate

but that could be purchased at less cost on a term-insurance basis from other sources during the first few years after age 65. Under such circumstances, many shortsighted persons might adopt the latter course until they could enroll in SMI only at a greatly increased premium rate. Then, they would bring strong pressure to let them come into the government system at the standard premium rate.

Excluded Services

Certain medical expenses are excluded from coverage under both HI and SMI. The covered services must be for the diagnosis or treatment of an illness or injury or for improvement of the functioning of a malformed body member. Accordingly, routine physical examinations, the prescription and furnishing of eyeglasses (except after a cataract operation) and hearing aids, routine dental work, and inoculations other than for pneumonia immunization are not covered. Also excluded are services paid for by a government agency, such as the Veterans Administration; services for which there is no legal obligation, such as chest X rays provided by voluntary health agencies without charge; services required as a result of war; and services for cosmetic purposes (except to repair the results of an accident), for custodial care, or for personal comfort.

Another major exclusion is for services covered by a Workers' Compensation (WC) law, which, of course, are not too likely to occur for persons aged 65 and over, although quite likely for the category of disabled persons on the OASDI benefits roll for at least two years. Such WC exclusion would be much more important if shorter-duration disability beneficiaries were covered under Medicare. If Medicare pays for such services first, and it is later determined that a WC program has liability, the latter must reimburse Medicare for the benefits it paid.

Yet another important exclusion is that, as a result of legislation in 1980, Medicare is the secondary payor when automobile or other liability insurance is liable for the medical expenses (i.e., Medicare pays no more than enough so that the person has no out-of-pocket cost). Formerly, under such circumstances, the beneficiary received reimbursement from both sources and so frequently got far more than the actual medical costs. However, there may be difficulty in enforcing this provision, because frequently claims settlements of liability cases do not break down the total amount into medical expenses, loss of earnings, pain and suffering, and so forth.

Two further important exclusions were added in 1982, and a further one was added in 1986, in connection with coverage under group

health insurance sponsored by employers, such that coverage under these plans will be primary, and coverage under Medicare will be secondary. First, this will be the case in the first 18 months of Medicare eligibility for end-stage renal disease (ESRD) benefits (as defined later) when one is not entitled to Medicare for some other reason (e.g., for being aged 65 or over), and the group health insurance plan (regardless of the number of employees an employer has) provides coverage. If a person is eligible as an ESRD case and also as a working-aged or disability case (as described next), Medicare coverage is, oddly enough, *always* secondary.

Second, this will be the case when the insured person is aged 65 or over and, as a result of being currently employed, is covered under a group health insurance plan of an employer who has at least 20 employees for each working day in each of 20 or more weeks in the current or preceding calendar year. This provision also applies to the spouse aged 65 or over of an insured worker of any age.[2] This change was made for cost-savings purposes, on the grounds that it is logical to have private-sector benefits be the primary payor.

Third, Medicare is the secondary payor with respect to disability beneficiaries and their family members if such beneficiary is covered by an employer plan which applied to at least 100 employees in a typical business day in the preceding calendar year if so covered as an "active individual." Disability retirees under the employer plan are *not* in this category unless they have the characteristics of an active employee and are similarly treated. This entire provision is effective only for services rendered in January 1987 through September 1995 and currently does not apply to governmental-employer plans, although it formerly did.

As to the "employer-plan-primary" situations, the individual can opt out of such plan, and then Medicare will be the primary payor, except as noted hereafter. The interrelationship between the provisions for the "employer plan primary/secondary" situations and the ESRD provisions is very complicated; for persons aged 65 or over who have ESRD and who opt out of an employer plan, no Medicare benefits are available in the 3-month period after dialysis began (or the shorter period ending in the month before a transplant is received or preparation began therefor or before the month when a self-dialysis program began).

Medicare benefit coverage is generally restricted to services rendered in the United States, including American Samoa, Guam, the

2. This "Medicare-secondary-payor" provision does not apply to persons who have SMI or voluntary-HI with SMI, but do not have HI on their own earnings record or on their spouse's earnings record.

Northern Mariana Islands, Puerto Rico, and the Virgin Islands. However, under certain circumstances, benefits are available for services rendered in Canada and Mexico; these provisions are described later in the separate sections on HI and SMI because they differ between these two programs.

Hospital Insurance Provisions

This section first discusses the eligibility conditions for the Hospital Insurance (HI) portion of the Medicare program. After that, the benefit provisions, the provisions for reimbursement of the providers of medical services, and the financing are discussed in turn.

Eligibility Conditions

General Conditions

HI benefits are available to all persons aged 65 or over who are "eligible" for monthly cash benefits under either OASDI or the Railroad Retirement (RR) system—that is, they have fully insured status, or in the case of persons who are eligible on the basis of their spouse's earnings record, the spouse is fully insured and is age 62 or over or is in receipt of disability benefits.

Persons who have had HI coverage, but not OASDI coverage, in so-called Medicare-qualified government employment (i.e., federal workers under the Civil Service Retirement System [or a similar one] for service after 1982 and state and local government workers hired after March 1986 and not under OASDI, and also those hired earlier if the government entity so elects for service after March 1986) also have HI benefits available at age 65. They must meet the fully insured status requirement, through both regular quarters of coverage and those derived from Medicare-qualified government employment. In addition, federal workers who were in service on January 1, 1983 can count their previous federal service in order to meet the requirement.

Government employees (federal, state, and local) who have not been covered under HI can receive windfall HI benefits by obtaining them from their spouse's earnings record. This situation is prevented under OASDI by the "spouse-government-pension offset" provision. In the long run this HI windfall benefit will be eliminated because of the compulsory HI coverage of all federal employees beginning in 1983 and of all state and local government employees hired after March 1986.

When the Normal Retirement Age for OASDI was increased from 65 to 67 (on a deferred, phased-in basis) by the 1983 Act, no change in the minimum age of 65 for Medicare was made.

HI benefits are also available to all disabled beneficiaries under those programs (namely, disabled workers, disabled widows and widowers aged 50 and over,[3] and adult children aged 18 and over of retired, disabled, or deceased insured workers who were disabled before age 22) after they have been on the benefit roll for at least two years on the basis of their disability alone. HI-benefit protection for disabled beneficiaries is continued for 36 months after cash benefits cease because the person is engaging in substantial gainful employment but has not medically recovered. Also, a person who recovers from a disability but becomes disabled a second time within a certain period (60 months for disabled workers and 84 months for other disabled beneficiaries) does not have to serve the 24-month waiting period if it has already been met (or, if not met, all months of prior benefit can be counted toward it).

Renal Disease Cases

A special type of catastrophic coverage applies with respect to persons with end-stage renal (kidney) disease (ESRD), who are considered for Medicare purposes (for both HI and SMI) to be eligible as though they were disabled persons on the cash-benefits roll. To be so eligible, they must be (1) fully or currently insured on their own earnings record, (2) entitled to monthly benefits, or (3) the spouse or dependent child of a fully or currently insured worker or of a person entitled to monthly benefits.[4]

Persons with Medicare-qualified government employment have HI benefit protection for ESRD just as they do for age-65 or disability cases. Persons who develop ESRD *after* becoming entitled to Medicare for another reason can obtain SMI coverage then at the standard rate, even though previously declining it or obtaining it at a surcharge rate (just as is done for disability beneficiaries on attaining age 65).

Such ESRD cases do not have the two-year waiting period for Medi-

3. Equitably, widows and widowers becoming disabled at ages 60–64, whose OASDI cash benefit is the same as though not disabled, can qualify for Medicare eligibility after two years of being in a disabled status that would have resulted in entitlement to the OASDI benefit if they had been aged 50–59.

4. For the few who are not eligible, manipulative measures are readily available; for example, if a married couple has never been in covered employment and one spouse develops ESRD, the other spouse can obtain, in a relatively short time, the necessary minimal QC to be currently insured (and thus produce ESRD benefit eligibility).

care protection that disabled beneficiaries have (and not even the five-month waiting period for cash DI benefits, if eligible for them). Rather, coverage begins in the third month after the month in which renal dialysis begins (or without such a waiting period if less costly, medically appropriate self-dialysis, generally home dialysis, is used) or in the first month of dialysis if a kidney transplant (or preparation therefor) takes place in that month or the two succeeding months. Coverage ends 12 months after the month in which maintenance dialysis treatment stops or 36 months after the month when a successful kidney transplant occurs. In the event that an individual has a transplant that fails, no second waiting period is imposed when treatment is resumed.

Such protection is only available for the person with ESRD and not for other members of the family. Any expenses incurred by a person who donates a kidney for transplant purposes is also covered (with no cost-sharing payments being required). It is important to note that this special coverage is available for an afflicted family member of a worker who is actively employed at customary earnings. Persons aged 65 or over eligible for HI and disabled beneficiaries eligible for HI (by meeting the two-year waiting period) are, and have always been, eligible for HI benefits for ESRD regardless of this special provision.[5] As mentioned previously, Medicare is the secondary payor during the first 18 months of eligibility when coverage under any type of group health insurance plan is present.

The term *dependent child* as used for ESRD benefits is not defined in the law, but it is interpreted more broadly than for OASDI monthly benefits. All children meeting the requirements for OASDI child's benefits qualify for ESRD benefits, and so too do children aged 18 who are not in full-time school attendance below college level and children aged 19–25 who have been at least 50 percent dependent on the insured worker continuously since age 18. Also, the cash-benefits requirements for the length of the relationship (e.g., for stepchildren) do not apply for ESRD benefits for children (or for spouses either).

Blanketed-in Cases

As a transition, HI-benefit protection was made available to virtually all persons who were aged 65 and over when the system began operation and to those near that age at that time even though they

5. In mid-1990, about 145,000 persons had HI benefit protection for ESRD; of these, 29 percent were aged 65 or over, 29 percent were disabled beneficiaries receiving cash benefits, and the remaining 42 percent received benefits solely due to the special provision.

were not "insured" under either OASDI or RR. The cost of the benefits and the related administrative expenses for this transitional-noninsured group is met from general revenues, rather than from the taxes of workers and employers, as is the case for the cost for the insured persons.[6]

When federal employees (including those covered by the Civil Service Retirement system) were covered under HI in 1983, a special transitional provision was made for those in service on January 1, 1983. Federal employment before 1983 can be used to meet the QC requirements for fully insured status (for HI purposes only, and not for OASDI benefits) for those who are not fully insured on the basis of covered employment or of their spouse's earnings record. Spouses of such employees can also qualify for HI-benefit protection on the basis of these deemed HI-only QC. The cost of the benefits payable solely under this transitional provision is met by the General Fund of the Treasury (and is expected to be relatively small, because about 85–90 percent of federal employees currently attaining age 65 are fully insured on the basis of their own earnings record, often in nonfederal employment, or are spouses of persons with fully insured status).

Voluntary HI System

A special voluntary HI system which is financed on a premium-payment basis was established for individuals aged 65 and over who do not qualify for HI benefits as either insured or blanketed-in persons, effective July 1973. This system was extended in July 1990 to persons under age 65 who had had "free" HI-benefit protection con-

6. Specifically, except for certain individuals covered under the Federal Employees Health Benefits program and certain short-residence aliens, individuals who attained age 65 before 1968 are entitled to HI-benefit protection without regard to their insured status under OASDI or RR. In order to avoid the abrupt change that would have occurred if those attaining age 65 before 1968 were insured for HI without any QC but those attaining age 65 in 1968 were required to have 17 QC for men and 14 QC for women, a special transitional provision was introduced. Under this provision, a noninsured individual who attained age 65 after 1967 must have at least 3 QC for each calendar year after 1966 and before the year of attainment of age 65. Thus, an individual who became age 65 in 1968 had to have at least 3 QC, whereas the requirement for OASDI monthly benefits for such an individual was 17 QC for men and 14 QC for women. Because this requirement increased at the rate of 3 QC per year, while the requirement for OASDI monthly benefits increased at only 1 QC per year, this transitional HI provision for noninsured persons washed out. For women attaining age 65 in 1974 or after and for men attaining age 65 in 1975 or after, the requirement for OASDI benefits was at least as easy to meet as the special requirement for HI benefits for transitionally noninsured persons. The restrictions applicable to short-residence aliens when they are admitted as residents were tested in the courts and found to be constitutional.

tinued for 36 months following the termination of cash disability benefits because of engaging in substantial gainful activity despite still being under a disability, applicable after the end of such 36-month period. The benefit protection is the same as under the regular program. Coverage election is on an individual basis and is made under provisions corresponding to those for SMI. Such voluntary HI coverage is possible only when SMI coverage has also been elected, except that this is not required of the disabled beneficiaries (who may elect SMI coverage as well). The premium amounts are discussed in Chapter 7.

