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Briefing Report to the Chairman, Special Committee on Aging, U. S. Senate

July 1987

MEDICARE

Catastrophic Illness Insurance

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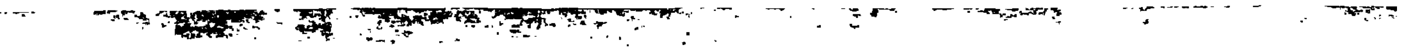

GAO

United States
General Accounting Office
Washington, D.C. 20548

Program Evaluation and Methodology Division

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July 31, 1987

The Honorable John Melcher
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

On January 20, 1987, you asked us to provide you with information about legislative proposals to protect Medicare enrollees from the financial hardships that often accompany catastrophic illness.

Initially, our review focused on six legislative proposals introduced into the first session of the 100th Congress. During the course of our review, the House Ways and Means Committee and the Senate Finance Committee approved H.R. 2470 and S. 1127. It is generally believed that these will form the basic structure for the Medicare coverage that the full Congress will eventually consider.

Therefore, with the concurrence of the committee staff, we focused on H.R. 2470, as approved by the House Ways and Means Committee on May 19, 1987, and S. 1127, as approved by the Senate Finance Committee on May 29, 1987. We also looked at the aspects of long-term care in S. 454, introduced by James R. Sasser.

In response to your request, we developed the following material:

1. a statement of our objectives, scope, and methodology;

2. a review and comparison of H.R. 2470 and S. 1127 against the current Medicare program with respect to benefits to enrollees, their costs, and the program's financing mechanisms;

3. a discussion of important issues that may still need attention; and

4. a synthesis of the lessons learned from the operation of state-financed insurance programs for catastrophic illness that the Congress might consider in the development of a federal program.

Principal Findings

In 1950, just over 8 percent of the population was 65 years old and older, but in 1980 this percentage was over 11 percent. One of the most

important issues of the late 1980's is how to protect the elderly and their families against the catastrophic expenses they may face when they have acute medical problems or when they need long-term care because of chronic illness and disabling conditions such as stroke and Alzheimer's disease.

Despite benefits from Medicare and private supplements to that program, out-of-pocket expenditures for medical care substantially burden them. This is especially true for nursing home care, for which more than one half of all costs are paid for by patients or their relatives.

Both bills are designed to expand Medicare coverage for acute care. Both are intended to be "budget neutral." That is, the cost of the expanded benefits would be paid for through higher Medicare premiums.

The provisions of the two proposals would significantly increase protection for the enrollees. For example, the bills would increase the number of covered hospital days and alter or eliminate deductibles and coinsurance payments. However, even if one of the current proposals or others similar to them are adopted, some gaps will remain.

The gaps in the Medicare program as they would be modified by H.R. 2470 or S. 1127 would be not in hospital services but in the incomplete coverage of physicians' charges and limited coverage of long-term care at home and in nursing homes. Therefore, it seems clear that the expanded Medicare benefits in either proposal would only partially protect the elderly from catastrophic expenses.

Issues that may require additional consideration are the definition of catastrophic expense, the specific health-care needs of the elderly, prescription drugs, and out-of-pocket expenses for services both covered and not covered by Medicare. We discuss these briefly below.

"Catastrophic expense" can be defined either in absolute terms or relative to income or wealth. Both bills define it absolutely, in the sense that they would limit how much an enrollee would have to pay for specific expenses without regard for individual income. The limit, called the "copayment cap," sets the maximum amount an individual would have to pay, either as deductibles or as coinsurance payments, for a spell of illness.

The lower copayment cap being proposed is $1,043. Approximately 91 percent of the Medicare beneficiaries have historically had copayment

expenses totaling less than $1,000 for services covered by Medicare. This means that under the proposed legislation, 91 percent of the enrollees who apply for benefits would not exceed the $1,043 cap (if past trends were to continue) and, therefore, would not be eligible for benefits.

Both Medicare and private insurance (called "Medigap" policies) are designed to deal largely with the cost of acute-care needs and do not cover the typical needs of patients in long-term care, who by and large do not require the services of a physician or a skilled nurse but, rather, need help in dressing, eating, toileting, moving from one place to another, and supervision. While both H.R. 2470 and S. 1127 would extend the number of days covered in a skilled nursing facility, neither bill addresses the long-term services mentioned above.

The Medicaid program does pay for the most expensive long-term service—nursing home care—but it is so structured that a condition of eligibility for it is the impoverishment of the beneficiaries and their spouses. To obtain Medicaid benefits, a person must be either poor or reduced to poverty in the process of trying to pay for care.

Another issue is out-of-pocket expenses. Although H.R. 2470 and S. 1127 differ slightly, the combined expenses for services partially covered and services not covered by Medicare (excluding expenses associated with long-term care) would leave some elderly persons burdened with out-of-pocket expenses quite large in relation to their income. This would be particularly a problem for the elderly "near-poor" who do not qualify for Medicaid.

Many other important issues are addressed in the version of H.R. 2470 approved by the House Energy and Commerce Committee. They include prescription drugs, protecting the sick person or the spouse from impoverishment, and providing for personal care in the home and respite care. However, your need for an immediate analysis of the basic proposal precluded a full analysis of the amended version of the bill at this moment.

The experience of five states in trying to implement catastrophic illness programs may be relevant to some aspects of the federal proposals. New Hampshire and Rhode Island currently operate state-financed catastrophic illness insurance programs; Alaska, Maine, and Minnesota have operated one at some time since the mid-1970's. We derived several lessons from our review of their programs.

