

BRIEF SUMMARIES
Of
MEDICARE &
MEDICAID

Title XVIII and Title XIX of
The Social Security Act

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

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Introduction

Since early in the 20th century, health insurance coverage has been an important issue in the United States. The first coordinated efforts to establish government health insurance were initiated at the State level between 1915 and 1920. However, these efforts came to naught. Renewed interest in government health insurance surfaced at the Federal level during the 1930s, but nothing concrete resulted beyond the limited provisions in the Social Security Act that supported State activities relating to public health and health care services for mothers and children.

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

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

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

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

After lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly, with coverage added in 1973 for certain disabled persons and certain persons with kidney disease. Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance.

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

National Health Care Expenditures

Historical Overview

Health spending in the United States grew rapidly over the 1960-1993 period. From \$27.2 billion in 1960, it grew to \$916.6 billion by 1993, increasing at an average annual rate of 11.2 percent. This strong growth boosted health care's role in the overall economy, with health expenditures rising from 5.0 percent to 13.3 percent of the Gross Domestic Product (GDP) for 1960-1993.

During 1993-1999, however, health care spending grew more moderately, at a 5.9-percent average annual rate. In 1999, total health expenditures were nearly \$1.3 trillion, and the share of GDP going to health care stabilized at 13.2 percent. This stabilization reflected the nexus of several factors: increased enrollment in lower-cost employer-sponsored managed care health plans; low general and medical-specific inflation; excess capacity among some health service providers, which increased competition and drove down prices; and GDP growth that was similar to slow health care spending growth.

Over the period 2000-2002, growth accelerated, averaging 8.4 percent annually, and in turn the share of GDP devoted to health care increased from 13.3 percent to 14.8 percent. Health care spending grew more slowly during 2003-2007, averaging 7.1 percent, while nominal GDP growth increased at an average annual rate of 5.7 percent; over these years, the share of the economy devoted to health care increased from 15.4 percent in 2003 to 15.9 percent in 2007. During 2008-2013, health care spending grew at historically low rates as the Great Recession and the modest economic growth that followed affected both health insurance coverage and the use of health care goods and services, while medical prices also grew at historically low rates. Total health care spending increased at an average annual rate of 3.8 percent over the 2008-2013 period, with 2013 experiencing the lowest increase on record at 2.9 percent. Spending grew more rapidly in 2014 and 2015, increasing 5.1 percent and 5.8 percent, respectively, as coverage expanded under the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)—collectively referred to as the Affordable Care Act—and as retail prescription drug spending increased rapidly, primarily reflecting increased spending on new drugs, particularly those used to treat hepatitis C. Total national health expenditure growth slowed in 2016 to 4.3 percent, reaching \$3.3 trillion, or \$10,348 per person.

The financial responsibility for health care spending resides with private businesses, households, and governments. These financiers, or sponsors, pay health insurance premiums and out-of-pocket costs or finance care through dedicated taxes and/or general revenues. Businesses and governments also decide what health care plans are offered, who is eligible to participate in the plans, and what cost-sharing arrangements (premiums, co-payments, and deductibles) are used.

In 1987, households paid for 38 percent of national health spending and were the largest sponsors of health care. In 1993, this share was 33 percent, and in 2016 spending by households accounted for 28 percent of total health expenditures, or \$938.8 billion.

The proportion of health spending sponsored by private businesses also declined, dropping from an average share of 23 percent during the 1987-2005 period to 20 percent in 2010, and then remaining at that share through 2016, when spending by private businesses reached \$664.6 billion.

Spending by governments (Federal, State, and local) reached \$1,508.6 billion in 2016 and accounted for 45 percent of total health spending, an increase from a 31-percent share in 1987, mainly due to growth in the Medicare and Medicaid programs.

A significant portion of national health spending can be attributed to programs administered by the Centers for Medicare & Medicaid Services (CMS)—Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP, known from its inception until March 2009 as the State Children’s Health Insurance Program or SCHIP). Together, Medicare, Medicaid, and CHIP spent \$1.3 trillion for health care goods and services in 2016—38 percent of the country’s total health care expenditures. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements in the provision of health care services to our nation’s aged, disabled, and disadvantaged and to reduce the overall cost of care for these programs.

Projected Expenditures

The latest update of the annual projections of national health spending consists of estimates for 2017-2026. These projections are based on national health expenditure historical data through 2016, which were released by CMS in December 2017. The projections reflect economic and demographic assumptions that are consistent with the 2017 Medicare Trustees Report and the 2017 Old-Age and Survivors Insurance and Disability Insurance Trustees Report, updated to reflect available information through October 2017. The provisions of the Tax Cuts and Jobs Act of 2017 (Public Law 115-97) are partially reflected in the projections of health spending and insurance coverage; specifically, the impacts associated with the repeal of the individual mandate are included, while potential effects of the legislation on economic growth are not included in order to maintain consistency with the economic assumptions in the 2017 Medicare Trustees Report.

Over the entire projection period 2017-2026, national health spending is projected to grow at an average rate of 5.5 percent annually, which would be 1.0 percentage point faster than the expected annual increase in GDP during these years. As a result, the health share of GDP is projected to rise from 17.9 percent in 2016 to 19.7 percent by 2026. National health expenditures are projected to reach \$5.7 trillion in 2026, up from \$3.3 trillion in 2016. The prices for medical goods and services are expected to increase over the period, from an average annual growth rate of 1.1 percent for 2014-2016 to an average of 2.5 percent for 2017-2026. Among the major sectors in personal health care, prescription drugs are expected to experience the highest spending growth rate, averaging 6.3 percent annually.

In 2017, the first year of the projection period, national health expenditures are projected to have increased by 4.6 percent—up slightly from 4.3 percent in 2016—due to accelerating growth in Medicare (after several years of historically low growth), faster growth in prices (driven by faster growth in economy-wide inflation), and increases in premiums for Marketplace plans.

Medicare spending growth is projected to have accelerated 1.4 percentage points in 2017 to 5.0 percent, largely due to faster growth in per beneficiary spending (from 0.8 percent in 2016 to 1.7 percent in 2017). Faster projected growth in the use of services, increases in payment updates, and faster enrollment growth all contribute to this expected trend.

Medical price inflation, as measured by the Personal Health Care Price Index (which measures price changes in medical goods and services purchased), is projected to have grown slightly faster in 2017 (1.4 percent versus 1.2 percent in 2016). Although prices rose more rapidly in 2017, this rate of growth remained near historic lows.