Period of Coverage

The terms *entitled* and *eligible* when used in connection with OASDI and RR benefits have technical meanings that are important to understand. Eligibility means attainment of the required age and possession of either the necessary insured-status conditions or relationship to a person who meets such conditions. Entitlement means being eligible and filing a claim. Thus, it is not necessary that the entitled individual actually receive the monthly OASDI or RR benefits to be eligible for HI benefits. In other words, a person (or his or her eligible spouse) may have HI protection even though fully employed at high earnings, under which circumstances the OASDI earnings test prevents the receipt of OASDI monthly benefits, HI-benefit protection can be filed for independently of filing for OASDI benefits (with the same retroactivity).[7]

HI-benefit protection is available for auxiliaries and survivors of insured workers only if they are at least 65 years old (except when such persons have ESRD, in which case—as mentioned before—no age requirement is present). Furthermore, for such a spouse, the insured worker must be at least age 62 (which can include the month of attainment of age 62). Because of the usual differential in age between husband and wife, there will be many instances of insured male workers who are aged 65 or over (and thus have HI protection) but whose wives are under age 65 and do not have HI protection. Conversely, there will be some cases (relatively fewer) where the insured male worker is aged 62–64 and is not eligible for HI benefits, but the wife is aged 65 or over and is eligible for HI benefits (if the worker applies for early-retirement OASDI benefits—even though they will not be payable, because of the earnings test).

7. Originally, it was required that filing for OASDI and HI had to be simultaneous. However, with the enactment of the 1977 Act, which allowed the monthly earnings test to be used only for the first year of claim, this joint filing could be disadvantageous to the beneficiary. Accordingly, separate filing has now been allowed.

Eligibility for HI benefits begins on the first day of the initial month of entitlement, just as is the case for OASDI benefits (e.g., for persons who attain age 65 in a month, on the first day of that month). Eligibility for HI benefits ceases when entitlement to OASDI monthly benefits terminates. For the vast majority of persons aged 65 and over, the various OASDI benefits that yield eligibility to HI protection cease only upon death. It may be noted that, although an OASDI monthly benefit is not payable for the month of death of the beneficiary, HI-benefit protection extends up through the date of death. If a disabled beneficiary recovers from disability, HI protection terminates at the end of the last month for which the person is entitled to cash benefits (which will be three months beyond the actual month of recovery). Those who are eligible as a result of ESRD have their protection terminated after the 12th month after the month in which dialysis ceased or the 36th month after the month in which the transplant occurred, whichever was later.

Benefit Provisions

The basic benefit principle under the HI system is to provide hospital services, posthospital services, and home health services to the beneficiaries after certain deductible and cost-sharing amounts are paid by them, rather than providing specified indemnity benefits and leaving it up to the beneficiary to pay the difference between the charges and the benefits. In this respect, HI is patterned along the lines of Blue Cross benefits instead of those of more usual insurance-company plans.

Four separate types of benefits are provided under HI—inpatient hospital services, posthospital skilled nursing facility services,[8] home health services, and hospice care. The most important of these benefits is the inpatient hospital benefit, with the other benefits and certain portions of SMI being designed to reduce hospital utilization. For example, if inpatient hospital services are made available at relatively little financial cost to the individual, but diagnostic services by hospitals on an outpatient basis are not covered, then significant use of hospital inpatient services might be made solely because of the lower cost to the individual (but at considerably increased cost to the insurance system). Accordingly, the insurance system might operate more economically by providing the outpatient diagnostic benefit directly than if beneficiaries utilize an inpatient benefit to obtain the diagnostic services indirectly. Such diagnostic benefits are covered under SMI.

8. Before 1973, these were called extended-care facility services.

Geographic Limitations

HI-covered services are generally available only from hospitals and other providers of services in the United States. As used here, the United States includes American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands.[9] One exception is an emergency illness occurring in the United States when the individual is taken to a hospital in Canada or Mexico because it is more accessible than the nearest suitable hospital in the United States. Another exception is for any type of hospitalization for those whose U.S. residence is more accessible to a foreign hospital than to a U.S. one. The vast majority of the cases where these two exceptions are applicable occur in the northernmost parts of the New England states. Yet another exception relates to emergency hospitalization in Canada while traveling between Alaska and another state.

Duration of Benefits and Definition of Spell of Illness

An individual is entitled to inpatient hospital benefits for the first 90 days in a spell of illness and for an additional "lifetime reserve" of 60 days, which can be used on an elective basis by the beneficiary at any time after exhaustion of the 90 days. The term *spell of illness* is defined as the period beginning on the first day for which a person receives these benefits and terminating after 60 consecutive days during which the individual has not been an inpatient in a hospital or a skilled nursing facility (SNF).

Certain special conditions apply to services rendered in psychiatric hospitals. During the individual's lifetime, HI benefits are available with respect to only 190 days of such care. Further, an individual who is in a psychiatric hospital when first eligible for HI has a 150-day maximum on the benefits for such stay.

As an example of how spells of illness are determined, consider a man eligible for HI benefits who attains age 65 in April 1991. Suppose he enters a hospital on October 1, 1991; his spell of illness begins at that time. If he leaves the hospital on October 10, 1991, and does not then enter an SNF, his spell of illness will continue for 60 days thereafter—until December 10, 1991. If he enters a hospital before the latter date, his spell of illness will continue for 60 days after his subsequent discharge, and so on. Once the spell of illness is ended, a new one begins only when he again enters a hospital.

9. Employment in the Commonwealth of the Northern Mariana Islands is covered under OASDI and HI.

The question might be raised why the inpatient hospital benefit protection covers only the first 90 days of hospitalization and an additional 60 days under some circumstances. It might be argued that there should be unlimited-duration protection, because one of the most important features of any insurance program is to cover catastrophic risks. On the other hand, many medical experts believe that, of the relatively few long-duration hospital cases, only a small proportion really should be in a hospital. Instead, lower-cost forms of medical care such as SNFs and home health services furnished in the patient's home can provide what is needed. Thus, financial limitations placed on long-duration hospital cases can motivate patients toward more economical, equally effective forms of medical treatment.

Inpatient Hospital Services

The inpatient hospital services covered under HI include (1) room and board, (2) general nursing services, (3) general medical social services, (4) use of the operating room and similar facilities, (5) drugs, medical supplies, and appliances, which are permanently installed while in the hospital (such as pacemakers, colostomy fittings, and artificial limbs; (6) diagnostic and laboratory tests, and (7) therapeutic services (such as physical therapy). Also covered under HI are preadmission diagnostic tests which are performed on an outpatient basis within 24 hours before admission as an inpatient; these would normally be covered under SMI (with larger cost-sharing by the patient), but this procedure is followed to provide a less costly substitute as against the person being hospitalized a day earlier to obtain such tests. Excluded are the services of private-duty nurses, the excess cost of a private room over a semiprivate room (unless determined to be medically necessary), luxury items such as telephone and television, and services of physicians other than interns or residents in training under teaching programs and other than physicians engaged in administration, research, and education.

The services of radiologists, anesthesiologists, pathologists, and physiatrists in hospitals (so-called hospital-based physicians) are not included under HI, although they are covered under SMI. The costs of X rays, anesthetic procedures, laboratory tests, and physical therapy treatment furnished to an inpatient and billed by the hospital are divided into the amount attributable to the personal services of the physician involved and the remaining amount attributable to auxiliary personnel, supplies, and equipment. The latter part is covered by HI, and the former part by SMI.

For a hospital to participate in HI, it must apply to do so and then

meet certain requirements. In general, these requirements are the same as those that hospitals meet to qualify under some Blue Cross plans. In addition, the hospital must maintain a hospital utilization review plan and comply with civil-rights provisions established by other federal legislation. Also included as hospitals are Christian Science sanatoriums.

Utilization review is accomplished by a committee that must include physicians. This committee studies the admissions, the lengths of stay, and the services provided with respect to medical necessity and efficiency. Each case that lasts for an extended period must be approved by the committee as requiring further hospitalization, or else benefits will terminate.

Inpatient Hospital Cost-Sharing

The beneficiary is covered for all inpatient hospital services but is required to make certain payments. First, there is an initial deductible, which initially was $40 in July 1966 through December 1968.[10] It was automatically increased each year in line with increases in the average daily per capita cost of insured persons covered under HI (disregarding the effect of the various cost-sharing payments), until reaching $204 for spells of illness that began in 1981. For 1982, it was increased, by a legislative change, more than would have resulted from the procedure used previously and became $260 (instead of $232). Then, in 1987, legislation reduced the promulgated initial deductible ($572) to $520; interestingly, if the legislated increase in 1982 and the legislated decrease in 1987 had not been made, the initial deductible in 1987 would have been $508.

Beginning with 1988, the automatic adjustment of the initial deductible is based on the estimated change in the hospital-cost "market-basket" index for the 12-month period ending with the September of the particular year as compared with that for the previous 12-month period. Further, an adjustment is made to reflect changes in "real" case mix. The initial deductibles for various years are shown in Table 7.3 ($676 in 1993).

Second, there is a daily cost-sharing charge for the 61st through the 90th day of the benefit period, determined as 25 percent of the initial deductible. Third, there is daily coinsurance equal to 50 percent of the

10. It is widely—and incorrectly—believed that the $40 figure for the initial deductible during 1966–68 was selected as the cost of the first day's hospital care or as the average cost of one day's care. Actually, this figure was selected somewhat empirically for cost-control purposes, although it happens to approximate what was expected to be the average daily cost under the program in the first year of operations.

initial deductible for lifetime reserve days used beyond the 90-day regular period. Fourth, the blood deductible requires the beneficiary to replace or pay the cost of the first three pints of whole blood used in his or her treatment; its purpose is to encourage and stimulate the voluntary blood donor program by volunteers replacing the blood used.

The initial deductible has been criticized as being a deterrent to a necessary hospitalization, which may be the case in some instances. On the other hand, it may have some effect in preventing overutilization, particularly for short-duration cases where hospitalization is really not necessary (e.g., minor illnesses for which hospital care is more convenient to the patient, the family, or the doctor; administration of diagnostic tests; and parent-sitting when the beneficiary's children take a short trip). The initial deductible is small enough not to present an unduly large financial barrier. Moreover, for those individuals who might find it to be a real barrier, Medicaid is available.

Through 1968, the initial deductible remained fixed at $40, as prescribed by the initial legislation. The amount for 1969 was determined by multiplying the initial figure by the ratio of (1) the average daily cost for covered inpatient hospital services with respect to insured persons for 1967 ($43.03) to (2) such average cost for 1966 ($37.95). The result for the initial deductible was rounded to the nearest multiple of $4 and was $44.[11] For subsequent calendar years, the inpatient deductible was $40 times the ratio of (1) the average daily cost for covered inpatient hospital services with respect to insured persons for the second year preceding the year for which the determination was being made to (2) such average cost for 1966. Beginning with the determination of the 1982 amount, the base initial figure was arbitrarily increased by legislation from $40 to $45.[12]

Beginning with 1988, the $45 base for 1966 is no longer used. Rather, the initial deductible for the preceding calendar year is merely

11. The initial deductibles for years subsequent to 1969 were determined in a similar manner. The determination made for 1973 actually yielded a figure of $76, but a rather strange (and possibly of doubtful legality) ruling of the Price Commission prevented the increase to the actuarially determined amount (but rather only an increase from $68 to $72). Since no further preventive action was taken, the initial deductible for 1974 showed a sharp increase, because it moved, in essence, from the $76 base to $84.

It is also interesting that the Price Commission took no action at all in late 1972 (when it prevented the full increase in the HI initial deductible) with regard to the increase in the "cost" of OASDI and HI that was to take place in 1973. An employee with earnings of at least $10,800 in both 1972 and 1973 had the OASDI-HI taxes increased from $468.00 to $631.80, or by 35 percent. For a similar self-employed person, the corresponding figures were $675 and $864, an increase of 28 percent. The same situation prevailed for persons with lower earnings; for employees with wages of $9,000 or less, the increase was 13 percent.

12. This action was taken primarily for budget-balancing reasons rather than to strengthen the financing of HI by reducing benefit outgo.

multiplied by the percentage change in the hospital-cost "market-basket" index as described above.