First, some of the states included assets as a factor in eligibility determinations. If assets are not included in determining whether an elderly person should receive the program's benefits, then an illness may be defined as catastrophic and covered by the program when the elderly person may in fact have enough wealth in the form of assets to finance care without serious financial effect on the family. The decision to include assets must be carefully considered also because large out-of-pocket expenses an elderly person pays by selling assets could lead to the impoverishment of the sick person or the spouse.

Second, high costs and rapid cost growth generally characterized the states' programs. Hospital benefits produced the main expense for the programs, from 71 percent of total expenditures in Alaska to 86 percent in Maine.

The states tried to contain the rapid growth in program costs with three basic cost-sharing mechanisms: deductibles, coinsurance, and limits to coverage. Rhode Island also created explicit incentives to the elderly to take private insurance coverage. It based a varying deductible on the quality of an applicant's insurance coverage: the more extensive the insurance coverage, the lower the deductible. This is a unique feature of Rhode Island's program, the only program that has been able to maintain hospital benefits. Providing expanded hospital benefits cost the state programs more than providing any other benefit.

The experience of the states indicates the need for continual attention to the ways in which current administrative structures could be used to implement a program and to identify and limit its costs. Administrative costs seem to be reduced to the extent that a program employs existing agencies and resources. Probably the most important lesson from the states' experiences is that the states often had to reassess the relative costs and revenues of their programs.

Summary

Overall, our review indicates that H.R. 2470 and S. 1127 would certainly add to the benefits available to the elderly. However, some of the elderly would still be at risk for substantial out-of-pocket health-care expenses, especially for long-term care, even if these bills are enacted.

For further information, please call me or Carl Wisler at (202-275-1854).

Sincerely,

Eleanor Chelimsky
Director

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Abbreviations

CBO	Congressional Budget Office
HHS	U.S. Department of Health and Human Services
SNF	Skilled nursing facility

Objectives, Scope, and Methodology

The Chairman of the U.S. Senate Special Committee on Aging asked us to review alternative legislative proposals for providing insurance against the expenses of catastrophic illness—a House of Representatives bill, H.R. 2470, originating in the House Ways and Means Committee, and a Senate bill, S. 1127, originating in the Senate Finance Committee.[1] Our overall goal in this report is to present factual information about the bills and the context in which such legislation would operate.

Objectives

Our review focuses on the following broad questions:

1. How do the House and Senate bills to provide insurance against catastrophic illness for Medicare enrollees compare with regard to benefits for enrollees, costs to enrollees, and financing mechanisms?

2. What important issues should be addressed in the development of a federal insurance program for catastrophic illness for the elderly?

3. What lessons learned from the operation of state insurance programs for catastrophic illness might the Congress consider in the development of a federal program?

Scope

The two legislative proposals, both designed to expand insurance for Medicare enrollees, provide the basic structure for a federal insurance program for catastrophic illness as it is being addressed by the 100th Congress. We have compared the two proposals to each other and to the existing Medicare program.

[1] H.R 2470, the Medicare Catastrophic Protection Act of 1987, was reported out of the House Ways and Means Committee on May 27, 1987, and referred to the House Committee on Energy and Commerce, Subcommittee on Health and the Environment. As amended by the House Committee on Energy and Commerce, H.R. 2470 was reported to the House on July 1 and approved on July 22, 1987 S. 1127, the Senate's Medicare Catastrophic Loss Prevention Act of 1987, was approved by the Senate Finance Committee on May 29, 1987, and reported on July 27, 1987 For a brief discussion of several other bills introduced in the 100th Congress, see U.S. General Accounting Office, Medicare: Comparison of Catastrophic Health Insurance Proposals, GAO/HRD-87-9BR (Washington, D.C June 1987). Except where noted otherwise, our discussion of H.R. 2470 is based on the bill as reported by the Committee on Ways and Means and our discussion of S 1127 is based on the bill approved by the Senate Finance Committee We do discuss subsequent legislative actions relevant to the bills in the final section of appendix II.

Although much of our discussion is focused on the elderly because they are the largest group covered by Medicare, we refer also to disabled persons and persons afflicted with end-stage renal disease when they would be especially affected by proposed legislative changes.[2]

Our review is further focused by concentrating on (1) major areas of difference between the House and Senate bills and (2) some additional controversial topics, some of which are included in both bills and some in neither. Whether or not the proposals are in fact "budget neutral" is a question that is outside the scope of our work.

Our analysis of lessons learned from the states is drawn from the experiences of all the states that have had insurance programs for catastrophic illness since 1975: Alaska, Maine, Massachusetts, Minnesota, and Rhode Island.

Methodology

To answer our evaluation questions, we carried out the four following steps.

Step 1

We began with a review of current literature. Computerized searches yielded approximately 600 references, which we screened. The items that appeared to be most relevant to our evaluation questions constituted a preliminary bibliography of 225 citations. To identify other references that we might have missed in the computerized search, we mailed the bibliography to 114 persons and organizations—state and federal governments, colleges and universities, private research organizations, the insurance and health care industries, and organizations representing the elderly. Deletions we made plus the additions suggested by the experts brought our final bibliography to 173 references.

Step 2

We compared the two catastrophic illness insurance bills with each other and with the current Medicare law with respect to their benefits and costs for enrollees and the financing mechanisms for the program.

[2]Medicare covers three major subpopulations that included 31.1 million persons on July 1, 1985: (1) beneficiaries 65 years old and older (28.2 million), (2) disabled beneficiaries younger than 65 (2.9 million), and (3) persons entitled to Medicare benefits solely because of end-stage renal disease (31,000).

Step 3

We interviewed experts in the field in order to identify the important, unresolved, and controversial issues in providing catastrophic illness insurance for the elderly. For further factual information about these issues, we reviewed the literature, statistical data bases, and the provision for long-term care in S. 454, introduced by James R. Sasser.