Finally, in 2017, Medicaid spending growth is projected to have slowed 1 percentage point to 2.9 percent. Underlying this deceleration is an expected reduction in Medicaid's net cost of health insurance (or the difference between payments received by Medicaid managed care organizations and the benefits paid on behalf of their enrollees) because of risk-mitigation payment recoveries. Risk-mitigation payments are exchanged between the Federal government, States, and managed care organizations to protect insurers from large losses. Since payments exceeded the costs associated with providing care in 2014-2016, managed care organizations returned a portion of those revenues to the government in 2017.

In 2018, growth in national health spending is expected to accelerate once more, to 5.3 percent, as a result of two primary factors. First, growth in prices for purchased medical goods and services is expected to be faster than in recent periods; in particular, rising price growth for prescription drugs is expected to contribute to an acceleration in growth for the Personal Health Care Price Index from 1.4 percent in 2017 to 2.2 percent in 2018. Second, a 4.0-percentage-point acceleration in Medicaid spending growth (from

2.9 percent in 2017 to 6.9 percent in 2018) is anticipated largely as a result of smaller recoveries of previous risk-mitigation payments. Partially offsetting faster growth in these areas is expected slower growth in private health insurance spending. For Marketplace plans, the net cost of health insurance is expected to better align with actual spending on behalf of plan beneficiaries, resulting in slowing growth for this category of spending.

For 2019-2020, health care spending growth is projected to average 5.5 percent, which is slightly higher than the projected rate of 5.3 percent in 2018. Underlying this trend is an anticipated increase in the Medicare spending growth rate from 6.0 percent in 2018 to an average of 8.0 percent for 2019-2020. The program's accelerating growth rate is driven in part by expected incentive payments for doctors who treat Medicare beneficiaries under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Public Law 114-10), as well as by expected continued increases in the use and intensity of services consumed. Slowing growth in private health insurance spending, on the other hand, is expected to somewhat offset the effect of Medicare's accelerating growth rate on overall national health spending growth. Private health insurance spending growth is projected to decelerate to 4.1 percent (compared to 4.8 percent in 2018), reflecting slower expected enrollment growth as a result of the repeal of the individual mandate beginning in 2019. The number of uninsured persons is projected to increase from 30.0 million in 2018 to 32.7 million in 2020.

In the latter portion of the projection period (2021-2026), spending growth is expected to average 5.7 percent, a slightly faster rate than the average for 2019-2020. Spending growth rates for both Medicare and Medicaid are projected to exceed the rate for private health insurance, largely as a result of faster enrollment growth related to the aging of the population. For Medicare, enrollment growth is expected to remain strong as the baby boomer generation continues to age into the program (a trend that simultaneously results in slower enrollment growth in private health insurance). For Medicaid, the share of relatively more expensive aged and disabled enrollees is projected to climb, leading to comparatively faster spending growth.

From a sponsor perspective, the share of total national health expenditures accounted for by Federal, State, and local governments is projected to rise from 45 percent in 2016 to 47 percent in 2026. Conversely, the proportion of spending attributable to private businesses, households, and other private sponsors is projected to decrease by 2 percentage points (to 53 percent) by 2026. These projections reflect an anticipated increase in the share of financing from the Federal government (from 28 percent in 2016 to 31 percent in 2026)—a trend that is largely driven by the baby boomers' continued shift from private health insurance to Medicare. Ongoing subsidy payments made by the Federal government for lower-income enrollees in Marketplace plans also contribute to this expected trend.

Medicare: A Brief Summary

Overview of Medicare

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

When first implemented in 1966, Medicare covered most persons aged 65 or older. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage. Beginning in July 2001, persons with Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease) are allowed to waive the 24-month waiting period. Beginning March 30, 2010, individuals in the vicinity of Libby, Montana who are diagnosed with an asbestos-related condition are Medicare-eligible. Medicare eligibility could also apply to individuals in other areas who are diagnosed with a medical condition caused by exposure to a public health hazard for which a future public health emergency declaration is made under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (Public Law 96-510). This very broad description of Medicare eligibility is expanded in the next section.

Medicare originally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), which in the past was also known simply as Part B. Part A helps pay for inpatient hospital, home health agency, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage. Part B helps pay for physician, outpatient hospital, home health agency, and other services. To be covered by Part B, all eligible people must pay a monthly premium (or have the premium paid on their behalf).

The Medicare Advantage program, sometimes known as Part C, is not a separate benefit but rather an optional program that allows most beneficiaries enrolled in both Part A and Part B to choose to receive their services through Medicare-approved private-sector health plans. Such plans have been available to some beneficiaries dating back to the 1970s, and, over time, numerous pieces of legislation have been enacted that have increased or decreased the attractiveness of, and enrollment in, the private plan option. The Balanced Budget Act of 1997 (BBA; Public Law 105-33) created Part C as the Medicare+Choice program; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Public Law 108-173) modified the program and renamed it as Medicare Advantage. (Most, but not all, Medicare Advantage plans also offer Part D prescription drug coverage, as discussed below.)

The MMA also established Medicare Part D to help pay for prescription drugs not otherwise covered by Part A or Part B. Part D initially provided access to prescription drug discount cards, on a voluntary basis and at limited cost, to all enrollees (except those entitled to Medicaid drug coverage) and, for low-income beneficiaries, transitional limited financial assistance for purchasing prescription drugs and a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out during 2006. In 2006 and later, Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis for all beneficiaries upon payment of a premium, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may choose to enroll in either a Medicare-approved private-sector drug plan or a Medicare Advantage plan that offers Part D coverage (as most, but not all, do).

Part D activities are handled within the SMI trust fund, but in an account separate from Part B. It should thus be noted that the traditional treatment of “SMI” and “Part B” as synonymous is no longer accurate, since SMI now consists of both Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other.

When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2018, almost 60 million people are enrolled in one or both of Parts A and B of the Medicare program, and over 21 million of them have chosen to participate in a Medicare Advantage plan.

Entitlement and Coverage

Part A is generally provided automatically, and free of premiums, to persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in Federal, State, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees or spouses with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. (As noted previously, the waiting period is waived for persons with Lou Gehrig’s Disease, and certain persons in the Libby, Montana vicinity who are diagnosed with asbestos-related conditions are Medicare-eligible. It should also be noted that, over the years, there have been certain liberalizations made to both the waiting period requirement and the limit on earnings allowed for entitlement to Medicare coverage based on disability.) Part A coverage is also provided to insured workers with ESRD (and to insured workers’ spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 2017, Part A provided protection against the costs of hospital and specific other medical care to over 58 million people (over 49 million aged and almost 9 million disabled enrollees). Part A benefit payments totaled \$293.3 billion in 2017.