Consider a few examples of how the foregoing provisions for inpatient hospital benefits actually work. If Mr. A was hospitalized in 1990 for the first time since he became aged 65, his spell of illness commenced then and continued until he had been out of a hospital and SNF for at least 60 consecutive days. He was liable for the $592 initial deductible (unless his stay was very brief and the hospital's charges were less than this).

If Mr. A went in and out of the hospital several times but did not end his spell of illness, he would have only the one $592 initial deductible to pay, although, after he had a total of 60 days of hospitalization, he would have to pay the cost-sharing amount of $148 for each of the next 30 days of hospitalization in 1990, or if it continued into 1991, at the rate of $628 then applicable. If he continued in the same spell of illness and had a cumulative total of more than 90 days of hospitalization, he could draw on his lifetime-reserve days (and pay the cost-sharing amount of $296 per day for days in 1990).

It should be noted that the various cost-sharing payments are dependent on the period when services are received and not when the spell of illness began.[13]

Under certain circumstances, it is to the individual's financial advantage to remain within the same spell of illness, thus having only the one initial deductible. This situation is reversed, however, for individuals with long hospitalization stays who have daily cost-sharing amounts to pay and then a complete cessation of benefit protection after 90 days of hospitalization (except for the lifetime-reserve days). For example, an individual with two hospital stays of 10 days each in a calendar year is financially better off if these occur within one spell of illness, whereas an individual with two 40-day hospital stays in a particular year is better off if these occur in separate spells.

Use of Nonparticipating Hospitals

Benefits can be provided in nonparticipating hospitals in the United States if the situation is an emergency, but sometimes in these cases the benefits may be at a reduced level. If the hospital will not accept reimbursement on a reasonable-cost basis, then the bene-

13. Before 1982, the daily cost-sharing amount depended solely on that applicable when the spell of illness began. Now, it depends on that which is applicable for the year in which each day of hospitalization occurs. This change was made for reasons of both administrative simplicity and program cost reduction (but it increased cost to beneficiaries in split-year spells of illness).

ficiary is reimbursed at the rate of 60 percent of room-and-board charges and 80 percent of ancillary charges, as determined on a reasonable-charges basis, less the usual cost-sharing amounts.

Use of Canadian and Mexican Hospitals

In those limited cases where HI coverage is applicable to Canadian and Mexican hospitals, if the hospital bills the Medicare program, it will be reimbursed 100 percent of charges, as determined under regular Medicare procedures less any cost-sharing payments for which the beneficiary is liable. If the hospital does not choose to bill the Medicare program, the beneficiary is reimbursed on the same basis as when in a nonparticipating hospital in the United States which does not accept reasonable-cost reimbursement.

Skilled Nursing Facility Services

Many hospital patients—and especially those aged 65 and over—reach a stage in their illness where they no longer require the intensive and costly care furnished by hospitals and yet they are not capable of returning to their homes. In recent years, there has been a growing tendency to have an intermediate facility for such cases. Some of these facilities have been part of a hospital, such as a convalescent wing. In other instances such facilities have been completely separate organizations, designated as SNFs (as distinguished from ordinary nursing homes, which almost always provide only custodial or domiciliary care).

Before HI was enacted, some Blue Cross and insurance-company plans provided benefits for services in SNFs. It was hoped that this would decrease the unnecessary use of hospital services, as well as provide benefits for another type of health care. Some experts believe that the total cost of hospital services and SNF services may be less when both are covered than if only hospital services are covered. Other experts, however, believe that this will not be the case, although better medical care is provided. In certain instances, however, SNF benefits are used (at little or no cost to the beneficiary) when, with a little personal effort on the part of the family, adequate care can be provided at home. The HI program has greatly accelerated the use of these intermediate facilities, and there will probably be a strong trend in this direction in the future.

Although there is great logic in the concept of an intermediate facility between the intensive care provided by hospitals and the care that can be furnished at home, new problems are created by this cov-

erage. Frequently, and especially for persons of advanced age, it is difficult to draw a clear distinction between the need for SNF services and the need for custodial care with a limited amount of nursing care. The intended distinction is based on the level of care and medical supervision required by the patient—and not the diagnosis, the patient's condition, or the degree of functional limitation. For example, a cardiac patient who has no serious associated illness but who requires only the assistance of an aide in feeding, dressing, and bathing is considered as being in need of only custodial care. On the other hand, a cardiac patient who requires a trained medical person to adjust the digitalis dosage in maintaining proper fluid balance and in constantly watching for signs of decompensation is considered as needing SNF care.

Custodial care is not covered under HI for either inpatient hospital services or SNF services (nor was it covered by previously existing insurance or benefit programs, because it is not medical care). Accordingly, strong pressures are often exerted to make it appear that SNF care is needed, because it involves obtaining needed personal care in a high-quality institution, without substantial cost. Moreover, many facilities provide both SNF care and domiciliary care, so that it is difficult to identify which is furnished in an individual case.

One might wonder why custodial or domiciliary care in an SNF is not covered under HI when some medical services are necessary and are provided. Probably the major reasons are the high cost involved because the use of such services could be largely at the choice of the beneficiary (and so it could be called an uninsurable risk) and the difficulty (even impossibility) of distinguishing this care from strictly "hotel" services. It is recognized widely that there are many instances where older people need this kind of service. Then, high (and even catastrophic) cost burdens fall on these individuals or on others who must support them, unless public assistance is sought and is available. However, if benefits for this risk were provided as an "insurance right," many would use them who now are adequately (and perhaps even better—at least from a psychological standpoint) taken care of by daughters, sons, or other persons.

The SNF services covered closely parallel the similar inpatient hospital services. Included are room and board in a semiprivate room, general nursing care, medical social services, physical and other types of therapy, drugs furnished by the SNF, and supplies and appliances. Similarly, physician services are not covered except when performed by interns or residents in training of a hospital with which the SNF has a transfer agreement.

To obtain SNF benefits, the individual must have been hospitalized

for at least three consecutive days and must be admitted to the SNF within 30 days (generally) after discharge from the hospital.[14] Furthermore, such person must need medical services that can be provided only in the SNF (other than in a hospital).

The hospitalization requirement to be eligible for SNF benefits was introduced to assure that an individual's treatment in the SNF is for causes that would otherwise have required the more expensive care of a hospital. This is done to assure that it is medical care that is being furnished, not custodial care. Legislation in 1981 provided that the three-day-hospitalization requirement could be eliminated by the Secretary of HHS if it were determined that this could be done without increasing the overall cost of the HI program (in the author's opinion, an utter impossibility!), but this has not been done as yet.

Cost-Sharing and Duration of SNF Benefits

The SNF-benefit provisions are also based on the spell-of-illness concept. The first 20 days of SNF care in a spell of illness are provided without cost to the individual. The following 80 days of SNF care have a cost-sharing provision of one eighth of the initial deductible per day.[15] The SNF cost-sharing will, on the average, represent about one third to one half of the SNF charges and will be somewhat more than the cost of living at home. Accordingly, it may significantly prevent overutilization.

Home Health Services

In certain instances, patients in a hospital or SNF may have progressed to the stage where they could be cared for at home with a minimal amount of services, which are generally referred to as visiting nurse services or home health services. These will generally be at a significantly lower cost to the insurance plan if covered thereby than if the individual stayed in the hospital or SNF, as might be done if the home health services were not covered. Furthermore, from a medical standpoint it is probably better for the patient to be at home instead of in an institution. It is required, however, that these services be provided by organizations meeting certain requirements as to professional standards, that the level of care furnished be necessary from

14. A person who has been in an SNF, after having satisfied the three-day hospitalization requirement, who is discharged from the SNF and who returns to it for further care within 30 days does not have to meet such three-day requirement.

15. Special provisions apply to those using Christian Science sanatoriums for SNF services. The benefits then are available for a maximum of only 30 days in a spell of illness, and the cost-sharing applies to all days.

a medical standpoint, and that, as a practical matter, such care cannot be furnished in another setting with lower cost (such as a physician's office or a hospital outpatient department).

The HI program provides for coverage of a wide range of home health (HH) services to homebound cases, regardless of prior hospitalization. (HH services of exactly the same type, and likewise with no cost-sharing, are also available under SMI, but they are always provided under HI if the person is eligible for HI benefits.) These HH services include not only visiting nurse services but also physical, occupational, and speech therapy,[16] medical social services, part-time services of a home health aide (not solely for housekeeping purposes), medical supplies (but not drugs), services of interns and residents in training of hospitals when the HH Agency (HHA) is affiliated therewith, and outpatient hospital, SNF, and rehabilitation center services arranged for by the HHA that require equipment that cannot readily be brought to the patient's home.

Cost-Sharing and Duration of HH Benefits

The HH benefits under HI have no cost-sharing provisions. For HH benefits, unlike SNF benefits, there is no requirement that the individual must have been hospitalized for at least three qualifying days (although there was such a requirement before legislation in late 1980 eliminated it).

Before legislation in 1980, there was a maximum of 100 HH visits provided within the period before the next spell of illness began. Now, there is no maximum. A visit consists of one specific service furnished to the individual. Thus, more than one service can be furnished on a particular visit of a team of technicians (such as nursing care provided by one member and speech therapy provided by another).

Hospice Services

Upon election by the beneficiary (which can later be revoked), hospice care is provided for terminally ill persons who are expected to die within six months. Under such circumstances, all other Medicare benefits are waived, except for physician services and except for conditions not related to the terminal illness.

Care is provided in both the hospice and at home, including health

16. Such therapy services are covered in general by SMI, but the person by being homebound can obtain them as HH services (and thus not have any cost-sharing payments to make).

aide and homemaker services, medical social services, and counseling. Prescription drugs for symptom management and pain relief are covered, whether in or out of the hospice, with coinsurance of 5 percent of the reasonable cost of the prescription (but not more than $5 per prescription, an unlikely occurrence).

Hospice care can be received for a lifetime maximum of 210 days—for two periods of 90 days each and one subsequent period of 30 days. If hospice benefits are canceled during a period, the individual can later elect such benefits again, but only for any periods remaining (days still left in the period when this benefit coverage is revoked are thus forfeited).

Respite care as an inpatient in the hospice is provided—to give a period of relief to the family of the patient which is providing home care. This is available for no more than 5 consecutive days. There is coinsurance of 5 percent, but such cost-sharing will not exceed, in the aggregate in a spell of respite care (which ends after 14 consecutive days when the hospice-care option is not in effect), the amount of the HI initial deductible.

Reimbursement Provisions

Reasonable-Cost Basis

Under HI, the institutional providers of services consist of hospitals, SNFs, and HHAs. The law in effect prior to the 1983 Act provided that reimbursement to these institutions should be on a reasonable-cost basis (or on the basis of customary charges, if these are lower, which is rarely the case). In essence, this meant that the reimbursement would be on a nonprofit basis. The fact that usually no profits are allowed in the amount reimbursed is relatively unimportant in the hospital area because about 90 percent of all short-stay hospital beds are in nonprofit or government hospitals. Similarly, virtually all HHAs are of a nonproprietary nature. On the other hand, a substantial proportion of SNFs are operated on a proprietary basis.

The reasonable-cost reimbursement approach had been more or less followed by Blue Cross in previous years, with certain approximations being made in actual practice to measure costs. Naturally, all types of indirect expenses such as a share of the interest on loans, bad debts, costs of research not paid for by other sources, and net expense of operating nursing schools are included, as well as the usual direct expenses associated with inpatient care. The general principle prevailed that HI would pay no more, and no less, than the actual cost of

providing care for its beneficiaries. This approach differs from that applicable to private-paying patients, who pay charges that may bear no specific relationship to the actual costs involved.

It was widely considered, upon the enactment of Medicare, that HI would be a great financial boon to hospitals. Previously, many had received less than full costs from medically indigent patients, and those aged 65 and over had made up a very large proportion of this category. In some instances, near-indigent patients did not pay their bills or paid only part of them. In instances where public welfare agencies took over responsibility for the bills of indigent persons, limited welfare funds resulted in less than adequate payments to hospitals. The hospitals were forced to take these low reimbursements—a preferable situation compared with the possibility of getting less from the patients themselves. Then, under Medicare, hospitals were assured of getting full reasonable costs with respect to patients aged 65 and over, according to the intent of the law.

Representatives of hospitals argue that, despite their generally nonprofit nature, a profit (or plus factor) must be made available. Otherwise, they assert, funds will not be available for the replacement of capital assets or for future expansion. In answer to this argument, it should be pointed out that this need should be met by the proper use of depreciation funding and, as in the past, by fund-raising from the general public, government grants, and loans (interest on which is considered a reasonable cost under HI). Moreover, if all hospitals are given a profit override, this would result in the undesirable situation of some hospital which should not expand then having available large sums that would not be needed for current operations. Furthermore, if the plus factor is a uniform percentage, the procedure would encourage inefficiency and high costs by giving a larger override under such circumstances.