Step 4

To identify lessons learned about catastrophic illness insurance programs, we analyzed the experiences of the five states named above. We reviewed the literature available on these programs and interviewed state officials and other experts for their views about how the programs operated.

Proposed Changes in Benefits, Costs, and Financing Mechanisms

We compared the current Medicare law, H.R. 2470, and S. 1127 across three critical dimensions: benefits to enrollees, costs to enrollees, and financing mechanisms.

Proposed Changes in Benefits for Enrollees

Under the present Medicare law, benefits fall into two categories. Hospital insurance (under Medicare Part A) covers inpatient care, short-term skilled nursing facility (SNF) care, intermittent home health care, and hospice care. Other benefits are grouped under supplementary medical insurance (under Medicare Part B), which covers outpatient services, physicians' services, laboratory services, and a small amount of home health care.

The benefit changes associated with H.R. 2470 and S. 1127 are summarized in table II.1. Below, we describe some of the similarities and differences between the two legislative proposals. Tables II.2 and II.3 on page 14 provide estimates of the average amount and distribution of benefits by type of enrollee under the two bills for 1989.

Table II.1: Summary of Current Medicare Provisions and Proposed Changes Under H.R. 2470 and S. 1127

Provision	Current law	H.R. 2470	S. 1127
Part A hospital insurance			
Coverage	Hospital inpatient care, short-term skilled nursing facility (SNF) care, intermittent home health care, hospice care	Same as current law, except for changes noted under benefits	Same as current law except for changes noted under benefits
Benefits	Hospital inpatient stays up to 90 days per "spell of illness" plus up to 60 "lifetime reserve" days; benefit periods unlimited in number	No limit on hospital inpatient stays except for psychiatric care	No limit on hospital inpatient stays except for psychiatric care
	Lifetime limit of 190 days for inpatient psychiatric care	Inpatient psychiatric same as current law	Inpatient psychiatric same as current law
	SNF stays up to 100 days per "spell of illness" following hospital stay	SNF stays up to 150 days a year no prior hospitalization required	SNF stays up to 150 days a year, no prior hospitalization required
	Home health care skilled nursing visits up to 8 hours a day for up to 2-3 weeks or longer under unusual circumstances	Home health care up to 35 consecutive days	Home health care up to 21 consecutive days for all enrollees and up to 45 days with prior hospital stay
	Lifetime limit of 210 days for hospice care	No limit on hospice days	No limit on hospice care
Deductibles	First day $580 (in 1989) for first hospital stay in each "spell of illness"	First day $565 (in 1989) for first hospital stay a year	First day deductible $580 (in 1989) for first hospital stay a year if not limited by copayment cap
	Part A indexed to hospital update factor; Part B to Social Security cost-of-living adjustment	Parts A and B indexed to Social Security cost-of-living adjustment	Indexed same as current law
	One deductible for units of blood in each "spell of illness"	One deductible a year for units of blood	One deductible a year for units of blood
Coinsurance	1/4 of the deductible for 61-90 hospital days ($130 a day in 1987) and 1/2 of the deductible for reserve days ($260 a day in 1987)	None for hospital stays	None for hospital stays
	1/8 of the deductible for 21-100 SNF days ($65 a day in 1987)	20% of reasonable SNF costs for first 7 days of each year	15% of reasonable costs for first 10 days of each year
	5% of charges for respite care provided under hospice care	The 5% coinsurance charged for respite care under hospice care counts toward the catastrophic limit	The 5% coinsurance charged for respite care under hospice care counts toward the catastrophic limit
Part B supplemental medical insurance			
Coverage	Physicians' services outpatient care, laboratory, home health care	Same as current law, except for changes noted under benefits	Same as current law
Benefits	Outpatient prescription drugs for cases such as cataract and first-year transplant patients	Prescription drugs at an undetermined level	Immunosuppressant drugs, requires the Institute of Medicine to study the cost of broader prescription drug coverage
	Reimbursement up to $250 a year for outpatient psychiatric care	Reimbursement up to $1 000 a year for psychiatric care	Reimbursement up to $250 a year for outpatient psychiatric care

(continued)

Provision	Current law	H.R. 2470	S. 1127
		Requires the General Accounting Office to assess the need for and costs of comprehensive long-term care	
Premiums	Flat Part B premium ($22 a month in 1988, $26 a month in 1992)	A new Part B premium of $4 a month in 1988, indexed in subsequent years to increases in the insurance value of catastrophic benefits, plus a supplemental income-related premium for Part B enrollees with tax liabilities for $150 or more	A Part A income-related premium at rates designed to cover benefit costs through 1992 plus a flat Part B premium increase of $1.00 a month in 1990 and an additional $0 40 a month in 1991
Deductible	Annual $75	Same as current law	Same as current law
Coinsurance	20% of reasonable charges above the deductible (50% for outpatient psychiatric services)	Same as current law	Same as current law
Copayment cap	None, no limit on expenses not paid by Medicare	$1,043 (in 1989) includes the annual and the Part B deductible for blood, $250 of the mental health deductible, and 20% coinsurance, indexed to Social Security cost-of- living adjustment	$1,773 (in 1989) includes Part A deductibles and the sum of Parts A and B services, indexed to Social Security cost-of-living adjustment
Medicaid-Medicare link	States may "buy in" to Part B for poor, elderly, and disabled who are eligible for Medicare; federal matching for premiums is available for Medicaid populations eligible for Medicaid cash assistance	Requires Medicare buy-in in all states	Requires states to spend Medicaid savings on the elderly to help prevent impoverishment of spouses
Total estimated benefit costs[a]		$1 06 billion in FY 1988 $4 02 billion in FY 1989 $5 95 billion in FY 1990 $7 15 billion in FY 1991 $8 41 billion in FY 1992 $26.59 billion in FY 1988-92	$1.34 billion in FY 1988 $3.43 billion in FY 1989 $4 73 billion in FY 1990 $5.60 billion in FY 1991 $6.53 billion in FY 1992 $21 63 billion in FY 1988-92
Financing	Part A Social Security payroll tax paid by employers, employees, and the self-employed; Part B, an enrollee's premium of $17 90 a month (in 1987) and federal general revenues	Same as current law plus a supplemental premium paid by all enrollees required to file tax returns, increasing according to adjusted income, and an additional Part B premium of $1 00 a month (in 1990) increasing an additional $0 40 a month beginning in 1991	Same as current law plus a supplemental premium paid by Part B enrollees with income tax liability of $150 or more and an additional catastrophic Part B premium of $4 a month (in 1988) indexed to the insurance value of catastrophic benefits