The following health care services are covered under Part A:

- Inpatient hospital care. Coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).
- Skilled nursing facility (SNF) care. Coverage is provided by Part A only if the care follows within 30 days (generally) of a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21 through 100. Part A does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.
- Home health agency (HHA) care (covered by both Parts A and B). The BBA transferred from Part A to Part B those home health services furnished on or after January 1, 1998 that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Part A and Part B has no copayment and no deductible.

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

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

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

All citizens (and certain legal aliens) aged 65 or older, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2017, Part B provided protection against the costs of physician and other medical services to over 53 million people (over 45 million aged and over 8 million disabled enrollees). Part B benefits totaled \$308.6 billion in 2017.

Part B covers certain medical services and supplies, including the following:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists.
- Services provided by Medicare-approved practitioners who are not physicians, including certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician.
- Services in an emergency room, outpatient clinic, or ambulatory surgical center, including same-day surgery.
- Home health care not covered under Part A.
- Laboratory tests, X-rays, and other diagnostic radiology services.
- Certain preventive care services and screening tests.

- Most physical and occupational therapy and speech pathology services.
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.
- Radiation therapy; renal (kidney) dialysis and transplants; and heart, lung, heart-lung, liver, pancreas, bone marrow, and intestinal transplants.
- Approved DME for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, casts, and braces.
- Drugs and biologicals that are not usually self-administered, such as hepatitis B vaccines and immunosuppressive drugs. (Certain self-administered anticancer drugs are covered.)
- Certain services specific to people with diabetes.
- Ambulance services, when other methods of transportation are contraindicated.

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for certain outpatient hospital services). The preceding description of Part B-covered services should be used only as a general guide, due to the wide range of services covered under Part B and the quite specific rules and regulations that apply.

Medicare Parts A and B, as described above, constitute the original fee-for-service Medicare program. Medicare Part C, also known as Medicare Advantage, is an alternative to traditional Medicare. While all Medicare beneficiaries can receive their benefits through the traditional fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. Medicare Advantage plans are offered by private companies and organizations and are required to provide at least those services covered by Parts A and B, except hospice services. These plans may (and in certain situations must) provide extra benefits (such as vision or hearing) or reduce cost sharing or premiums. Following are the primary Medicare Advantage plans:

- Local coordinated care plans (LCCPs), including health maintenance organizations (HMOs), local preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet standards set forth in the law. Generally, each plan has a network of participating providers. Enrollees may be required to use these providers or, alternatively, may be allowed to go outside the network but pay higher cost-sharing fees for doing so.
- Regional PPO (RPPO) plans, which began in 2006 and offer coverage to 1 of 26 defined regions. Like local PPOs, RPPOs have networks of participating providers, and enrollees must use these providers or pay higher cost-sharing fees. However, RPPOs are required to provide beneficiary financial protection in the form of limits on out-of-pocket cost sharing, and there are specific provisions to encourage RPPO plans to participate in Medicare.
- Private fee-for-service (PFFS) plans, which were not required to have networks of participating providers prior to 2011. Beginning in 2011, this is still the case for PFFS plans in areas (usually

counties) in which there are fewer than two network-based LCCPs and/or RPPOs, and members may go to any Medicare provider willing to accept the plan's payment. However, for PFFS plans in network areas with two or more network-based LCCPs and/or RPPOs, provider networks are now mandatory, and members may be required to use these participating providers.

- Special Needs Plans (SNPs), which are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain severe and disabling conditions.

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

Beginning in 2006, Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. Enrollment began in late 2005. In 2017, Part D provided protection against the costs of prescription drugs to over 44 million people. Part D benefits totaled an estimated \$100.1 billion in 2017. (This amount includes an estimated \$10.5 billion in benefits that are financed by the portion of enrollee premiums that are paid directly to the Part D plans. These direct premium amounts are available only on an estimated basis.)

Part D coverage includes most FDA-approved prescription drugs and biologicals. (The specific drugs currently covered in Parts A and B remain covered there.) However, plans may set up formularies for their prescription drug coverage, subject to certain statutory standards. Part D coverage can consist of either standard coverage (defined later) or an alternative design that provides the same actuarial value. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

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

Program Financing, Beneficiary Liabilities, and Payments to Providers

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

Program Financing

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. Currently, employees and employers each pay 1.45 percent of a worker's wages, for a combined payroll tax rate of 2.9 percent, while self-employed

workers pay 2.9 percent of their net earnings. Since 1994, this tax has been paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) Beginning in 2013, earned income in excess of \$200,000 (for those filing income tax singly) and \$250,000 (for those filing jointly) is subject to an additional Part A payroll tax of 0.9 percent. (The earnings thresholds are not indexed.) The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

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

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

For Part B, the contributions from the general fund of the U.S. Treasury are the largest source of income, since beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. The standard Part B premium rate will be \$135.50 per beneficiary per month in 2019. There are, however, three provisions that can alter the premium rate for certain enrollees. First, penalties for late enrollment (that is, enrollment after an individual's initial enrollment period) may apply, subject to certain statutory criteria. Second, beginning in 2007, beneficiaries whose income is above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their standard monthly premium. Finally, a "hold-harmless" provision, which prohibits increases in the standard Part B premium from exceeding the dollar amount of an individual's Social Security cost-of-living adjustment, lowers the premium rate for certain individuals who have their premiums deducted from their Social Security benefits.

[Note: The standard monthly premium for 2019 of \$135.50 includes a repayment amount of \$3 (as did the 2016, 2017, and 2018 premium rates). This \$3 amount is to be transferred to the general fund of the Treasury, as mandated by the Bipartisan Budget Act of 2015 (Public Law 114-74) and explained in detail in the 2015 and 2016 Summaries.]

Following are the 2019 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns:

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$135.50
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$54.10	\$189.60
Greater than \$107,000 and less than or equal to \$133,500	Greater than \$214,000 and less than or equal to \$267,000	\$135.40	\$270.90
Greater than \$133,500 and less than or equal to \$160,000	Greater than \$267,000 and less than or equal to \$320,000	\$216.70	\$352.20
Greater than \$160,000 and less than \$500,000	Greater than \$320,000 and less than \$750,000	\$297.90	\$433.40
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$325.00	\$460.50

The Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$135.50
Greater than \$85,000 and less than \$415,000	\$297.90	\$433.40
Greater than or equal to \$415,000	\$325.00	\$460.50

For Part D, as with Part B, general fund contributions account for the largest source of income, since Part D beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The Part D base beneficiary premium for 2019 will be \$33.19. The actual Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. As of this writing, it is estimated that the average monthly premium for basic Part D coverage, which reflects the specific plan-by-plan premiums and the estimated number of beneficiaries in each plan, will be about \$32.50 in 2019.