The reimbursement principles developed by the federal government initially consisted of a 2-percent supplement on the determined reasonable costs. Effective July 1, 1969, this 2-percent factor was eliminated on the ground that, by this time, hospital cost-accounting systems should have been sufficiently refined so that all costs were being adequately recognized. The hospitals urged a change in the reimbursement principles to a basis that would give them more equitable treatment (e.g., by recognizing the alleged higher per capita nursing costs for persons aged 65 and over). As a result, about half of the 2-percent factor was restored by building an "excess nursing cost for the aged" differential into the reimbursement formula; this, however, was eliminated in 1982.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

made a number of changes to tighten up and cut back on the reimbursements to hospitals and SNFs. Among these were the establishment of limits on total inpatient costs per admission and on increases in such costs and restrictions on reimbursement of provider-based physicians. Some of these changes were overridden by the new method of reimbursement prescribed by the 1983 Act.

Another change was made in this legislation so as to discourage hospitals from withdrawing their employees from OASDI-HI coverage. Under such circumstances, by a complex procedure, they would receive lower overall reimbursement. This provision was repealed by the 1983 Act, as being no longer necessary after compulsory coverage was applied to this category of employment.

This legislation also provided for a new form of prospective reimbursement under risk-sharing contracts with Health Maintenance Organizations (HMOs) and other comprehensive medical plans. They will be paid prospectively at a rate equal to 95 percent of the Adjusted Average Per Capita Cost of providing services to Medicare beneficiaries in the same geographic area—a great attraction to establish such organizations in high-cost areas (i.e., high not because of real underlying factors, but rather because of unusually high charges there). The adjustment is made on the basis of variations by age, sex, welfare status, and institutional status for the organization as compared with the general Medicare population in the same geographic area. The organization can keep any profit over the 95-percent reimbursement, but is supposed to use it to provide additional benefits or lower the premium rates charged to the members (which are, in essence, in lieu of the Medicare cost-sharing amounts).

In an attempt to slow down the increase in hospital costs, a new method of reimbursement by the HI program was developed and incorporated into the Social Security Amendments of 1983. The genesis of this new method of hospital reimbursement was that prospective procedures had been studied for some time, but specifically TEFRA required the Secretary of HHS to develop recommendations therefor. The report of the Secretary of HHS was submitted in late 1982, and its recommendations were embodied in administration-sponsored legislation. The provisions in the enacted legislation represent a modified version of these recommendations.

General Nature of New Reimbursement Procedure

The law provided, on a phasing-in basis, a major change in the method of reimbursement of hospitals under the HI program. Payment for inpatient operating costs of hospitals will, as a general prin-

ciple (but with a number of exceptions), be determined in advance and paid on a per case basis, depending on the type of illness. A fixed amount (varying by geographic regions, of which there are nine, and by rural-urban locality) will be paid for each of some 475 types of cases, or Diagnosis Related Groups (DRG).

These changes are intended to create incentives for hospitals to operate in a more efficient manner, because they will be allowed to keep payment amounts in excess of their costs or, in turn, will be required to absorb any costs in excess of the reimbursement produced by the DRG rates. The new method was phased in over a three-year period beginning with hospital fiscal years which started after September 1983 (as described later).

Reimbursement for capital outlays of hospitals with respect to inpatient services continued to be related to actual costs therefor. Under the 1983 Act, this would continue only until October 1986, when they would be included within the DRG process. However, this deadline was postponed several times by legislation, and was not put into effect until October 1991. Now, hospitals are paid a fixed capital payment per Medicare patient, which can be used toward the cost of capital investments or for other purposes.

Development of DRG Payment Amounts

The Secretary of HHS determines the applicable DRG payment amounts. Initially, this was done from sample data which have been collected for Medicare beneficiaries and from other sources where necessary. As experience develops, refinements and greater accuracy are possible. The DRG amounts for the second year of operation (beginning October 1984) were obtained from the initial amounts, by increasing the latter by the percentage rise in a "market basket" of goods and services purchased by hospitals, plus ¼ percentage point (originally, 1 percentage point, but reduced by legislation in 1984). The Secretary of HHS promulgated that such increase would be only about 4 percent, which many hospitals protested as being considerably too low.

For subsequent fiscal years, the DRG amounts have been increased by percentages, as determined by the Secretary of HHS, after considering recommendations made by the Prospective Payment Commission. This commission has been appointed by the Congressional Office of Technology Assessment and is composed of experts in the provision and financing of health care.

There are several exceptions and differences in treatment for dif-

ferent types of cases and hospitals. Not subject to the DRG procedure are psychiatric, rehabilitation, long-term care, and children's hospitals and all hospitals in outlying areas of the United States (e.g., Puerto Rico).

Special treatment is provided in the following instances:

1. Additional payments for cases with unusually long durations (so-called outliers).
2. Until October 1986, capital expenses were reimbursed on a reasonable-cost basis (later, this was extended through September 1991, but with certain small percentage reductions at times).
3. Direct medical education expenses (such as for interns and residents) continue to be reimbursed on a reasonable-cost basis.
4. Special treatment is given to sole community hospitals (namely, part of their own costs are used in all years).
5. Special treatment is given to public and other hospitals which serve a disproportionately large number of low-income persons and HI beneficiaries (because such patients may be more severely ill than the average patient).
6. Adjustments may be made for hospitals in Alaska and Hawaii (because of their possible unique circumstances).
7. The DRG procedure is superseded in any states which have established their own reimbursement system (of general applicability) if the aggregate HI expenditures thereunder, for a three-year period, are not greater than they would be under the DRG procedure. Maryland, Massachusetts, New Jersey, and New York have such systems.
8. The cost of all services furnished by hospitals which previously were paid under SMI are, with certain exceptions, reimbursed under HI under the new procedure.

The Department of HHS was required to make studies as to the applicability of the DRG procedure to extended-care facilities and to physician services rendered to hospital inpatients.

Phasing-In of DRG Payment Amounts

The new reimbursement procedure was phased in according to the procedure shown in the following table. In all instances, DRG rates differ as between rural and urban hospitals and will be adjusted for area differences in hospital wage levels.

Year of Operation	Proportion of Total Payment Based on: Particular Hospital's Reasonable-Cost Basis	DRG Rate: Regional	DRG Rate: Nationwide
1	75%	25.0%	—
2	50	37.5	12.5%
3	25	37.5	37.5
4 and later	—	—	100.0

Estimated Cost Savings under DRG Procedure

The additional savings to the HI program resulting from the DRG procedure, over and above what had been estimated to result from the temporary (until October 1985) provision on hospital rate-of-increase limits as provided under TEFRA, would be $18 billion in 1985–89, according to the intermediate-cost estimate. The estimated reduction in cost in 1989 ($7 billion) represented about 8 percent of the total outgo that there would have been without this change in the hospital reimbursement basis.

Possible Problems with DRG Procedure

Will the new hospital reimbursement basis, using DRGs, be successful? Time alone will tell! Certainly, some problems will arise because of the drastic changes in reimbursement procedures. There is always a question as to the net cost effect of comprehensive (and complex) governmental controls over any portion of the economy, as against free-market forces.

The DRG procedure will involve many new and costly administrative processes. However, the previous reasonable-cost procedure was not entirely simple and of low cost to operate. Nor were the results always reasonable and logical.

The question arises as to whether the diverse conditions which can arise for patients can be neatly "pigeonholed" into a relatively small number of categories. Also, the allocation of hospitals to certain rural-urban and regional groups may result in borderline situations of considerable differences.

Perhaps the most important question is whether physicians will follow the urgings of hospitals to provide less costly medical treatment (including drugs and tests) and/or shorter hospital stays. Will the patients receive less adequate medical care, or instead will unnecessary

(which is difficult, or even impossible, to define) medical care be reduced? Will the hospitals attempt to "game" the DRG-procedure by upgrading the severity of the diagnoses (there have already been some allegations that this is being done)?

Another important question is what hospitals, especially not-for-profit community hospitals, will do with any "profits" (excess of DRG payment over their costs), or, conversely, how they will offset any "losses."

Will hospitals spend profits for unnecessary expenditures? Or will they use profits to lower rates for other-than-Medicare patients or to lower their general fund-raising requests?

More serious, however, is the question of how hospitals will make up for losses. Will this be done by cost-shifting to other patients (or, really, primarily to their insurers and thus, in the end, to employers and workers)?

Despite all of these potential problems and difficulties, it would appear that the new DRG procedure is worth trying. In theory, the best way would be to let free-market pricing principles apply *and* to have conscientious, devoted efforts on the part of all parties concerned to hold down utilization of services and thus costs. But this has apparently not been too successful in the past. Perhaps, the American public is willing to pay what seem to be the ever-increasing costs in order to obtain what it considers high-quality medical care.

Special Treatment of Proprietary Institutions

The owners of proprietary institutions receive a reasonable return on their investment capital, although not necessarily on their net equity. They initially obtained, in the reimbursement computations, a rate of return on their net investment capital equal to 1½ times the trust-fund interest rate, which is the rate on currently acquired special issues (see Chapter 2). After the 1983 Act, such rate of return for hospitals was the trust-fund rate (but continuing at 1½ times this rate for SNFs and HHAs). Then the Consolidated Omnibus Budget Reconciliation Act of 1985 eliminated such returns for hospitals and reduced the rate of return for SNFs and HHAs to the trust-fund interest rate.

Pros and Cons of Reasonable-Cost Reimbursement

Reimbursement of institutional providers of medical services on a cost basis has been widely criticized as promoting inefficiency—or, at least, not encouraging efficiency. This criticism has been particularly

relevant in recent years, when hospital costs have risen rapidly. Reimbursement on a cost-plus basis is even more susceptible to this criticism. Accordingly, it has often been suggested that hospitals should be given financial rewards when they operate extremely efficiently—and, conversely, should be financially penalized when their operations are inefficient.

In theory, this system of rewards and sanctions sounds very logical and desirable. There is, however, the difficulty of measuring efficiency of operation. Simple statistical measures such as average daily cost or average duration of stays are not valid because of differences in the characteristics of the patient loads in different hospitals. Even more important are basic philosophy and purpose. If all hospitals were of a proprietary nature, then rewards and sanctions would provide strong incentives to increase efficiency. However, since the vast majority are operated on a nonprofit basis, the granting of rewards to be spent in any way the hospital wishes (or the invoking of penalties, which must be recovered somehow by the hospital from other sources) is anomalous.

Actual Reimbursement Operations

Up to this point, the discussion of reimbursement has implied that hospitals receive payments only after a bill has been rendered for each individual patient. Such procedure is often followed for private patients, whether paying out of their own pockets or through an insurance-company plan. It was possible from the inception of the program until mid-1973 for hospitals to obtain HI interim reimbursement so as to be, more or less, on an accrual basis, and the vast majority of hospitals did so. This procedure was stopped on the ground that the performance of the fiscal intermediaries and the hospitals had reached such a high level of efficiency and speed that it was no longer necessary, so in most cases reimbursement could properly be on a rendered-bill basis. Another reason this was done was to improve the current budgetary situation of the federal government by having a one-time "gain," when outgo was temporarily reduced or suspended. Such action should be viewed in light of the discussion on Social Security and the unified budget in Chapter 4.

Implementing the reasonable-cost reimbursement provisions for hospitals involved many complicated cost-accounting problems for such matters as depreciation and the allocation of costs by departments and services. The charges that hospitals make to their bill-paying patients usually differ widely from determined costs in both levels and patterns.

The reimbursement principles for SNFs and HHAs are similar to those used for hospitals before the 1983 Act. In fact, the reimbursement procedure is much simpler for these facilities, because of their lesser scope of operations. Furthermore, the HHAs have no problems with regard to the cost-sharing provisions under HI. Similarly, the SNFs have no problem with an initial-deductible provision, and the cost-sharing from the 21st through the 100th day creates no difficulties, because invariably the reasonable costs of operation amount to more than this.