[a]These estimates represent projected outlays to cover the costs of new program benefits Both bills are proposed as being budget neutral and as providing for revenues to maintain the solvency of the trust funds

Source Adapted from U S Congressional Budget Office "A Comparison of Selected Catastrophic Bills," Washington, D C , May 27 1987 p 3

Table II.2: Average Projected Benefits Per Enrollee by Family Income and Poverty Status in 1989

Income and status	Current law	Increase in average benefit: H.R. 2470	Increase in average benefit: S. 1127
Family income			
Under $10,000	$3,370	$183	$151
$10,000-$15,000	3,395	174	142
$15,000-$20,000	3,111	159	127
$20,000-$30,000	2 809	144	114
$30,000 or more	2,957	147	117
Poverty status			
Poor	$3,337	$201	$167
"Near poor"[a]	3,619	187	153
Nonpoor	2,928	146	115
All enrollees	$3,113	$161	$129

[a]Includes those with incomes above the poverty line but less than 1 5 times the poverty line

Source Congressional Budget Office simulations for 1989 using 1985 Medicare claims data adjusted for underreporting. Income information was imputed from the 1984 Health Interview Survey Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable

Table II.3: Projected Percentage of Benefits by Type of Enrollee in 1989

Enrollee category	% of enrollees	Benefits received: Current law	Benefits received: H.R. 2470	Benefits received: S. 1127
Elderly				
Without renal disease	90.2%	86 4%	74 5%	72.0%
With renal disease	0 1	1 6	5 2	6 5
Disabled				
Without renal disease	9 4%	9.4%	10 5%	10 3%
With renal disease	0.3	2.6	9 5	11 0
All enrollees				
Younger than 65	10 1%	12 4%	20 3%	21 7
65-69	28 0	20 2	19 0	18 4
70-74	23 4	22 1	20 5	20 2
75-79	17 4	19.1	17 6	17 3
80-84	11 4	13 8	12 1	12 0
85 or older	9 7	12 2	10 1	10 6

Source Congressional Budget Office simulations for 1989 using 1985 Medicare claims data adjusted for underreporting Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable

Similarities in Benefits

Both bills propose to

1. build on the existing Medicare benefit structure;

2. provide for unlimited hospital inpatient stays for general acute care but not psychiatric care;

3. eliminate coinsurance requirements for hospital stays;

4. extend the 210 days of coverage currently allowed for hospice stay to an unlimited number of days[1]

5. extend the coverage of care in skilled nursing facilities from 100 to 150 days;[2]

6. institute a "per year" instead of a "per spell of illness" basis for determining deductible costs for hospital inpatient care, SNF care, and units of blood;

7. provide the greatest increase in benefits to lower-income enrollees—under H.R. 2470, the average increase in benefits is estimated to be $161 but would be $201 for poor enrollees and $146 for nonpoor enrollees, and under S. 1127, the average increase in benefits is estimated to be $129 but would be $167 for poor enrollees and $115 for nonpoor enrollees;

8. distribute 20 to 21 percent of the new benefits to the 10 percent of all Medicare enrollees who are disabled;

9. distribute at least 14 percent of the new benefits to the 0.4 percent of the Medicare enrollees with end-stage renal disease, whether elderly or disabled;

10. finance a majority of the new benefits through a "supplemental premium" that would be collected with income taxes for the estimated 35-40 percent of the elderly who have incomes high enough to incur a tax liability.

[1]H R 2470 requires the certification of a physician.

[2]For the 150 days of SNF care under H.R 2470, beneficiaries would have to pay for the first 7 days of each year at 20 percent of the reasonable costs, under S. 1127, beneficiaries would have to pay for the first 10 days of each year at 15 percent of the reasonable costs.

Differences in Benefits

Important differences between the bills include the following:

1. H.R. 2470 would expand benefits but would also require all higher-income beneficiaries, even if they have only Part A hospital inpatient coverage, to pay a supplemental premium to finance the catastrophic benefits.[3] Benefits under S. 1127 would be completely optional in that only those who enroll in Medicare's Part B program would be eligible for the new catastrophic coverage. About 98 percent of Medicare beneficiaries presently choose Part B coverage.

2. Under H.R. 2470, only the basic Part B premium would remain deductible; under S. 1127, both the supplemental and basic premiums would be deductible.

3. The basic monthly Part B premium under H.R. 2470 would be $24.90 (in 1990); under S. 1127, it would be $29.00.

4. Under H.R. 2470, a single elderly person with an income of about $19,000 would be assessed the top supplemental premium of $580, but under S. 1127, this person would pay a supplemental premium of $108. The premium would be $580 under the Senate bill if income were between $42,000 and $52,000, and it would be capped at $800 for persons with higher incomes.