The estimated \$32.50 average premium does not account for three circumstances that can also alter premiums for individual beneficiaries. First, penalties for late enrollment may apply. (Late enrollment penalties do not apply to enrollees who have maintained creditable prescription drug coverage.) Second, beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced premiums or no premiums at all (and are not subject to late enrollment penalties). Third, beginning in 2011, beneficiaries with income above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their monthly premium.

Following are the 2019 Part D income-related monthly adjustment amounts to be paid by beneficiaries who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns. A beneficiary pays his or her plan premium plus the amounts shown below.

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Part D income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.40
Greater than \$107,000 and less than or equal to \$133,500	Greater than \$214,000 and less than or equal to \$267,000	\$31.90
Greater than \$133,500 and less than or equal to \$160,000	Greater than \$267,000 and less than or equal to \$320,000	\$51.40
Greater than \$160,000 and less than \$500,000	Greater than \$320,000 and less than \$750,000	\$70.90
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$77.40

The Part D income-related monthly adjustment amounts to be paid by beneficiaries who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses:	Part D income-related monthly adjustment amount
Less than or equal to \$85,000	\$0.00
Greater than \$85,000 and less than \$415,000	\$70.90
Greater than or equal to \$415,000	\$77.40

In addition to contributions from the general fund of the U.S. Treasury and beneficiary premiums, Part D also receives payments from the States. With the availability of prescription drug coverage and low-income subsidies under Part D, Medicaid is no longer the primary payer for prescription drugs for Medicaid beneficiaries who also have Medicare, and States are required to defray a portion of Part D expenditures for those beneficiaries.

During the Part D transitional period that began in mid-2004 and phased out during 2006, the general fund of the U.S. Treasury financed the transitional assistance benefit for low-income beneficiaries. Funds were transferred to, and paid from, a Transitional Assistance account within the SMI trust fund.

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. It is important to note that beneficiary premiums and general fund payments for Parts B and D are redetermined annually and separately.

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

Beneficiary Payment Liabilities

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both Part A and Part B. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private “Medigap”

insurance; or (3) by Medicaid, if the person is eligible. The term “Medigap” is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by Blue Cross and Blue Shield and various commercial health insurance companies.

In Medicare Advantage plans, the beneficiary’s payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries, in general, pay the monthly Part B premium. However, some Medicare Advantage plans may pay part or all of the Part B premium for their enrollees as an added benefit. Depending on the plan, enrollees may also pay an additional plan premium for certain extra benefits provided (or, in a small number of cases, for certain Medicare-covered services).

For hospital care covered under Part A, a fee-for-service beneficiary’s payment share includes a one-time deductible amount at the beginning of each benefit period (\$1,364 in 2019). This deductible covers the beneficiary’s part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments (\$341 per day in 2019) are required through the 90th day of a benefit period. Each Part A beneficiary also has a lifetime reserve of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments (\$682 per day in 2019) are required.

For skilled nursing care covered under Part A, Medicare fully covers the first 20 days in a benefit period. But for days 21 through 100, a copayment (\$170.50 per day in 2019) is required from the beneficiary. After 100 days per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of his or her spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the 2019 Part A monthly premium rate will be \$437; for those with 30 to 39 quarters of coverage, the rate will be reduced to \$240. Penalties for late enrollment may apply. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom coverage has ceased due to earnings in excess of those allowed.

The Part B beneficiary’s payment share includes the following: one annual deductible (\$185 in 2019); the monthly premiums; the coinsurance payments for Part B services (usually 20 percent of the remaining allowed charges, with certain exceptions noted below); a deductible for blood; certain charges above the Medicare-allowed charge (for claims not on assignment); and payment for any services not covered by Medicare. For outpatient mental health services, the beneficiary is liable for 20 percent of the approved charges for 2014 and later; this percentage had been 50 percent through 2009, phasing down to 20 percent during the period 2010-2014. For services reimbursed under the outpatient hospital prospective payment system, coinsurance percentages vary by service and currently fall in the range of 20 percent to 50 percent. There are currently no deductibles or coinsurance for certain services, such as laboratory tests paid under the clinical laboratory fee schedule, home health agency services, and some preventive care services (including an initial, “Welcome to Medicare” preventive physical examination and, beginning in 2011, an annual wellness visit to develop or update a prevention plan).

For the standard Part D benefit design, there is an initial deductible (\$415 in 2019). After meeting the deductible, the beneficiary pays 25 percent of the remaining costs, up to an initial coverage limit (\$3,820 in 2019). A coverage gap starts after an individual's drug costs reach the initial coverage limit and stops when the beneficiary incurs a certain threshold of out-of-pocket costs (\$5,100 in 2019). Previously, the beneficiary had to pay the full cost of prescription drugs while in this coverage gap. However, provisions of the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)—collectively referred to as the Affordable Care Act—lower the out-of-pocket costs in the coverage gap gradually between 2010 and 2020. In 2019, beneficiaries who enter the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies) will receive a 70-percent manufacturer discount and a 5-percent benefit from their Part D plans for applicable prescription drugs and a 63-percent benefit from their plans for non-applicable drugs. “Applicable” drugs are generally covered brand-name Part D drugs (including insulin and Part D vaccines); “non-applicable” drugs are generally covered non-brand-name (that is, generic) Part D drugs (including supplies associated with the delivery of insulin). Reductions to beneficiary cost sharing in the coverage gap continue to increase such that, by 2020, the coverage gap will be fully phased out, with the beneficiary responsible for 25 percent of all prescription drug costs.

The 2019 out-of-pocket threshold of \$5,100 is equivalent to estimated average total covered drug spending of \$8,139.54 under the defined standard benefit design, during the initial coverage period and the coverage gap, for enrollees not eligible for low-income cost-sharing subsidies. This estimated amount is based on an average blend of usage of applicable and non-applicable drugs by enrollees while in the coverage gap. In determining out-of-pocket costs, the dollar value of the 70-percent manufacturer discount for applicable drugs is included, even though the beneficiary does not pay it. The dollar values of the 63-percent drug plan benefit on non-applicable drugs and the 5-percent drug plan benefit on applicable drugs do not count toward out-of-pocket spending. Under the defined standard benefit design, the out-of-pocket threshold of \$5,100 for 2019 is equivalent to \$7,653.75 in total covered drug costs for enrollees eligible for low-income cost-sharing subsidies.