Special Treatment of HMOs and CMPs

Special reimbursement provisions are applicable to Health Maintenance Organizations—HMOs (which, generally speaking, are group-practice, prepayment plans) and Competitive Medical Plans (CMPs). Such organizations may choose to receive risk-based reimbursement, instead of reasonable-cost-based or reasonable-charge-based reimbursement. Such risk-based reimbursement is a single combined per capita payment for both HI and SMI for each of their Medicare members who have coverage therefor (or for SMI for those who have only this coverage; those who have only HI cannot be covered in this manner). Such payments are 95 percent of the average cost of providing Medicare services in the fee-for-service sector (the Adjusted Average Per Capita Cost, or AAPCC) in the given geographic area, as actuarially determined, with appropriate adjustment to reflect the particular demographic structure of the HMO or CMP. Thus, the organization can make an "excess profit" on the arrangement, dependent on its relative efficiency, which will be used to provide greater benefit protection for its Medicare members. This "excess profit" is the excess of the reimbursement (95 percent of the AAPCC) over the Adjusted Community Rate (as computed by the HMO). Such profit must be used to provide Medicare members with additional health benefits and/or reductions in cost-sharing payments. On the other hand, Medicare members must obtain all of their Medicare services from the organization, except for hospital services and emergency services (or else they will not receive Medicare benefits for such "outside" services). On the contrary, if the organization has bad operating experience, it may have a loss under this procedure as compared with what would have occurred under the cost basis.

Thus, in essence, the HMO or CMP is a risk-bearer under the risk-sharing reimbursement approach. Supporters of this method of delivering health care have long asserted that great savings are possible thereunder. Accordingly, they believe that, over an extended period,

there is no likelihood of anything but profits (i.e., larger benefit protection for members) under this procedure. In actual practice, HMOs and CMPs have not always used this approach, because of its complexity, preferring instead the reasonable-cost basis or the reasonable-charge basis; until about 1985, only one HMO did so. However, currently a number of plans have been established on this basis, although some (which are on a proprietary basis) seem to have done so to make a profit by being in a generally high-cost geographic area and obtaining the services of low-paid, foreign-trained physicians and by giving inadequate service (such as long waits and perhaps insufficient hospitalization). Also, they may be able to select, at least initially, more-healthy-than-average clients.

Financing Provisions

The HI benefits and the accompanying administrative expenses are paid out of the Hospital Insurance Trust Fund. The income to this trust fund is derived basically from payroll taxes from covered workers and employers and from the investment earnings of the trust fund. The cost for noninsured persons aged 65 and over during the initial stages of the program is met from the General Fund of the Treasury (i.e., from general revenues) by payments that flow through the trust fund, with appropriate interest adjustment for any timing differences. In fiscal year 1990, such payment amounted to $413 million and in 1991 to $605 million.

The General Fund similarly has made payments to the HI Trust Fund for the cost of HI benefits arising from (1) noncontributory military service wage credits, (2) noncontributory wage credits to U.S. citizens of Japanese ancestry who were interned during World War II, and (3) persons with Medicare-qualified government employment who were employed by the U.S. government on January 1, 1983 (and before as well), but who did not have sufficient quarters of coverage to qualify without counting service before 1983 and were not otherwise eligible. The total payments in the past for the "Japanese" cost were $2.0 million, while that for the nonqualified U.S. government employees in fiscal year 1990 was $35.0 million. Payments for military service wage credits were $107 million in fiscal year 1990 and $89 million in 1991.

Premium payments by noninsured persons not blanketed-in initially on a "free" basis who elect to come in on a voluntary, self-supporting premium basis also go into the trust fund. Such payments were $113 million in fiscal year 1990 and $367 million in 1991 (see page 812).

The administrative expenses paid from the HI Trust Fund include

all of those involved—salary and fringe-benefit costs for the employees of the Health Care Financing Administration and the employees of the Social Security Administration who deal with the HI program; the cost of supplies, postage, equipment, rental of space, travel, and so forth; and the cost of private-sector organizations which adjudicate and pay HI claims.

Tax Rates and Earnings Base

The tax rates are applied to the earned income of the covered workers up to the earnings base, which until 1991 was the same as for OASDI. Then, the HI base was legislated at $125,000, whereas the OASDI base rose under the automatic-adjustment procedure from $51,300 for 1990 to only $53,400 for 1991. The HI base for 1992 is $130,200 (as against $55,500 for OASDI)—see Chapter 2. In fact, the OASDI and HI taxes are assessed and collected together, except for federal workers under the Civil Service Retirement System (or some similar plan for federal employees) who were hired before 1983 and for state and local government employees hired after March 1986 who could be, but are not, covered under OASDI (those hired before April 1986 can be covered at the option of the government entity); these groups are covered for HI only, not OASDI. (Federal workers hired after 1983 are not covered under CSR, but rather under the Federal Employees Retirement System *and* also under both OASDI and HI.) The HI tax collections are deposited in the trust fund as received. The advance-tax transfer procedure applicable to the OASDI Trust Funds (as a result of the 1983 Act) was applicable to the HI Trust Fund for about a year, until repealing legislation was enacted in 1984 (see Chapter 3).

As with OASDI, the employer and employee HI tax rates are the same. Until 1984, differing from OASDI, the self-employed HI rate was the same as the employee rate, instead of being somewhat higher. Now, the self-employed rate is the same as the combined employer-employee rate (except for an allowance for the income-tax treatment applicable to employer OASDI-HI taxes; see Chapter 2 for details). These HI tax rates are shown in Table 6-1.

Financial Situation

As indicated previously, the tax schedule in the law is intended to provide sufficient income to finance the program adequately over the next 75 years. As discussed in more detail in Chapters 8 and 10, the official actuarial cost estimates made in the years following 1977 have

TABLE 6.1. Hospital Insurance Tax Rates, 1984 and After

Calendar Year	*Combined Employer-Employee Rate*	*Self-Employed Rate**
1984	2.60%	2.60%
1985	2.70	2.70
1986 and after	2.90	2.90

*The self-employed received a deduction in the combined OASDI-HI tax rate in 1984–89 as an allowance for the income-tax savings which employers receive with respect to their share of OASDI-HI taxes. This was not subdivided in the law as between OASDI and HI. The HI Trust Fund received the amounts based on the tax rates shown here, with the balance coming from the General Fund. See Chapter 2 for a complete description of how procedure operates and the logic underlying it.

indicated a sizable actuarial deficit. Accordingly, this criterion of financial self-support is not met, as had been the case to some extent in most previous years (because of rapidly rising hospital costs).

The 1977 Act made virtually no change in the HI-benefit provisions, but it did readjust the financing provisions, the basic intent being to affect as little as possible its actuarial balance.[17] In general, compared with previous law, the HI tax rates were reduced (and thus, in essence, transferred to OASDI).[18] This was offset by the ad hoc increases in the taxable earnings base in 1979–81, which were then expected to be significantly larger than they would have been under the automatic-adjustment provisions. With regard to the latter matter, unlike the situation in OASDI, increases in the earnings base produce only additional income to the system, and not additional benefit liability.

Premiums for Voluntary Coverage

The standard premium rate for those voluntarily covered was set by law at $33 per month for the year beginning July 1973. The rate for subsequent years through 1988 (changed to a calendar-year basis in 1983) was $33 multiplied by the ratio of (1) the inpatient hospital deductible for the calendar year in which the premium year begins to

17. In the cost estimates made at the time of enactment of the 1977 Act, the actuarial imbalance of the HI system was estimated at 1.01 percent of taxable payroll under the new law, compared with 1.16 percent under the previous law.

18. The situation of a small increase in the tax rate for 1985 followed by a larger one the next year was solely an accidental development arising from the procedure in the House-Senate conference and did not have any policy or financial significance.

(2) such deductible promulgated for 1973,[19] with rounding to the nearest whole dollar. The rates so determined for various years are shown in Table 7.4 ($234 for 1988).[20] This basis was changed for 1989 and later, so that now the premium rate is merely 1/12 of the estimated actuarial value of the average per capita cost of the benefit payments and related administrative expenses for the pertinent year for *all* persons aged 65 or over covered by HI (and not for the aged persons and the few disabled persons covered by the voluntary HI program). Thus, the premium rate will not necessarily be in an amount that will exactly meet the cost of the benefit protection of the group under the voluntary HI program. As shown in Table 7.4, the rate for 1992 is only $192 per month, or well below the level in 1986–88. Just as in the case of SMI premiums, persons enrolling later than their first date of eligibility in the voluntary HI program must pay an extra premium (10-percent increase for a delay of one year or more, with such surcharge payable for twice the number of full years of nonenrollment; originally, the surcharge had been 10 percent for each full year of delay, payable for life).

Investment of Assets

The assets of the HI Trust Fund are invested in exactly the same manner as are those of the OASDI Trust Funds (see Chapter 4). The operations of the HI Trust Fund are included in the unified budget of the U.S. government until fiscal year 1993. Then and thereafter, such operations will not be so included. For more detailed discussion of this subject, see Chapter 4.

Supplementary Medical Insurance Provisions

This section first discusses the eligibility and enrollment conditions for the Supplementary Medical Insurance portion of the Medicare program. Then, the benefit provisions, the provisions for reimbursement of the providers of medical services, and the financing are considered successively.

19. For these purposes, the initial deductible that is used as the base is taken from the 1973 determination, which was made according to the provisions of the law, $76—and not $72, the amount that was promulgated for 1973 at the insistence of the Price Commission (as discussed in footnote 11).

20. It is interesting that the dates for rate promulgations under the Medicare program are different—September 1–15 for the HI cost-sharing amounts, September for the voluntary HI premium rate, and September for the SMI premium rate (see Appendix D).

Eligibility Conditions

The basic coverage principle of SMI is individual voluntary participation. The program provides indemnity coverage for certain nonhospital medical expenses for persons aged 65 and over and for certain disabled persons (the same who are covered for HI benefits). The program is financed on a sharing basis by the individual and by the federal government out of general revenues, with the government paying at least half the cost.

SMI is patterned after indemnity plans sold by insurance companies and thus has a basic difference from the traditional service-type plans of Blue Shield, which provided full coverage only when the individual fell below a prescribed income limit.[21] In the same way, SMI with its indemnity-type approach differs from the basis of HI, which provides service-type benefits, although the services are not furnished by the government.

With certain minor exceptions, any person aged 65 or over in the United States can participate in the SMI program. All persons aged 65 or over who participate in the voluntary HI program must enroll in SMI. The exceptions are aliens who have not been lawfully admitted for permanent residence (such as officials of foreign embassies or of international organizations) and aliens so admitted who have not resided continuously in the United States during the five years preceding their application for enrollment.[22] The disabled persons who can participate in SMI are those disability beneficiaries under OASDI and RR (including the ESRD cases) who have HI protection, and not disabled persons in general. Persons who have been convicted of engaging in subversive activities are precluded from receiving SMI benefits.

Timing of Enrollment

The general basis of enrollment in SMI is that such action should be taken at about the time of attaining age 65 or, for the disabled, at about the time of first eligibility. Individuals who attain age 65 or who are disability beneficiaries have initial enrollment periods of seven months that are centered on the "base" month—the month of attainment of age 65 or, for disability beneficiaries, the month of first eligibility for SMI benefits (i.e., after having been on the cash-benefits

21. Currently, the vast majority of Blue Shield plans operate on the basis of usual, customary, and reasonable charges, rather than fee schedules.

22. This requirement was tested in the courts. A lower court found it to be unconstitutional, but the Supreme Court decided otherwise.

roll for two years). Any person who is entitled to HI benefits is deemed to have enrolled in SMI in the first three months of the initial enrollment period, although it is possible to opt out then. In such cases and in other cases where the election for SMI is made in the three months before such base month, benefit protection (and premium payment) starts with the month of attainment of age 65. If election is made in such base month, protection starts with the next month. If election is made in the month following such base month, protection begins with the second month after enrollment, whereas if enrollment occurs in the second or third month following such base month, protection begins with the third month after enrollment.

Individuals who are covered under a group health insurance plan of an employer (regardless of the employer's size) and who do not initially elect to enroll in SMI have a special initial enrollment period. Such period begins with the month when such plan coverage ends and runs through the seven following months. Coverage is effective for the month of enrollment if enrollment is done in the month when such plan coverage ends or in the next month; otherwise, coverage is effective for the month following the month of enrollment.

If individuals fail to enroll in their initial enrollment period, then enrollment can take place only during a general enrollment period—in the first three months of every calendar year (for a short time in 1980–81, enrollment could be done at any time, but with a delay of three months before protection began). Persons who do not enroll in their initial enrollment period but who do so later are subject to two disadvantages. First, the benefit protection does not begin until the July after the month of enrollment. Second, an increased premium rate (which is charged for the higher cost expected for this group as a result of antiselection—and is not a "penalty") over that for persons who enroll in their initial enrollment period may be payable—an additional 10 percent for each full 12 months that the individual could have been in the program but was not. However (regardless of the size of the firm), periods when covered by an employer group plan are not counted in determining the increased rate.