5. The bills also differ in their treatment of the so-called "windfall" that the states would receive when Medicare, an all-federal program, begins to pick up some of the costs now borne by the Medicaid program. The financing of that program, which provides health coverage to 23.5 million poor people, is split between the federal and state governments. Under both proposals, some health-care expenses of the poor paid for by Medicaid would in the future be paid for by Medicare.[4] However, under H.R. 2470, the states would be required to use the consequent "windfall" money to pay all Medicare premiums, deductibles, and copayments for elderly persons whose incomes are below the federal poverty line

[3]One of the bill's authors Willis D Gradison, Jr., terms this supplemental premium "an income-related mandatory user's fee."

[4]The federal government pays an average of 55 percent of Medicaid costs. The Congressional Budget Office (CBO) estimates that because Medicare will pick up some of the expenses currently paid by Medicaid through the mandatory "buy-in" provision, the federal government will save an estimated $55 million in Medicaid expenses in 1988, $200 million in 1989, and $410 million in 1992.

but above the threshold for Medicaid eligibility.[5] S. 1127 would direct the states to use the "windfall" money either to expand Medicaid to cover more low-income elderly persons or to protect spouses of long-term nursing-home residents from poverty. Protection for spouses would be accomplished by raising the income and asset limits that must not be exceeded if the costs of long-term care are to be covered by Medicaid.

6. H.R. 2470 provides for a prescription drug benefit that the bill leaves undetermined. S. 1127 would partially cover one group of costly outpatient prescription drugs: the bill would allow patients with organ transplants to count the cost of immunosuppressant drugs toward the Part B copayment cap. (See the discussion below on how the proposed cap would work.)

Discussion

Both H.R. 2470 and S. 1127 provide for many of the services generally associated with hospital care for acute illnesses and with services for transitional care such as skilled nursing facilities and home health care, which are sometimes required immediately after a patient's release from a hospital. Both proposals offer a limited expansion of Medicare's coverage of transitional care.

Recent evidence indicates that the average hospital stay has been growing shorter, largely because of efforts to contain hospital costs. The frequency of hospital admissions has declined as well. This move toward fewer admissions and earlier discharges may mean that elderly patients will need still more long-term care in the home or in a nursing home.[6] We discuss long-term care further in appendix III.

Both proposals offer some relief to the elderly who are most likely to accumulate catastrophic illness expenses—the poor and "near-poor"—by the manner in which the bills distribute benefits among income groups and by their Medicaid "buy-in" provisions. Both take advantage of the Medicaid "windfall" to reduce the threat of catastrophic expenses for persons who are poor and elderly.

[5]The states are to "buy in" to Part B of Medicare for both their cash-assistance and noncash-assistance Medicaid population who are eligible for Medicare. Federal matching for premium payments is available only for the cash-assistance group. If a state does not buy in for Part B coverage, it cannot receive federal matching payments for medical services that would have been covered under Medicare if there had been a buy-in agreement

[6]See U.S. General Accounting Office, Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient, GAO/PEMD-86-10 (Washington, D.C.: June 2, 1986)

Proposed Changes in Cost to Enrollees

Under the current law, all Medicare beneficiaries have out-of-pocket costs in one or more of three categories. (1) Persons not automatically covered under Part A pay premiums for Part A coverage and for the optional Part B coverage. (2) Deductible payments are initial charges a beneficiary pays for hospital inpatient care, supplemental medical insurance benefits, and units of blood under Parts A and B before Medicare coverage applies. (3) Coinsurance payments are percentages of total charges for hospital care, skilled nursing facilities, outpatient mental health services, and hospice benefits applied after the deductible has been accounted for. In our discussion, the term "copayment" includes deductible and coinsurance payments.

A beneficiary pays for these costs plus the cost of services not covered by Medicare, either directly out-of-pocket or indirectly by paying for a Medigap plan. A Medigap plan is private insurance designed primarily to fill in the deductible and coinsurance costs for Medicare; such policies typically use the same definitions and rules about allowable charges as Medicare.

The elderly may incur health care costs that are not paid for by Medicare or Medigap policies. Instances include premiums for Medigap insurance policies and the costs of services that exceed Medicare and Medigap limits, as when a patient exceeds the number of hospital days currently allowed by Medicare. Balance-billing is another cost that entails payments to physicians who charge more than Medicare's allowed limits and therefore send a bill to a patient for the "balance" of the fee. We do not discuss any of these costs in this report.

Premiums

Under current law, the Part B flat premium will be $22 monthly in 1988, rising to $26 monthly by 1992. This premium, which is paid only by persons who choose to enroll in Part B, would be continued under both H.R. 2470 and S. 1127. (See table II.4.)

Table II.4: Projected Premiums Per Enrollee in 1988-92

Legislation	1988	1989	1990	1991	1992
Current law					
Flat premiums					
Monthly	$22 00	$22 90	$23 90	$24 90	$26 00
Annual	264 00	274 80	286 80	298 80	312 00
Income-related premiums maximum annual liability	0	0	0	0	0
H.R. 2470					
New flat premiums					
Monthly	$0	$0	$1 00	$1 50	$1 50
Annual	0	0	12 00	18 00	18 00
Income-related premiums maximum annual liability	580 00	699 00	777 00	862 00	958 00
S. 1127					
New flat premiums					
Monthly	$4 00	$4 40	$5 10	$5 80	$6.60
Annual	48 00	52 80	61 20	69 60	79 20
Income-related premiums maximum annual liability	800 00	850 00	900 00	950 00	1 000 00

Source Congressional Budget Office A Comparison of Selected Catastrophic Bills Washington. D C May 27 1987

Both proposals would add new premiums. Under H.R. 2470, all Part B enrollees would pay, in addition to the existing annual premium, another flat premium of $1 beginning in 1990. In 1991 and 1992, the additional flat premium would be $1.50 monthly. Under S. 1127, the additional flat premium would be $4 a month in 1988, and by 1992, it would rise to $6.60 a month.