For costs incurred after the out-of-pocket threshold is reached, catastrophic coverage is provided, which requires the enrollee to pay the greater of 5-percent coinsurance or a small defined copayment amount (\$3.40 in 2019 for generic or preferred multi-source drugs and \$8.50 in 2019 for other drugs). The benefit parameters are indexed annually to the growth in average per capita Part D costs. Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced cost-sharing amounts. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exceptions to this “true out-of-pocket” provision are cost-sharing assistance from the low-income subsidies provided under Part D and from State Pharmacy Assistance programs and the manufacturer discount (50 percent in 2011-2018 and 70 percent in 2019 and later) on applicable brand-name drugs purchased by enrollees in the Part D coverage gap.

Many Part D plans offer alternative coverage that differs from the standard coverage described above. In fact, the majority of beneficiaries are not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, additional partial coverage in the coverage gap. The monthly premiums required for Part D coverage are described in the previous section.

Payments to Providers

Before 1983, Part A payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under the PPS for acute inpatient hospitals, each stay is categorized into a diagnosis-related group (DRG). Each DRG has a specific predetermined amount associated with it, which

serves as the basis for payment. A number of adjustments are applied to the DRG's specific predetermined amount to calculate the payment for each stay. In some cases the payment the hospital receives is less than the hospital's actual cost for providing the Part A-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays and other situations. Payments for skilled nursing care, home health care, inpatient rehabilitation hospital care, long-term care hospitals, inpatient psychiatric hospitals, and hospice are made under separate prospective payment systems.

For non-physician Part B services, home health care is reimbursed under the same prospective payment system as Part A; most hospital outpatient services are reimbursed on a separate prospective payment system; and most (although not all) payments for clinical laboratory and ambulance services are based on fee schedules. A fee schedule is a comprehensive listing of maximum fees used to pay providers. Most DME payments have also been based on a fee schedule, but a transition to a competitive bidding process for certain DME began on January 1, 2011, with implementation in nine metropolitan statistical areas (MSAs). On July 1, 2013, competitive bidding was expanded to cover about 100 MSAs in all, and a national mail-order program for diabetic testing supplies was also implemented. As of July 1, 2016, the transition was completed for included DME, and all areas of the country are now subject to competitive bidding (or to payments based on the competitively bid rates).

In general, the prospective payment systems and fee schedules used for Part A and non-physician Part B services are increased each year either by indices related to the "market basket" of goods and services that the provider must purchase or by indices related to the Consumer Price Index (CPI). These indices vary by type of provider. The Affordable Care Act mandates that these payment updates be decreased, in most cases, from what they would have been, by stipulated amounts during 2010-2019, with starting dates and amounts varying by type of provider. In addition, payment updates are further reduced, on a permanent basis, by the growth in economy-wide productivity, with starting dates varying by type of provider, with some having started as early as October 2011. (There is a strong likelihood that the lower payment increases will not be viable in the long range. The best available evidence indicates that most health care providers cannot improve their productivity to this degree due to the labor-intensive nature of most of these services.)

For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality. Beginning January 1992, allowed charges have been defined as the lesser of (1) the submitted charges, or (2) the amount determined by a fee schedule based on a relative value scale (RVS). In practice, most allowed charges are based on the fee schedule. Under 1997 legislation, this fee schedule was supposed to be updated each year by a sustainable growth rate (SGR) system prescribed in the law, which set limits on how much doctor payments could change based on how quickly the rest of the economy was growing. For 2003 through June 2015, however, significant physician fee reductions scheduled under the SGR system were postponed by legislative action that was taken at least annually.

Effective April 1, 2015, the SGR system was permanently repealed and replaced by a new annual payment update system. Payment updates for all future years were prescribed, and incentive payments for 2019-2024—based on participation by individual physicians in an alternative payment model (APM) program or performance under the merit-based incentive payment system (MIPS)—were set forth in the law. (While the scheduled updates provided relief in the short term from significant reductions to physician payments scheduled under the SGR system, the specified rate updates are not expected to keep up with underlying physician costs over the long range and would provide lower physician payments than under the SGR system in the long run.)

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

Medicare Advantage plans and their precursors have generally been paid on a capitation basis, meaning that a fixed, predetermined amount per month per member is paid to the plan, without regard to the actual number and nature of services used by the members. The specific mechanisms to determine the payment amounts have changed over the years. In 2006, Medicare began paying to plans capitated payment rates based on a competitive bidding process.

For Part D, each month for each plan member, Medicare pays Part D drug plans (stand-alone PDPs and the prescription drug portions of Medicare Advantage plans) their risk-adjusted bid, minus the enrollee premium. Plans also receive Medicare payments representing premiums and cost-sharing amounts for certain low-income beneficiaries for whom these items are reduced or waived. In addition, under the reinsurance provision, Medicare pays plans for 80 percent of costs in the catastrophic coverage category (less corresponding rebates that the plans receive from drug manufacturers).

To help them gain experience with the Medicare population, Part D plans are protected by a system of “risk corridors” that allow Medicare to assist with unexpected costs and share in unexpected savings. The risk corridors became less protective after 2007.

Under Part D, Medicare provides certain subsidies to employer and union prescription drug plans that continue to offer coverage to Medicare retirees and meet specific criteria in doing so. These retiree drug subsidy (RDS) payments were previously tax-exempt but became taxable under the Affordable Care Act beginning in 2013.

Medicare Claims Processing

Since the inception of Medicare, fee-for-service claims have been processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal government. These entities apply the Medicare coverage rules to determine appropriate reimbursement amounts and make payments to the providers and suppliers. Their responsibilities also include maintaining records, establishing controls, safeguarding against fraud and abuse, and assisting both providers and beneficiaries as needed.

Before the enactment of the MMA in 2003, contractors known as fiscal intermediaries processed Part A claims for institutional services, including claims for inpatient hospital, SNF, HHA, and hospice services. They also processed outpatient hospital claims for Part B. Similarly, contractors known as carriers handled Part B claims for services by physicians and medical suppliers. By law, the Centers for Medicare & Medicaid Services (CMS) was required to select fiscal intermediaries from among companies that were nominated by health care provider associations and to select carriers from among health insurers or similar companies.