Termination of Enrollment

An individual may withdraw from SMI by election at any time, effective as of the end of the following calendar quarter. An individual's coverage can also be terminated for nonpayment of premiums, which is possible only for persons who are not on the OASDI or RR monthly benefits roll, or who are on the roll but are not receiving benefits regularly because of being employed and subject to the earnings test.

To put it another way, persons who pay premiums directly may at any time stop paying premiums and thus have their benefit coverage terminated. A grace period of not more than 90 days for payment of the SMI premiums is provided before coverage lapses. As in the case of HI, coverage under SMI terminates for disabled beneficiaries and ESRD cases upon recovery (under the same conditions as under HI).

If individuals' SMI coverage is terminated by their own action (or inaction), reentry into the program can be by an election at any subsequent general enrollment period, but with a delay before protection is available and with an increased premium rate (on the same basis as for late initial enrollment). If an individual's coverage is terminated again, reenrollment can occur at any later time (before 1980 legislation, this was not possible).

The foregoing coverage rules are strict. This is necessary to prevent antiselection against the system. Otherwise, many individuals attaining age 65 and in good health would not elect to participate in SMI and pay the standard premium rate if they could easily enroll in the future at the same rate at some time when the need for medical care became more apparent.

Benefit Provisions

Medical Services Covered

SMI, in supplementing HI, focuses principally on insurance with respect to physician services. In addition to physician services, coverage applies for unlimited HH services during a calendar year and for certain other specified medical and health services. The HH services under SMI are the same as those available under HI, and it makes no difference to the individual which program pays the cost of the benefits (in actual practice, HI is charged with such cost when there is coverage under both HI and SMI).

The other medical and health services covered by SMI include a broad array of miscellaneous items such as (1) diagnostic tests; (2) X-rays and various types of therapy services, such as physical therapy, speech pathology, and occupational therapy;[23] (3) surgical dressings and splints used for bone fractures; (4) drugs and antigens (for allergy treatment) given incidentally as part of a physician's services which cannot be self-administered (e.g., local anesthetics); hemophilia blood clotting factors and the supplies to administer them;

23. Therapy treatments for homebound persons are considered as HH services (which is advantageous to them because no cost-sharing is then applicable).

(5) injectable osteoporosis drugs (during 1991–95); (6) immunosuppressive drugs in connection with organ transplants; (7) outpatient hospital services (but pre-admission diagnostic tests done within 24 hours before admission are covered as part of DRG reimbursement); (8) rental (or, in some cases, purchase) of medical equipment (e.g., iron lungs, oxygen tanks, hospital beds, and wheelchairs); (9) ambulance services (subject to limitations, such as being to or from nearest hospital); (10) prosthetic devices, artificial limbs, and supplies (such as colostomy bags); (11) service and maintenance of permanently installed appliances (such as pacemakers and artificial limbs); (12) pneumococcal vaccine; (13) podiatrist services (only for other than routine foot care, although this is covered for persons with medical conditions, such as severe diabetes, affecting lower limbs); (14) services of clinical psychologists if they would be covered if performed by a physician; (15) screening pap smears (only once every three years, shorter periods for high-risk cases); (16) nurse midwife services; (17) routine mammography screening (only 1 at ages 35–39, at ages 40–49 annually for high-risk cases and biannually for others, at ages 50–64 annually, at ages 65 and over biannually), and (18) certain chiropractic services (limited to treatment of spine, when verifiable by X-ray showing sublimation).[24]

The physician services covered include those of doctors of medicine and osteopathy, wherever performed (including second opinions for surgical cases). Not covered are services for regular dental care, prescribing eyeglasses and hearing aids, immunizations (except for hepatitis-B-vaccine for high and intermediate risk beneficiaries, generally those with ESRD, and pneumococcal vaccine), and routine physical exams (it may be difficult at times to distinguish between a physical exam and a diagnosis for an ill-defined ailment). Services of dentists are covered only for surgery related to the jaw or any facial bone.

Physician and related services provided by Health Maintenance Organizations, outpatient departments of hospitals, Federally Qualified Health Centers (including Rural Health Clinics), and Comprehensive Outpatient Rehabilitation Centers are covered by SMI. Certain

24. Also covered are certain inpatient hospital services (such as X-ray and laboratory services) that would normally be covered by HI (and that would have been covered under SMI if furnished on an outpatient basis) but were not so covered because the individual had exhausted the benefits available, such as after a very long period of hospitalization (or else the person was not covered under HI). Blood received in a hospital outpatient department, a physician's office, or a clinic is an SMI-covered expense, but only with respect to blood in excess of the first three pints a year (considering also any counted under the HI blood-deductible provision).

preventive services which are not covered generally under SMI are covered at Federally Qualified Health Centers (e.g., all vaccinations and immunizations, physical checkups, and eye and hearing examinations).

ESRD costs are covered in the same general manner as other illnesses. The cost for dialysis treatments, whether on an outpatient or home basis, is considered by SMI in the usual manner. Self-dialysis is encouraged (as being less costly in the long run) by recognizing training cost, rental or purchase of equipment, certain drugs and supplies necessary for such treatments, and periodic support services (i.e., visits to monitor or repair the equipment). Surgical expenses in connection with kidney transplants are covered in the usual manner (but those in connection with the donor are covered in full, with no cost-sharing being required).

Medical Services Not Covered

The most important "other medical and health services" not covered by SMI are acupuncture, eyeglasses, dentures, hearing aids, and out-of-hospital prescription drugs. Some might question why there are these various exclusions. Most of them have been instituted because of cost reasons and the difficulty of controlling utilization (or preventing costly overutilization).

Probably the most concern has been over the exclusion of routine physical examinations, which many experts advocate, although others question whether these are really desirable on a universal regular basis. Such preventive medical care has its merits, but there is also a question of priorities. Consider the cost aspects if the 33 million SMI beneficiaries had regular annual comprehensive physical examinations at a cost of several hundred dollars each. It must be recognized, however, that many persons really receive physical examinations that are disguised as regular office visits for treatment of an ailment.

The coverage of out-of-hospital prescription drugs (in addition to the few "rare" ones for unusual conditions that are now covered) has also received widespread attention. Not only is this a costly benefit to provide—and one that would be subject to widespread overutilization if little direct cost to the individual were involved—but also there would be great administrative problems if all prescriptions were covered (there being about 600 to 700 million prescriptions each year for SMI beneficiaries). Most prescriptions cost only a few dollars and, except for the small proportion of persons who have large numbers of prescriptions, can readily be budgeted out of current income.

Geographic Areas Covered

The services under SMI must be performed within the United States, including not only the 50 states and the District of Columbia but also American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. Physician services and ambulance services are covered in Canada and Mexico when the case involves hospitalization that is covered by HI.

Cost-Sharing

Although SMI is patterned closely after indemnity health insurance plans of the comprehensive type, it differs significantly in that, with two minor exceptions, there is no maximum limitation on the benefits provided for covered services rendered in a particular calendar year. No more than $750 per year of services of independent physical therapists are covered (and the same amount for independent occupational therapists). Only 62½ percent of the incurred expenses for psychiatric services rendered by physicians out of hospitals (mental-health services) are considered an incurred expense, which means that, as a result of the general 80-percent reimbursement basis, at most 50 percent is paid by the SMI program. This special limitation was introduced because previous insurance experience indicated that some cost-controlling element was necessary in this area, where usage frequently depends on the personal wishes of the individual, especially if only a small portion of the cost is out of pocket. (A $500 limit on such services had applied for some years; it was later raised to $1,100 but was eliminated after 1989.) As an exception, all such out-of-hospital expenses are considered when provided on a hospital-outpatient basis, in the absence whereof, hospitalization would have been required. No special limitations apply to psychiatric services furnished to hospital inpatients.

The SMI program has a procedure for reimbursing the beneficiary for physician services that is different from the procedures used by Blue Shield plans and indemnity health insurance plans with fee schedules. Blue Shield plans were formerly on a full-service basis for those with incomes below the prescribed limits and a fee-schedule indemnity basis for all other persons, but they are now on a "usual, customary, and reasonable fee" basis for all persons. Insurance-company indemnity plans such as major medical insurance operate without a fee schedule—namely, on a "reasonable and customary charges" basis, like some Blue Shield plans. Under SMI, reimbursement for these services is determined on a so-called reasonable-

charges basis (the term used in the law), which should more properly be "recognized charges" or "approved charges."

Insofar as the beneficiary is concerned, the proportion of the costs for other medical services covered by SMI is determined from the reasonable charges of the institutional suppliers thereof. On the other hand, reimbursement to suppliers under SMI that are hospitals, SNFs, and HHAs is on the basis of "reasonable costs," as is the case under HI. All other institutional suppliers, such as ambulance services and renters of medical equipment, are remunerated on a reasonable-charge basis. Reimbursement to independent laboratories and hospital outpatient departments for diagnostic tests is now on a fee-schedule basis, varying by locality (formerly on a recognized charges basis for independent laboratories and on a reasonable-cost basis for hospitals).

Insofar as the individual is concerned, it may be said in general that SMI provides for reimbursement of 80 percent of the recognized charges of physicians for incurred services and of institutional providers for other services covered, after he or she has paid an initial deductible of $100 per calendar year. In other words, the beneficiary must annually pay the first $100 and then 20 percent of the remaining amount of reasonable charges. Until 1973, this initial deductible was fixed at $50—in 1973–81, at $60 and in 1982–90, at $75. It is not on a dynamic basis, however (i.e., varying with the unit cost under the program as had been the case with the HI initial deductible and the related daily coinsurance amounts). If the $50 deductible applicable initially (in 1966) had been automatically adjusted for the change in the CPI for physician fees, it would be about $225 in 1992.

Neither the $100 initial deductible nor the 20 percent cost-sharing is applicable to HH benefits, to outpatient clinical diagnostic laboratory tests (no matter who performs them, except when done by a hospital in Maryland, the supplier of services must always accept assignment), and to pneumococcal vaccine (and its administration). The cost-sharing provisions as to certain services provided in ambulatory surgical centers were waived for several years before 1988, so as to encourage use of such facilities rather than higher-cost inpatient care. Also, the $100 initial deductible is not applicable to services rendered by Federally Qualified Health Centers.

Examples of Benefits Payable

First, let us consider the procedures involved and the protection provided with respect to physician services other than those for out-

of-hospital psychiatric services. For example, Mr. C has physician bills of $350 during a calendar year. These are all considered by the insurance carrier representing the SMI program to be reasonable charges. Then, the benefit protection that he has is $200 (80 percent of the excess of the $350 of total charges exclusive of pathology charges over the $100 deductible)—so his out-of-pocket costs are the remaining $150. In the event that the physician services had totaled $500 because Mr. C was wealthy (or for other reasons) and was billed accordingly, the reasonable charges would still be determined as $350, and SMI would still pay only $200, with Mr. C being responsible for the remaining $300.

Payment Procedures

Two procedures are available in the way that the beneficiary receives the benefit protection. If the doctor agrees to accept an assignment from SMI, and thereby agrees to bill for no more than "reasonable charges," he or she will be paid directly by SMI whatever amount is payable—that is, after taking into account the deductible and coinsurance applicable. Then the physician may collect the balance of the bill from the patient. This procedure can have distinct financial advantages to the physician, because of the certainty of collecting at least an amount equal to the SMI benefit, even though the patient does not pay the balance of the bill due (for the cost-sharing provisions).

The other procedure is used when the doctor will not accept an assignment—and the American Medical Association has urged its members to follow this course of action. Under this procedure, before September 1990, the beneficiary needed only to present an itemized bill from the doctor to the SMI carrier in order to obtain the benefit, which is based on the "reasonable charges" for the services rendered (as determined under the program). Some doctors, although not accepting assignments, instead sent the bill to the SMI carrier, with the benefit check going to the beneficiary. It was then up to the doctor to see that the patient pays, including any excess of the actual charges over the determined "reasonable charges." After August 1990, the latter procedure must be followed in all instances when the physician does not take assignment (i.e., the physician must submit the bill to Medicare). Such a change had been considered for several years before being enacted in 1990, but was not adopted for budget reasons. This procedure would increase the general budget deficit, because some benefits that would be paid would

otherwise not have been paid due to nonfiling of some claims. This is an outstanding example of how, when a social security program is included in the general budget, changes that would be desirable are often not made. It seems most inequitable that budgetary problems should be alleviated at the expense of not paying benefits which are properly due.