Under both proposals, enrollees with taxable income would be subject to an income-related premium. The maximum premium for any enrollee under H.R. 2470 would be $580 annually in 1988 but would rise to $958 in 1992. Thereafter, the maximum would be indexed to the rate of growth in the subsidy value of Medicare benefits.[7] Under S. 1127, the maximum income-related premium would be $800 in 1988, and this would increase to $1,000 in 1992.

Deductibles

Under H.R. 2470 and S. 1127, beneficiaries would be liable for an annual deductible for Medicare Part A ($520 in 1987). However, the Part A deductible would count toward a copayment cap only under S. 1127.

[7] "Subsidy value" for each enrollee is defined as half the value of Part A hospital insurance benefits plus the excess of the average Part B supplementary medical insurance benefit over the amount of flat premiums the enrollee pays

Under current law, the hospital deductible is indexed to the annual cost of hospital care, which has historically increased faster than the general cost of living. Under H.R. 2470, the Part A deductible would be indexed to the cost-of-living adjustment, but under S. 1127, it would continue to be indexed as it is now.

Under H.R. 2470, the Part A deductible would rise from $541 in 1988 to $641 in 1992. Under S. 1127, it would rise from $544 in 1988 to $700 in 1992.

Under H.R. 2470 and S. 1127, beneficiaries would continue to be liable for the current $75 deductible for the services covered under Part B.

Both H.R. 2470 and S. 1127 provide that under Parts A and B there would be only one deductible for units of blood per year and that it would count toward the copayment cap.

Coinsurance

The current 20-percent coinsurance charge for services covered by Part B would be continued under H.R. 2470 and S. 1127.

Under current law, the SNF coinsurance rate is one eighth of the hospital inpatient deductible for each day after the 20th and before the 101st of SNF services furnished during a "spell of illness." For 1987, this is $65 a day. Under current law, the rate will rise to $68 in 1988 and $87.50 in 1992. Under H.R. 2470 and S. 1127, SNF coinsurance rates would be keyed to reasonable costs per day, resulting in a daily coinsurance payment of $23.50 or $17.50, respectively, in 1988 and of $30 or $22.50 in 1991.

Under H.R. 2470 and S. 1127, the current coinsurance requirement for respite care provided as part of hospice care would be maintained but would count toward the copayment cap.

Copayments

Reductions in copayment costs under the House and Senate proposals would be largest for lower-income groups. In this section, we summarize estimates of how the bills would distribute costs among enrollees.

Under current law, 9.4 percent of the enrollees in Medicare will pay more than $1,500 in copayment costs in 1989. Under H.R. 2470, 6.7 percent of the enrollees would incur copayment costs of more than $1,500. Under S. 1127, slightly more than 8 percent would incur copayment

costs of more than $1,500, and a very small number of those who pay only hospital insurance under Part A (who are not protected under this bill) would incur copayment costs of $3,000 or more. (See table II.5.)

Table II.5: Projected Percentage Distribution of Enrollees by Copayment Costs in 1989

Copayment costs per enrollee	Current law	H.R. 2470	S. 1127
$0	3 2%	3.2%	3 2%
$1-$100	39.2	39.2	39 2
$101-$200	22.3	22.2	22 2
$201-$500	7.7	7 5	7 5
$501-$1,000	10 9	11.8	11 5
$1,001-$1,500	7 3	9 3	8.3
$1,501-$2,000	3 9	6 7	8.1
$2,001-$2,500	2 0	[a]	0
$2,501-$3,000	1 2	0	0
$3,001 or more	2 3	0	[a]
Total	**100.0%**	**100.0%**	**100.0%**

[a] Less than 0 05 percent

Source Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989 Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable

Both H.R. 2470 and S. 1127 would establish a cap on copayments but with different limits. (See table II.6.) Under H.R. 2470, the cap would apply to Part B only; under S. 1127, it would apply to Part A and Part B. In both, the cap would be indexed to the cost-of-living adjustment.

Table II.6: Projected Deductibles and Coinsurance Per Enrollee in 1988-92

Legislation	1988	1989	1990	1991	1992
Current law					
Hospital deductible	$544.00	$580 00	$620.00	$660 00	$700 00
Reasonable SNF cost per day	118 00	126.00	134 00	141 00	149 00
SNF coinsurance per day	68 00	72.50	77 50	82 50	87 50
Copayment cap	[a]	[a]	[a]	[a]	
H.R. 2470					
Hospital deductible	$541 00	$565.00	$589 00	$614 00	$641 00
Reasonable SNF cost per day	118 00	126.00	134 00	141 00	149 00
SNF coinsurance per day	23 50	25 00	27 00	28.00	30 00
Copayment cap[b]	[a]	1 043 00	1.089 00	1,136 00	1 185.00
S. 1127					
Hospital deductible	$544 00	$580 00	$620 00	$660 00	$700 00
Reasonable SNF cost per day	118.00	126 00	134.00	141 00	149 00
SNF coinsurance per day	17 50	19 00	20.00	21 00	22 50
Copayment cap[c]	1,700.00	1,773 00	1,851 00	1 931 00	2,014 00

[a]Not applicable

[b]Cap would apply only to Part B copayments

[c]Cap would apply only for the last half of 1988

Source Congressional Budget Office. A Comparison of Selected Catastrophic Bills. Washington D C , May 27 1987 Under both the House and Senate proposals average copayment costs would be reduced The average 1989 cost reduction for an enrollee would be $136 under H R 2470 and $115 under S 1127

Under H.R. 2470, 1 percent of the enrollees would face an increase in copayment costs in 1989 that would vary from a few dollars to more than $1,000. (See table II.7.) About half the enrollees' whose copayment costs would be reduced would do so because of a $15 reduction in the hospital deductible.