The MMA mandated that this system of intermediaries and carriers be replaced with a new system of contract entities known as Medicare Administrative Contractors (MACs). Each MAC processes and pays

fee-for-service claims, for both Part A and Part B services, to all providers and suppliers within the MAC's defined geographical jurisdiction. MACs are selected through a competitive procedure. This new system is intended to improve Medicare services to beneficiaries, providers, and suppliers, who now have a single point of contact for all claims-related business. CMS evaluates MACs based in part on customer satisfaction with their services. The new system enables the Medicare fee-for-service program to benefit from economies of scale and competitive performance contracting.

The transition from fiscal intermediaries and carriers to MACs began in 2005, and the last intermediary and carrier contracts ended in September 2013. Under the initial implementation of the MAC system, Part A and Part B claims were processed by 15 "A/B MACs," with the exception of (1) durable medical equipment claims, which were processed by 4 specialty "DME MACs," and (2) home health and hospice claims, which were processed by 4 specialty "HH+H MACs." CMS has since consolidated the number of A/B MACs from 15 to 12, and the processing of home health and hospice claims has been assumed by 4 of the A/B MACs (although it should be noted that, for these 4 A/B MACs, their HH+H geographical areas do not coincide with their A/B geographical areas). DME claims continue to be processed by the 4 specialty DME MACs.

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

Part D plans are responsible for processing their claims, akin to Part C. However, because of the "true out-of-pocket" provision discussed previously, CMS has contracted the services of a facilitator, who works with CMS, Part D drug plans (stand-alone PDPs and the prescription drug portions of Medicare Advantage plans), and carriers of supplemental drug coverage, to coordinate benefit payments and track the sources of cost-sharing payments. Claims under Part D also have to be submitted by the plans to CMS, so that certain payments based on actual experience (such as payments for low-income cost-sharing and premium subsidies, reinsurance, and risk corridors) can be determined.

Because of its size and complexity, Medicare is vulnerable to improper payments, ranging from inadvertent errors to outright fraud and abuse. While providers are responsible for submitting accurate claims, and intermediaries and carriers are responsible for ensuring that only such claims are paid, there are additional groups whose duties include the prevention, reduction, and recovery of improper payments.

Quality improvement organizations (QIOs, formerly called peer review organizations or PROs) are groups of practicing health care professionals who are paid by the Federal government to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. One function of QIOs is to ensure that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

The ongoing effort to address improper payments intensified after enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Public Law 104-191), which created the Medicare Integrity Program (MIP). The MIP provides CMS with dedicated funds to identify and combat improper payments, including those caused by fraud and abuse, and, for the first time, allows CMS to competitively contract with entities other than carriers and intermediaries to conduct these activities. MIP funds are used for (1) audits of cost reports, which are financial documents that hospitals and other institutions are required to submit annually to CMS; (2) medical reviews of claims to determine whether services provided are medically reasonable and necessary; (3) determinations of whether Medicare or other insurance sources have primary responsibility for payment; (4) identification and investigation of potential fraud cases; and (5) education to inform providers about appropriate billing procedures. In addition to creating the MIP, HIPAA established a fund to provide resources for the Department of Justice—including the Federal

Bureau of Investigation—and the Office of Inspector General (OIG) within the Department of Health and Human Services (DHHS) to investigate and prosecute health care fraud and abuse.

The Deficit Reduction Act of 2005 (DRA; Public Law 109-171) established and funded an additional activity called the Medicare-Medicaid Data Match Program, which is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information. As is the case under the MIP, CMS can contract with third parties. The funds also can be used (1) to coordinate actions by CMS, the States, the Attorney General, and the DHHS OIG to prevent improper Medicaid and Medicare expenditures, and (2) to increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and the recoupment of fraudulent, wasteful, or abusive expenditures.

The Affordable Care Act included many provisions intended to improve the accuracy of payments and to link those payments to quality and efficiency in the Medicare program. Because these provisions are so numerous and broad in scope and cannot be described in detail in this brief summary, reputable documents that provide such detail should be consulted if more information is desired. One of the most important of these provisions is the establishment of the Center for Medicare and Medicaid Innovation (CMMI) within CMS. The purpose of the CMMI is to test innovative payment and service delivery models, with the goal of reducing program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP, known from its inception until March 2009 as the State Children's Health Insurance Program or SCHIP) while preserving or enhancing quality of care.

Administration

DHHS has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with CMS. SSA assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums from the Social Security benefits of most beneficiaries, and by maintaining Medicare data on the master beneficiary record, which is SSA's primary record of beneficiaries. The MMA requires SSA to undertake a number of additional Medicare-related responsibilities, including making low-income subsidy determinations under Part D, notifying individuals of the availability of Part D subsidies, withholding Part D premiums from monthly Social Security cash benefits for those beneficiaries who request such an arrangement, and, for 2007 and later, determining the individual's Part B premium if the Part B income-related monthly adjustment applies. For 2011 and later, the Affordable Care Act requires SSA to determine the individual's Part D premium if the Part D income-related monthly adjustment applies. The Internal Revenue Service (IRS) in the Department of the Treasury collects the Part A payroll taxes from workers and their employers. IRS data, in the form of income tax returns, play a role in determining which Part D enrollees are eligible for low-income subsidies (and to what degree) and which Part B and Part D enrollees are subject to the income-related monthly adjustment amounts in their premiums (and to what degree).

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

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

Medicare Financial Status

As measured by expenditures, Medicare is the largest health care insurance program—and the second-largest social insurance program—in the United States. Medicare is also complex, and it faces a number of financial challenges in both the short term and the long term. These challenges include the following:

- The solvency of the HI trust fund, which fails the Medicare Board of Trustees' test of short-range financial adequacy. (Trust fund assets are currently below 100 percent of projected annual expenditures and are not expected to attain the 100-percent level under the Trustees' intermediate assumptions.)
- The long-range health of the HI trust fund, as the trust fund fails the Trustees' test of long-range close actuarial balance.
- The rapid growth projected for SMI costs as a percent of Gross Domestic Product. (Although the Part B and Part D accounts in the SMI trust fund are automatically in financial balance—in both the short range and the long range—since premiums and general revenue financing rates are reset each year to match estimated costs, the rapid growth of SMI expenditures nevertheless places steadily increasing demands on beneficiaries and taxpayers.)
- The likelihood that the lower payment rate updates to most categories of Medicare providers for 2011 and later, as mandated by the Affordable Care Act, will not be viable in the long range (as discussed previously).
- The likelihood that the specified rate updates under the new Part B physician payment update system will not keep up with underlying physician costs over the long range (as discussed previously), possibly leading to decreased access to, or quality of, physician services for beneficiaries or to the overriding of the specified updates (as repeatedly occurred when the SGR system was in place), which would in turn lead to higher costs.