Many doctors have taken a position against accepting assignments because of their strong views against dealing directly with the federal government and having their fees dictated by it. This is so even though they do not intend to charge more than the reasonable charges for the vast majority of their SMI patients and thus have no great financial incentive (and perhaps even a financial disincentive) not to follow the assignment procedure.

A special category, "participating physicians," has been established. This consists of physicians who will *always* take assignments. For those not in this category (even though they may take assignment in a particular case), the "reasonable" (or recognized) charges are 5 percent lower. Further, nonparticipating physicians have limits imposed on the amount that they can charge above the recognized charge (i.e., so-called "balance billing"). Such limit is 125 percent of the recognized charge in 1991 (but 140 percent for "evaluation and management" services, which are essentially for primary care—such as office visits, not surgery—120 percent in 1992, and 115 percent thereafter). Thus, eventually, the maximum that a nonparticipating physician can charge is only 9.25 percent more than the recognized charge of a participating physician (i.e., 95 percent of 115 percent).

The result of this reimbursement procedure is to put great pressure on physicians to become participating physicians. If they do not do so, their income will not be much higher than if they were participating physicians, but their patients will have much higher out-of-pocket costs. For example, a participating physician with a recognized charge of $100 will receive, in total, this amount, whereas a nonparticipating physician will receive only $9.25 more. However, the patient who has already met the $100 annual deductible will have out-of-pocket costs of $20 for the participating-physician case, but as much as $33.25 otherwise ($109.25, minus 80 percent of $95).

Also, when assignment is not taken for elective-surgery cases, when the actual charge is $500 or more, the physician must inform the patient in advance, or else such excess cannot be collected.

It may be recalled that insurance-company health insurance plans use an assignment method, but on a different basis. At the request of the insured person, the company pays the doctor whatever benefit is

determined to be due (based on the charges being reasonable and customary). This amount is then considered merely as a payment on the account due, without any restraint placed on the doctor to accept total payment of no more than reasonable charges.

Finally, one might question why the assignment method under SMI was developed in its original form. Many persons influential in the development of the program believed that, otherwise, some physicians would increase their normal charges to the patients because the patients would be relieved by Medicare of having to pay much of what they had previously been accustomed to pay and that, as a *quid pro quo* for assignment (and thus certainty of some payment), the doctors should agree to limit charges to the patients to the difference between the reasonable charges and the SMI benefit payable.[25]

Psychiatric Benefits

Next, let us consider the effect of the special limitations on out-of-hospital psychiatric services. If Mr. D had no medical expenses during a year other than $300 of such psychiatric services, then 62½ percent thereof, or $187.50, would be considered as an SMI-incurred expense (assuming that the charges were considered to be reasonable). After taking into account the $100 deductible, SMI would provide benefits of $70 (80 percent of $87.50).

Benefits with Respect to Institutional Providers

With respect to the various nonphysician medical services and supplies covered by SMI which are furnished by institutional providers, the beneficiary is insured on a reasonable-charges basis. As indicated, some of these providers are reimbursed on a reasonable-charges basis, while others are reimbursed on a reasonable-cost basis. This means that the beneficiary must pay 20 percent of the reasonable charges for these services after the $100 deductible has been met in the year (whether by these charges, by physician charges, or by a combination of both). The reasonable charges—just as in the case of physician charges—can, of course, not exceed the customary charges for the particular services or supplies.

25. In actual practice, largely for administrative reasons, the determination of which claims come first is based on the order in which they are processed by the SMI carrier. Logically, the order should be determined on a time-incurred basis, but this would be difficult to do administratively and could involve many retroactive adjustments. Such differences in the order of considering claims do not produce different results.

Reimbursement Provisions

Reimbursement of Institutions

Services furnished by institutional providers are reimbursed under SMI on a reasonable-cost basis, except the professional component thereof (generally with respect to pathologists and radiologists), which is billed separately on a reasonable-charge basis. The procedure followed is exactly the same as that followed under HI.

Ambulatory surgical centers are reimbursed by SMI at a rate of 80 percent of certain fixed amounts for their facility services, if they agree to this mode of reimbursement (instead of 80 percent of reasonable costs). The remaining 20 percent comes from the beneficiary.

SMI-covered services provided by Health Maintenance Organizations and Competitive Medical Plans are reimbursed in the same manner as is done for HI covered services which they provide (see page 565).

Legislation in 1984 changed the reimbursement basis for outpatient diagnostic laboratory tests performed by independent laboratories, physicians in their offices, and hospitals. Hospitals and independent laboratories must accept assignment (and then the beneficiary has no cost-sharing payment, as is also the case for such tests performed by physicians, who must accept assignment).

Reimbursement of Physicians

Initially, payments to insured persons with regard to physicians' fees or to physicians in assignment cases were made on a reasonable-charges basis that was determined relative to both the particular doctor's customary charges and the adjusted prevailing fees for similar services in the particular geographic area. This does not mean that each physician must operate under a fixed-fee schedule that applies either nationwide or in the particular locale, or even rigidly to himself or herself. Rather, a doctor may have a range of charges for a given procedure that, in order to be at the level that is fully reimbursable, must be consistent both with his or her customary charges to non-Medicare patients and with the adjusted general level of charges prevailing in the community. The range so allowed would permit reasonable variation to reflect the particular circumstances of each case (i.e., the relative difficulties involved).

When physicians accept assignment, SMI pays them directly 80 percent of the determined reasonable-charges amount (which should

more properly be called "recognized charges") minus any of the $100 initial deductible which has not been met. The physician can then collect the remainder of the recognized charges from the patient.

Health insurance plans operated by insurance companies and other types of insurers, including some Blue Cross plans, had previously used (and still use) a concept somewhat similar to what SMI used initially when fee schedules were not contained, as for example in major medical plans. (Most Blue Shield plans do not operate on this basis, because in essence they use fee schedules for reimbursement purposes.) The administration of such plans is carried out on a very broad and flexible basis. Fees are questioned only if they are obviously out of line. It is believed by the insurers that this rough-and-ready procedure is both efficient and sufficient to operate a sound program that is equitable to both the physicians and the insured persons (in the resulting premium rates that have to be charged). It is also believed that too close a surveillance of fees is both administratively expensive and irritating to the physicians and that it does not achieve any significantly greater cost savings than are achieved under the looser method actually used.

Under the administration of the SMI program as it operated until 1992, a different and more detailed and complex procedure was followed. A so-called profile was built up for each doctor, showing his or her charges for various procedures. Then bills were compared with this profile to determine whether they were reasonable charges. In developing the profile originally, its reasonableness would be determined in relation to the charges of other doctors in the same area. Specialists with certain skills were, of course, entitled to have a higher charge structure.

The customary charge of a particular physician for a given service was determined by statistical methods. This procedure was done by regulations, because the law did not provide specifically in this respect. The reasonable charge was based on the median charge made for the particular service by the physician.

When a physician changed the fee structure, SMI naturally recognized this in determining the reasonable charge according to the customary-charge criterion. The question arises as to when the changed fee structure becomes "customary." Changes in charges were not recognized as soon as they were made. Rather, such changes had a built-in lag of about 18 months on the average. Originally, this lag was the result of regulations, but the 1972 Act legitimatized it for the future.

At first glance, this lag in the determination of customary charges seems logical as well as beneficial to the SMI program by holding down its cost and possibly also by discouraging increases in physicians'

fees. Some questions, however, have been raised about this. When a physician posts a new schedule of fees to be effective at a certain future date, why should not his or her accepted customary charges also change simultaneously? Also, would such a procedure cause physicians to increase their fees somewhat sooner than they would otherwise, to produce the same overall effect as if increases were recognized simultaneously?

Under the procedure of failing to recognize fee increases immediately when they occur, the cost of SMI may be lower than it would be under simultaneous-recognition procedures. But, at the same time, some of this cost falls on the enrollees, who must pay the increases in fees in full (except when the physician accepts the assignment procedure and therefore must absorb the difference during the lag period).

The law required that, for any physician, the reasonable charge for a service could not be higher than either his or her customary charge or the adjusted prevailing charge in the locality. The adjusted prevailing charges were determined from what might be called the prevailing charges in the 12-month period beginning July 1972 as adjusted for subsequent years by an economic index reflecting general earnings levels (weighted 60 percent) and the costs of operation of a physician's office (weighted 40 percent). Actually, the prevailing charges for that 12-month base period were not really those current then, but rather they had about an 18-month lag built into them. On that basis, the prevailing charge in a locality was the 75th percentile of charges for the particular service. During 1973–75, when wage and price controls were in effect, the Cost of Living Council imposed overriding control limits, such as a maximum increase of 2½ percent per year. For example, as a result of this economic index, prevailing charges for July 1983–June 1984 could not be more than 206.3 percent of the prevailing charges in effect on June 30, 1973 (i.e., slightly more than double).

The procedures of the 18-month lag and the 75th percentile were later prescribed by law as a result of the 1972 Act.[26] Before then, they were effectuated solely by regulation. This seemed to some to be contrary to the law, or at least to its intent. The original philosophy of SMI was that those aged 65 and over should no longer be second-class citizens insofar as medical bills were concerned by paying lower, charity rates. Instead, with the aid of SMI, they would be able to pay the

26. The reasonable-charge screens were updated each July 1 and were based on the experience of the previous calendar year until legislation in 1984 froze the screen for 15 months, beginning July 1984, and made the future updates effective each October 1 (beginning with 1985), based on the experience in the 12-month period ending with the preceding March.

regular fees. But with the lags introduced in the past, the 15-month freeze beginning July 1, 1984, and the economic-index adjustment for the future, this was no longer the case, and SMI beneficiaries were charged lower fees than the remainder of the population (in assignment cases) or paid substantially more than SMI had originally promised (in nonassignment cases).

The economic-index adjustment, as it operates in the future, would have resulted eventually in a flat, uniform fee schedule in each locality. This would occur because physicians' customary fees would probably rise more rapidly than the adjusted prevailing-charges screen (which would no longer reflect actual prevailing fee levels, but rather be well below them). As a result, after some time, all physicians would be on the adjusted prevailing-charge basis.

Legislation in 1984 instituted a 15-month freeze on the prevailing-charges screen. Inducements were made for physicians to accept assignments (and thus not pass along any increasing excesses of customary charges over recognized charges), such as publicizing those who always accepted assignments and providing in such cases for electronic receipt of claims. Also, penalties are provided for physicians who do not take assignments and who increase their actual charges to Medicare patients during the period of the freeze. Such penalties can be civil monetary ones (of up to $2,000 for each violation) and exclusion from the program (which means that the beneficiary could not be reimbursed at all for any services rendered by such physician and would thus probably seek services elsewhere)—strong "medicine" indeed to solve the Medicare financing problem! Subsequent legislation made many restrictions on the reimbursement of physicians, especially nonparticipating ones.

The foregoing basis prevailed through 1991. Then, beginning in 1992, and phased in over the next five years, the recognized charges will be determined from a uniform national fee schedule (Resource-Based Relative Value Scale, or RBRVS), with minor geographic variations. The reimbursement rules are such that, as against the previous practice, they favor family practitioners and "hands on" practitioners of medicine as against surgeons and "high-tech" medicine. In addition, future increases in the fee schedule will depend upon how closely the targets for overall SMI outlays for physicians services (Medicare Volume Performance Standards) are met nationwide. This would seem to be a potential powerful control on physician reimbursement that could lead further toward some form of national health insurance.

The effect of the RBRVS method of physician reimbursement is intended to be cost-neutral insofar as SMI is concerned. Conceivably, this will not turn out to be the case. In order to prevent their income

from Medicare patients from decreasing, surgeons and other physicians who are adversely affected by RBRVS may find ways to evade the controls (e.g., by increasing services). As far as the nation is considered, RBRVS may inflate health-care costs, because family practitioners may increase their fees to non-Medicare patients to parallel what SMI will do, and at the same time surgeons will not lower their fees.

Financing Provisions

The SMI benefits and the accompanying administrative expenses (determined similarly to what is done under the HI program) are paid out of the Supplementary Medical Insurance Trust Fund. The income to this trust fund is derived solely from premium payments from the enrollees, the matching payments from the General Fund of the Treasury, and the investment earnings of the trust fund.

The standard premium rate and the adequate actuarial rates for enrollees aged 65 and over and for disabled enrollees are determined annually (in September, for the 12-month period beginning the following January) by the Secretary of Health and Human Services by appropriate actuarial methods. However, legislation in 1990 established the standard premium rates for 1991–95. More details on such determinations and on past experience are presented in Chapter 8.