Table II.7: Projected Percentage Distribution of Enrollees by Change in Copayment Liabilities in 1989

	% of enrollees	
	H.R. 2470	**S. 1127**
Decrease		
$1-$250	15 0%	1 1%
$251-$500	1 3	0 8
$501-$1,000	3 5	3 0
$1,001-$2,000	1 9	1 5
$2,001-$3,000	0 6	0 5
$3,001 or more	41 0	0 9
Total	**23.3%**	**7.8%**
Increase		
$1-$250	0 3%	0 3%
$251-$500	0 1	0 1
$501-$1,000	0 6	0 6
$1,001-$2,000	a	0
$2,001-$3,000	0	0
$3,001 or more	0	0
Total	**1.0%**	**1.0%**
Average change	$−136	$−115

[a]Less than 0 05 percent

Source Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989 Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable

Under H.R. 2470, the reduction in the average copayment costs would be greater in 1989 for the poor, at $174, than for the nonpoor, at $122. Under S. 1127, the change would be in the same direction—a $150 reduction in costs for the poor and $102 for the nonpoor. (See table II.8.)

Table II.8: Average Projected Change in Copayment Costs Per Enrollee by Income and Poverty Status in 1989

		Change	
Income and status	**Current law**	**H.R. 2470**	**S.1127**
Family income			
Under $10,000	$568	$-160	$-136
$10,000-$15,000	562	-148	-126
$15,000-$20,000	524	-134	-113
$20,000-$30,000	479	-119	-100
$30 000 or more	499	-122	-102
Poverty status			
Poor	$570	$-174	$-150
'Near poor''[a]	592	-160	-137
Nonpoor	496	-122	-102
All enrollees	**$524**	**$-136**	**$-115**

[a]Includes those with incomes above the poverty line but less than 1 5 times the poverty line

Source Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989 Income information was imputed from the 1984 Health Interview Survey Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable

Under H.R. 2470, 23 percent of the enrollees would see their copayment costs fall by amounts ranging from a few dollars to more than $3,000. Under S. 1127, almost 8 percent of the enrollees would see their copayment costs fall similarly. Seventy-six percent under H.R. 2470 and 91 percent under S. 1127 would experience no change in copayment costs.

The proportion of enrollees for whom some portion of current copayment costs would be assumed by Medicare would be 8.1 percent under H.R. 2470 or 5.7 percent under S. 1127. (See table II.9.)

Table II.9: Projected Benefits and Copayments Per Enrollee in 1989

	Current law	**H.R. 2470**	**S. 1127**
Average benefit relative to current law	$3,113	$3,273	$3 242
Change		1 05%	1 04°
Change in average benefit	0	$161	$129
Average copayment relative to current law	$524	$388	$410
Change		26%	22
Enrollees affected by copayment cap[a]	0	8 1%	5 7

[a]H R 2470 applies only to Part B copayments S 1127 applies to Part A and Part B copayments together

Source Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989 Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable

Discussion

Although less than 9 percent of the Medicare beneficiaries are expected to exceed the lowest proposed copayment cap ($1,043), out-of-pocket hospital expenses can be very high for the few who are in acute-care hospitals for more than 60 days in a year and who are not covered by Medigap insurance.[8] A hospital stay of longer than 60 days requires a payment of $130 a day between 61 and 90 days and $260 a day after 90 days.

In addition, the initial deductible under Medicare ($520 in 1987) must be paid out-of-pocket by the 20 percent of enrollees who have neither Medigap policies nor coverage under Medicaid. The same people must make out-of-pocket coinsurance payments. Under the current law, as a consequence, a Medicare beneficiary can incur almost $19,000 in hospital expenses before Medicare coverage runs out. This means that families may incur catastrophic expenses even before reaching the limits of their Medicare coverage. The provisions in H.R. 2470 and S. 1127 that would eliminate or alter the current provisions on deductible and coinsurance charges and limits for hospital inpatient and hospice stays could provide some financial relief from copayment costs, particularly for the poor and "near-poor."

If the essential features of either bill were to become law, the major gaps remaining in Medicare would be not in the coverage of hospital expenses but in the limited coverage of Part B physicians' charges and coverage of certain very important items such as long-term care and prescription drugs.[9]

Under Part B, an enrollee must pay a $75 deductible before any reimbursement is provided. After paying the deductible, the Medicare enrollee is reimbursed for 80 percent of an "allowable" charge but not for balance-billing by the physician. Thus, in some instances the real payment not covered by Medicare may be not 20 percent of the physician's charge but significantly more.

To avoid out-of-pocket payments for deductible and coinsurance costs, 65 percent of all Medicare enrollees buy supplementary plans in the form of private insurance (another 10 percent are eligible for Medicaid).

[8] According to the Health Care Financing Administration, less than 1 percent of the Medicare beneficiaries each year stay in the hospital longer than 60 days and therefore incur the additional Medicare coinsurance fees

[9] See our report entitled Medicare Prescription Drug Issues, PEMD-87-20 (Washington, D.C. July 16, 1987)

These Medigap policies are an additional expense for the elderly. For the 80 percent of Medicare beneficiaries who carry them, they provide limited coverage for prescription drugs and other charges beyond what Medicare reimburses. They do not deal at all with the cost of long-term care.[10]

Medicare Financing Mechanisms

Medicare Part A is financed primarily through Social Security payroll tax contributions paid to a trust fund by employers, employees, and the self-employed. Part B is financed through premiums from its enrollees and from general federal revenues, also paid to a trust fund. The benefits being proposed are intended to be "budget neutral" or "pay-as-you-go," indicating that the bills could be implemented with no cost to the federal government and with small, predictable increases in the beneficiaries' premiums. The program's costs for the new benefits are the difference between outlays, or the money the federal government spends to provide benefits, and revenues, or the money enrollees pay to the government as premiums. In a "budget-neutral" bill, the costs would be zero.