Though a detailed description of these issues is beyond the scope of this summary, more information can be found in the most recent Medicare Trustees Report, available on the Internet at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>.

Data Summary

The Medicare program covers most of our nation's aged population, as well as many people who receive Social Security disability benefits. In 2017, Part A covered over 58 million enrollees with benefit payments of \$293.3 billion, Part B covered over 53 million enrollees with benefit payments of \$308.6 billion, and Part D covered over 44 million enrollees with benefit payments of \$100.1 billion. Administrative costs in 2017 were about 1.1 percent, 1.6 percent, and -0.1 percent of expenditures for Part A, Part B, and Part D, respectively. (Negative Part D administrative costs reflect transfers made to the Part D account from the other parts of Medicare; Part D had previously overpaid administrative costs and was reimbursed in 2017.) Total expenditures for Medicare in 2017 were \$710.2 billion.

Medicaid: A Brief Summary

Overview of Medicaid

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

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

Title XXI of the Social Security Act, the Children’s Health Insurance Program (CHIP, known from its inception until March 2009 as the State Children’s Health Insurance Program or SCHIP), is a program initiated by the Balanced Budget Act of 1997 (BBA; Public Law 105-33). The BBA provided \$40 billion in Federal funding through fiscal year (FY) 2007 to be used to provide health care coverage for low-income children—generally those in families with income below 200 percent of the Federal poverty level (FPL)—who do not qualify for Medicaid and would otherwise be uninsured. CHIP funding was extended through FY 2027 by subsequent legislation, including the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA; Public Law 111-3); the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)—collectively referred to as the Affordable Care Act; the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Public Law 114-10); the Federal Register Printing Savings Act of 2017 (Public Law 115-120); and the Bipartisan Budget Act of 2018 (Public Law 115-123). Under CHIP, States may elect to provide coverage to qualifying children by expanding their Medicaid programs or through a State program separate from Medicaid. A number of States have also been granted waivers to cover parents of children enrolled in CHIP.

Medicaid Eligibility

Prior to 2014, Medicaid did not offer health care services for all poor persons. To qualify for the program, an individual needed not only to have low income but also to meet one of several eligibility criteria, such as being a child, a parent or caretaker adult of an eligible child, a disabled child or adult, or an aged adult. Other criteria also applied; for example, in many cases eligibility might have depended on an “asset test,” which measured a person’s assets against certain threshold levels.

In 2014 and later, the Affordable Care Act expands eligibility to all individuals under the age of 65 in households with income up to 138 percent of the FPL, as explained in more detail below. As a result of this legislation, most persons no longer need to meet the previously applied criteria, such as being in a designated group or undergoing an asset test, to qualify for Medicaid. However, due to a 2012 Supreme

Court ruling that made the eligibility expansion effectively optional for each State's Medicaid program, some States have chosen not to implement it, but many have elected to do so.

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

- Limited-income families with children, as described in section 1931 of the Social Security Act, are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996.
- Children under age 6 whose family income is at or below 133 percent of the FPL. (As of January 2018, the FPL has been set at \$25,100 for a family of four in the continental U.S.; Alaska and Hawaii's FPLs are \$31,380 and \$28,870, respectively.)
- Pregnant women whose family income is below 133 percent of the FPL. (Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care.)
- Infants born to Medicaid-eligible women, for the first year of life with certain restrictions.
- Supplemental Security Income (SSI) recipients in most States (or aged, blind, and disabled individuals in States using more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV-E of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance under Title IV-A or SSI due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries (described later).

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

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

- Institutionalized individuals, and individuals in home and community-based waiver programs, who are eligible under a “special income level.” (The amount is set by each State—up to 300 percent of the SSI Federal benefit rate.)
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Aged, blind, or disabled recipients of State supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
- Tuberculosis-infected persons who would be financially eligible for Medicaid at the SSI income level if they were in a Medicaid-covered category. (Coverage is limited to tuberculosis-related ambulatory services and tuberculosis drugs.)
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control and Prevention. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.
- “Optional targeted low-income children” included in the CHIP (formerly SCHIP) program established by the BBA.
- “Medically needy” persons (described below).

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

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain groups must be covered (including children under age 19 and pregnant women) and certain services must be provided (including prenatal and delivery care for pregnant women and ambulatory care for children). A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services as part of its MN program. Data from 2013 indicate that 34 States plus the District of Columbia have elected to have a MN program and are providing services to at least some MN beneficiaries. All remaining States utilize the “special income level” option to extend Medicaid to the “near poor” in medical institutional settings.

Transitional Medical Assistance (TMA) is a Medicaid program that offers up to 1 year of additional Medicaid health insurance benefits for certain low-income families who would otherwise lose coverage. Specifically, under TMA provisions, families who would otherwise lose Medicaid eligibility because of earned income or hours of employment, or the loss of a time-limited earnings disregard, receive at least 6 months and as many as 12 months of Medicaid coverage. TMA provisions were subject to periodic

reauthorization from the time of their enactment in 1988 but were made a permanent part of Medicaid by MACRA in April 2015.

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

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

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

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

The Deficit Reduction Act of 2005 (DRA; Public Law 109-171) refined eligibility requirements for Medicaid beneficiaries by tightening standards for citizenship and immigration documentation and by changing the rules concerning long-term care eligibility—specifically, the look-back period for determining community spouse income and assets was lengthened from 36 months to 60 months, individuals whose homes exceed \$500,000 in value are disqualified, and the States are required to impose partial months of ineligibility.

Beginning in 2014, the Affordable Care Act expands Medicaid eligibility to all individuals under age 65 in families with income below 138 percent of the FPL. (Technically, the income limit is 133 percent of the FPL, but the Act also provides for a 5-percent income disregard.) In addition to the higher level of allowable income, the legislation expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children. Since individuals are no longer required to be parents of eligible children, the category of non-disabled non-aged adults has experienced the greatest increase in Medicaid enrollment. However, in *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.*, 132 S. Ct. 2566 (2012), the United States Supreme Court ruled that States could

not be required to implement this expansion as a condition of continuing to operate their existing Medicaid programs and receiving Federal financial participation. This ruling has made the eligibility expansion effectively optional for each State's Medicaid program. As of January 1, 2018, a total of 33 States and the District of Columbia have adopted the Medicaid expansion.

Scope of Medicaid Services

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

- Inpatient hospital services.
- Outpatient hospital services.
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

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

- Diagnostic services.
- Clinic services.
- Intermediate care facility services.
- Prescribed drugs and prosthetic devices.

- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Hospice care.
- Home and community-based care to certain persons with chronic impairments.
- Targeted case management services.