Although originally payments from the General Fund of the Treasury shared the cost of SMI equally with the enrollees, this has not been so since 1973. Instead, such payments will meet considerably more than half the cost. They will also pay any excess cost for the disabled enrollees (first covered in July 1973) over that for the aged enrollees. Also, the standard premium rate for the aged (and for the disabled as well) will not be permitted to rise more rapidly than the level of OASDI benefits, except that, for the seven premium years beginning with 1984, there was the overriding provision that the SMI enrollee premium rate for those aged 65 and over must not be less than 25 percent of the total cost. Also, for the five premium years beginning with 1991, legislation in 1990 set the premium rates at prescribed amounts (see Table 8.2).

There are the further exceptions that such rate will not be increased at all for any year when there is no OASDI COLA for the preceding December and that, for beneficiaries on the roll at the end of the preceding year, the increase in such rate cannot exceed the amount of the COLA given, so that the benefit check will never decrease, so that the amount of the monthly benefit payable to the beneficiary will not decrease.

As an example of the operation of the "no-reduction" exception, suppose that, for some future year, the OASDI benefit before reduction for the SMI premium ($49.70) is $93.60. Thus the benefit check is $43.00 (after the prescribed rounding down to an even dollar). Further suppose that for December a COLA of 5.0 percent is given (payable in the check issued for January 3 of the next year). Also suppose that the SMI premium for such next year increases to $58.10 as a result of ad hoc legislation. Then the benefit amount before reduction for the SMI premium is $98.20 (rounding down to the dime). The check payable before considering the "no-reduction" exception would be $40.00 (after rounding to an even dollar). With the exception, the check would remain at $43.00 and the SMI Trust Fund would be credited with a premium of only $55.10 rather than $58.10 (the $3.00 "give back" being subtracted from the "normal" premium).

Persons who enroll 12 or more months after first eligibility pay an additional 10 percent for each full 12 months of nonparticipation, with the monthly premium rate rounded to the nearest 10 cents. Those who drop out of SMI and later reenroll are similarly charged on extra premium rate based on the intervening months of nonparticipation (except under the conditions described on p. 571).

This 10-percent per year of noncoverage is often referred to as a "penalty," but this is not the case. It was intended to reflect the higher cost applicable, on the average, for persons who do not enroll promptly because they are in good health and see no reason to pay the premiums until later when they "need" the insurance protection. This extra-premium situation is similar to that under life insurance policies, where the premium increases as the age at purchase rises.

The 10-percent basis was based on actuarial judgment when this provision was adopted, because no experience on this matter was then available. Unfortunately, no studies of the actual experience for the late enrollees in the 25 years of operation has been made.

The standard premium rate, payable by both aged and disabled enrollees who elect to participate as soon as they are eligible (or within 12 months thereof), has been set at $36.60 a month for the 12-month

27. The premium is payable monthly, in advance, for those OASDI and RR beneficiaries who are in current-payment status (i.e., by deducting it from the benefit check for the previous month; in those few cases where the benefit is less than the SMI premium, the entire benefit is withheld, and the beneficiary is billed periodically for the difference). Persons who are receiving CSR annuities (or other retirement pensions administered by the Office of Personnel Management) and who are not OASDI or RR beneficiaries have the premium deducted from such benefits (if they elect SMI coverage). All other persons generally pay quarterly. Before 1984, the 12-month periods were on a July–June basis (to correspond with when benefits were automatically ad-

period beginning January 1993.[27] The past history of the premium rate, and the method of computing it, are discussed in Chapter 8; the past rates are presented in Tables 7.2 and 8.2.

The assets of the SMI Trust Fund are invested in exactly the same manner as are those of the HI Trust Fund—that is, the same as is done for the OASDI Trust Funds (see Chapter 2). The operations of this fund are included in the Unified Budget of the U.S. government (see Chapter 4 for detailed discussion).

Administration of Medicare

The administration of the Medicare program differs considerably from that of OASDI. The latter is almost entirely administered by the federal government, the only exception being the initial determination of disability and its continuance. On the other hand, much of the administration of Medicare is done by private organizations. This was required by Congress so that there would be less likelihood of interference by the government with the practice of medicine.

Role of the Federal Government

The administration of HI originally involved the Social Security Administration of the Department of HEW in several ways—maintaining the earnings records from which eligibility was determined, giving eligible persons information about the program and their individual utilization records, developing regulations for the reimbursement of providers of services, reviewing and providing the funds for such reimbursements, and maintaining the individual records of utilization of services.

In March 1977, the Health Care Financing Administration was created in the Department of HEW. Some of the responsibilities formerly assigned to the SSA were taken over by HCFA—namely, developing regulations, reviewing the reimbursements for providers of services (and providing the necessary funds), and maintaining the individual records of utilization of services. SSA continues to maintain the earnings records (for eligibility purposes), and its district offices supply individuals with information about enrollment under HI and SMI. The Treasury Department collects the HI taxes (along with the OASDI taxes) and administers the trust-fund operations.

The Treasury Department provides the necessary financial services in connection with the operation of the SMI Trust Fund. The pre-

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justed for changes in the CPI). The change for 1984 and after was made to correspond with the change in the COLA date.

mium payments are largely collected by the deduction method—from OASDI and RR benefit checks and from Civil Service Retirement annuity checks (for those not receiving OASDI or RR). In all other cases, SMI enrollees pay the premiums directly to HCFA, usually quarterly in advance, although it is possible to do so monthly; in most of such cases the individual is working and not receiving benefits because of the earnings test (and then also with respect to the noninsured spouse of such individual).

HCFA—unfortunately, in the author's opinion—does not have any field offices that can give face-to-face information (nor do the private organizations which do most of the administration of the Medicare program). As a result, the beneficiaries can obtain information from written material or by telephone.

There are separate boards of trustees for the HI and SMI Trust Funds, although they have exactly the same membership constitution (and also the same as for the OASDI Trust Funds as to the three government members). The two public trustees of the HI and SMI Trust Funds could, under the law, be different pairs of people (and each pair could be different from the OASDI public trustees), but in practice the same two persons have always served as trustees of each of the three boards simultaneously. The duties and functions of these two boards of trustees are the same as those of the OASDI Trust Funds (see Chapter 2), the only difference being that the required estimates of the operations in the annual report are to be for only the next three years for the two Medicare trust funds, instead of for the next five years.[28] Similarly, the board must report whenever either trust fund has a balance ratio (balance at the beginning of the year after deducting any loans from other trust funds, but including loans to other trust funds, expressed as a percentage of estimated outgo for the year) of less than 20 percent—just as for the OASDI Trust Funds (see discussion on this subject in Chapter 2 for more details).

Role of HI Fiscal Intermediaries

Virtually all of the direct relations with the providers of services under HI (hospitals, SNFs, and HHAs) are handled by fiscal interme-

28. The shorter period was probably selected because the SMI financing depends on a premium rate promulgated annually and thus is not readily forecastable for long periods. The same procedure was followed for HI for the sake of consistency. In actual practice the reports contain cost projections far beyond three years (75 years for HI and 10 years for SMI). Also, the Secretary of the Board of Trustees of the two Medicare trust funds is now the Administrator of HCFA, rather than the Commissioner of Social Security.

diaries. Each provider is permitted to select its own intermediary, subject to the approval of the qualifications of such intermediary by HCFA. A provider can, however, elect to deal directly with HCFA, but only a few (mostly government hospitals) have chosen to do so. The fiscal intermediary reviews the operations of the provider and obtains from it the necessary financial reports in line with the provisions of the law and the directives of HCFA. The fiscal intermediary obtains funds from the HI Trust Fund, on approval of HCFA, and passes these along to the providers. Most providers have selected the Blue Cross Association as their fiscal intermediary, although some insurance companies serve in this capacity too (especially for SNFs). The providers have their administrative expenses reimbursed from the HI Trust Fund.

Role of SMI Carriers

Unlike the procedure under HI, all relations with providers of SMI services go through a third party, and the providers do not deal directly with the federal government. HCFA designates carriers for each geographic area—usually an entire state, but in some instances only part of a state. These carriers are Blue Shield plans in the majority of the cases, although a significant number of areas are assigned to insurance companies and, in a few instances, to other organizations similar to Blue Shield.

The carriers play a large role in the actual administration of SMI. They maintain the enrollee utilization records and inform the enrollees about them. The carriers also determine the recognized charges of physician and other services that are reimbursed on this basis. They also pay the benefits (to physicians in assignment cases and to the enrollees in other cases) for all providers in their area. The only exceptions to this are for RR beneficiaries, who deal with a single national carrier, and for providers who are reimbursed on a reasonable-cost basis, who deal with their HI fiscal intermediary. The administrative expenses of the carriers are reimbursed by the SMI Trust Fund.

Apparently, and quite oddly, present law provides that carriers should neither process "clean" claims (i.e., ones which contain complete and uncomplicated data) too slowly—at least 95 percent should be paid within 24 days of their receipt (17 days as to participating physicians), nor too rapidly—none should be paid within 14 days of their receipt. Interest must be paid on all claims which take over 30 days to pay. The first restriction was introduced both for the sake of the beneficiaries and to encourage physicians to be "participating"

ones. The second restriction was a budget "gimmick" to make the cash-flow situation look better.

Controls on Hospitals

The law contains many controls on the operation of the program that affect the quantity, quality, and cost of covered health services. Insofar as the operation of hospitals is concerned, these include such matters as not paying costs for capital expenditures that have been disapproved by state or local health-facility plans, not paying costs that are excessive compared with similar services in comparable facilities in the locality, and requiring annual operating budgets and capital-expenditure plans. Of course, when the Diagnosis Related Groups method of reimbursement is applicable, these types of control are not applicable.

Utilization review committees must be established by hospitals and SNFs. Such a committee consists of either staff physicians (possibly also including other professional personnel) or a similar outside group established by the local medical society (or, in the absence of other action, named by the Department of HHS). Its functions are to review (possibly on a sample basis) admissions, durations of stay, and professional services rendered with regard to medical necessity and efficiency and with a view to the provision that limits beneficiary liability when a claim is disallowed.[29]

Controls on Physicians (As to Quality and Quantity of Services)

Before repeal by 1982 legislation, Professional Standards Review Organizations (PSROs) had to be established in localities. They consisted of substantial numbers of physicians (300 or more) and had the responsibility of reviewing the services furnished under both Medicare and Medicaid to assure that they were medically necessary and provided in accordance with professional standards. Such groups had no responsibility for the determination of reasonable charges under SMI. The PSROs were organized by physician-sponsored groups (such as local medical societies), but in the absence of a satisfactory PSRO in a locality, the Department of HHS was to designate a qualified group. Some physicians were greatly concerned about the PSRO concept, which was introduced in the 1972 Act, because they thought that it cast aspersions on their professional ability and work and because it would be cumbersome, administratively expensive, and generally not

29. As a result, the efficient functioning of this committee is necessary to the institution, to prevent the liability for disallowed claims from falling on it.

productive or cost-effective. Moreover, they pointed out that they would not object to *peer* review but that they were strongly opposed to medical review by nonphysician personnel who, in their belief, were not professionally qualified to judge on their work.

The actual experience with PSROs was not successful. A study by the Congressional Budget Office came to the following conclusions:

1. Review and reanalysis of the research on the effectiveness of PSROs indicate that concurrent review is reducing the number of days of hospital care of Medicare enrollees by about 2 percent. This estimate has to be viewed with caution, however.
2. Although PSROs seem to be effective in reducing Medicare utilization, it is doubtful that they produce a net savings.
3. A HCFA analysis concluded that the monetary benefits of the Medicare portion of the PSRO program had been about 10 percent greater than its costs. That analysis implied an extremely small net savings relative to expenditures for services that were currently being reviewed by PSROs (less than 0.1 percent of relevant Medicare disbursements). A CBO reanalysis of the data revealed no net savings at all; CBO concluded that the best estimate is that the savings generated by the program are about 30 percent less than program costs.[30]

As a result, legislation in 1982 repealed the provisions for PSROs and established instead Peer Review Organizations. The PROs are responsible for utilization and quality control of the professional activities of physicians, other practitioners, and other providers in furnishing services to Medicare beneficiaries. The PROs are composed of doctors actually practicing in the geographic area, with priority consideration given to representatives of physician-sponsored organizations which are representative of physicians in the area.

30. Congressional Budget Office, *Effect of PSROs on Health Care Costs: Current Findings and Future Evaluations* (Washington, D.C.: U.S. Government Printing Office, June 1979).