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

Amount and Duration of Medicaid Services

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

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

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific

restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the disproportionate share hospital (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. Legislation that was passed in 1991 and 1993, and amended in the BBA of 1997 and later legislation, capped the Federal share of payments to DSH hospitals.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services. Under the DRA, new cost-sharing and benefit rules provided States the option of imposing new premiums and increased cost sharing on all Medicaid beneficiaries except for those mentioned above and terminally ill patients in hospice care. The DRA also established special rules for cost sharing for prescription drugs and for non-emergency services furnished in emergency rooms.

The Federal government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In FY 2018, the FMAPs varied from 50 percent in 14 States to 75.65 percent in Mississippi, and averaged 59.3 percent overall.

The BBA permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent. The American Recovery and Reinvestment Act of 2009 (ARRA; Public Law 111-5) provided States with an increase in their Medicaid FMAPs of up to 14 percentage points, depending on State unemployment rates, for the first quarter of FY 2009 through the first quarter of FY 2011. Section 201 of Public Law 111-226 (referred to as the Education, Jobs, and Medicaid Assistance Act of 2010) extended these increases for the second and third quarters of FY 2011, but at lower levels than had been the case under ARRA.

For children covered through the CHIP (formerly SCHIP) program, the Federal government pays States a higher share, or enhanced FMAP, which averaged 88 percent in FY 2018. An Affordable Care Act provision raises the enhanced FMAP for CHIP by 23 percentage points, to a maximum of 100 percent, through FY 2019; for FY 2020, the Federal Register Printing Savings Act of 2017 raises it by a lower amount—11.5 percentage points—to a maximum of 100 percent. Without these increases, the average enhanced FMAP would be about 71 percent.

The Federal government also reimburses States for 100 percent of the cost of services provided to American Indians and Alaskan natives through facilities of the Indian Health Service, for 100 percent of the cost of the Qualifying Individuals (QI) program (described later), and for 90 percent of the cost of family planning services, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the CHIP program, the QI program, DSH payments, and payments to Territories, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

Medicaid Summary and Trends

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

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

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

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. Estimates for 2017, for example, show that Medicaid payments for services for 28.2 million children, who constituted 39.8 percent of all Medicaid beneficiaries, averaged \$3,917 per child; for 27.7 million non-disabled non-aged adults, who represented 39.1 percent of beneficiaries, payments averaged \$5,858 per person. Of these adults, 12.2 million were newly eligible under the Medicaid expansion, with average per enrollee costs of \$6,152. Still, other groups had much larger per-person expenditures. Medicaid payments for services for 5.8 million aged, who

constituted 8.2 percent of all Medicaid beneficiaries, averaged \$15,703 per person; for 10.6 million disabled, who represented 15 percent of beneficiaries, payments averaged \$20,999 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2017 payments to health care vendors for 72.3 million Medicaid beneficiaries averaged \$8,119 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. According to the most recent projections (2017-2026) from the national health expenditure accounts, the Medicaid program paid \$43.3 billion for nursing facility services, or over 25 percent of the national cost of nursing facility care, in 2017. Similarly, Medicaid paid \$55.2 billion for home health agency services, or over 56 percent of the national cost of home health care, in 2017. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided States a new option to use managed care without a waiver. According to expenditure data reported by the States to the Centers for Medicare & Medicaid Services (CMS), managed care and capitated payments to providers constituted 49.6 percent of total Medicaid expenditures in 2017.

In FY 2017, net outlays for the Medicaid program (Federal and State) were an estimated \$584.9 billion, including direct payment to providers of \$266.1 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$272.8 billion, payments to disproportionate share hospitals of \$19.7 billion, and administrative costs of \$26.3 billion. In addition, there were \$4.4 billion in expenditures for the Vaccines for Children Program under Title XIX. With no other changes to the Medicaid program except for those already prescribed by current law, total Medicaid outlays are projected to reach \$814.7 billion by FY 2023.

Expenditures under the CHIP program in FY 2017 were \$17.5 billion. CHIP is funded by appropriations through FY 2027.

The Medicaid-Medicare Relationship

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

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs

are those Medicare beneficiaries who have financial resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes above 120 percent and less than 135 percent of the FPL, States receive a capped allotment of Federal funds for payment of Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike the QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The QI benefit is 100 percent federally funded, up to the State's allotment. The QI program was established by the BBA for FY 1998 through FY 2002 and was extended numerous times before being made permanent by MACRA in April 2015.

In 2017, payments for beneficiaries enrolled in both Medicare and Medicaid constituted an estimated \$154.5 billion, or 26.3 percent of total Medicaid expenditures.

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

Since the Medicare drug benefit and low-income subsidy replace a portion of State Medicaid expenditures for drugs, States see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Public Law 108-173) requires each State to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006, this payment was 90 percent of the projected 2006 reduction in State spending. The percentage decreased by $1\frac{2}{3}$ percent per year to 75 percent for 2015 and beyond.

NOTES:

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

<u>Articles</u>	<u>Also available on the Internet at</u>
“National Health Care Spending in 2016: Spending and Enrollment Growth Slow after Initial Coverage Expansions,” by Micah Hartman <i>et al.</i> , <i>Health Affairs</i> , January 2018, Volume 37, Number 1, pages 150-160.	https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1299
“National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth,” by Gigi A. Cuckler <i>et al.</i> , <i>Health Affairs</i> , March 2018, Volume 37, Number 3, pages 482-492.	https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1655
“National Health Expenditure Data”	http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

Medicare enrollment data are based on estimates prepared for the 2018 Medicare Trustees Report, known formally as the *2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (available on the Internet at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>). Medicare benefit payments, administrative costs, and total expenditures for 2017 are actual amounts for the calendar year, as determined from financial statements provided by the Department of the Treasury and CMS, except that premiums from enrollees, total income, benefit payments, and total expenditures for Medicare Part D—and thus for SMI and for total Medicare—include premium amounts paid by beneficiaries directly to Part D plans. These premium amounts are available only on an estimated basis; in this article, estimates prepared for the 2018 Medicare Trustees Report were used.

Medicaid data are based on Medicaid and CHIP projections from the Mid-Session Review of the President’s 2019 Budget and on the *2017 Actuarial Report on the Financial Outlook for Medicaid* (available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf>) and are consistent with data received from the States through the Medicaid Statistical Information System (MSIS) and the CMS-64 expenditure form. (The most recent MSIS update was in 2013, and the system has been discontinued. State MSIS data have been supplemented with Medicaid Analytic eXtract (MAX) data where available.)