Some details on the financing mechanisms and the costs of H.R. 2470 and S. 1127 are as follows:

1. Both proposals would be financed by an additional two-part premium for Part B enrollees. Under H.R. 2470, the additional benefits would be financed through ad hoc increases of $1.00 a month in 1990 and an additional $0.40 a month in 1991. In addition, all taxpayers eligible for benefits under Part A would pay a supplemental income-related premium through the income tax system at a rate designed to cover the remaining costs of benefits through 1992. Under S. 1127, all Part B enrollees would pay a new premium of $4.00 a month in 1988, this premium being indexed in subsequent years to increases in the insurance value of catastrophic benefits. In addition, Part B enrollees with an income-tax liability of $150.00 or more would pay a supplemental income-related premium designed to cover the remaining costs of the new benefits.

2. H.R. 2470 would be the more expensive of the two proposals, totaling $26.6 billion in estimated outlays over the 5-year period from 1988

[10]See U.S. General Accounting Office, Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, GAO/HRD-87-8 (Washington, D.C.: October 17, 1986).

through 1992; outlays for S. 1127 for the same 5-year period are estimated at $21.6 billion.[11]

While the two bills are intended to be "budget neutral," some are concerned that they will not be. In fact, the estimates for S. 1127 show a net cost for the last 3 years. For example, the secretary of the Department of Health and Human Services (HHS), commenting on H.R. 2470, has stated that preliminary estimates indicate that program outlays would exceed revenues and that a shortfall of close to $10 billion would be likely by the year 2000. In addition, 12 members of the House Energy and Commerce Committee presented dissenting views in the committee report on H.R. 2470, stating that the federal government will have to pick up an even greater proportion of the total bill because of outyear limits on premium levels mandated in the legislation.

The Status of the Legislative Proposals

On July 22, 1987, the House of Representatives passed H.R. 2470 by a vote of 302 to 127 as a compromise version of the provisions approved by the Committee on Ways and Means and the Committee on Energy and Commerce.[12] H.R. 2470 covers catastrophic expenses for prescription drugs and personal care in the home. The Part B premiums would be increased to cover the costs of these benefits. Finally, the bill would require the states to add provisions to their Medicaid programs that would protect spouses from impoverishment, limit the transfer of assets in order to qualify for Medicaid benefits, and require the states to pay the Medicare premium, deductibles, and coinsurance costs for Medicaid enrollees eligible for Medicare.

H.R. 2470 as the House passed it provides that a beneficiary's copayment for all physicians' and outpatient services would be limited to $1,043 in 1989. Medicare would pay 80 percent of a beneficiary's outpatient prescription drugs after a $500 deductible. Total out-of-pocket expenditures for hospital, physicians' fees, and other covered benefits except drugs would be limited to $1,800 annually.

[11] CBO's projected outlay estimates include administrative costs. The annual administrative cost has been reported as about 2 percent of total program outlays for Medicare Part A and around 5 percent of total outlays for Part B

[12] As passed, H R 2470 incorporates the text of H R 2941. On July 27, 1987, the Senate Finance Committee reported S 1127 to the full Senate We do not discuss the Senate bill in this section because we do not yet know enough about it

Dissenting opinions in the Committee on Energy and Commerce report indicate serious concern about the addition of benefits for drugs. Opponents of the provision point out that many Medicare beneficiaries already pay for private Medigap policies that provide drug coverage and do not want to pay an additional premium for drugs that becomes effective only after a $500 deductible has been met.

There are some wide disparities in the outlay estimates for the provision on drugs. On the one hand, CBO estimates that the outlay for this benefit would be approximately $965 million in fiscal year 1989. On the other hand, HHS estimates that it would cost between $7 billion and $9 billion in its first year, stating further that even if the bill is finally enacted, the provision could not be managed through Medicare, because of tremendous administrative problems, until January 1989 or perhaps even 1990.[13]

H.R. 2470 as the House passed it would be financed by premiums. A Part B flat premium added to the current law would cost beneficiaries $2.60 per month in 1989 and rise to $5.50 by 1992. In addition, enrollees would pay an additional income-related premium of about 7 percent on their gross income in excess of $6,000 a year per person, to a maximum of $580 in 1988 for those with incomes over $15,000. The maximum would gradually rise to $1,117 by 1992. The average income-related premium for those subject to it—about 40 percent of the Medicare enrollees—would be $155 a year in 1988 and $271 in 1992.

H.R. 2470 also requires state Medicaid programs to pay all Medicare premiums, coinsurance payments, and deductibles for elderly and disabled Medicare beneficiaries below the poverty line.

Another major provision would prevent the spouse of a person who goes to a nursing home from having to be impoverished before Medicaid assumes the financial burden. The bill also provides for up to 80 hours a year of home health aid and personal care services for chronically dependent homebound persons.

Other benefits include unlimited hospital inpatient acute care, increasing the maximum number of consecutive days of allowed home health care to 35, increasing the limit on Medicare payments for outpatient mental health care from $250 a year to $1,000, and extending hospice care beyond 210 days.

[13]It is unclear if the "costs" HHS is referring to are program outlays or the difference between outlays and revenues.

Important Issues

Beyond our discussion in appendix II, a number of issues may still need attention. In this appendix, we discuss five of the more important ones.

1. the definition of "catastrophic expense,"

2. the health-care needs of the elderly,

3. long-term care,

4. prescription drugs, and

5. out-of-pocket costs for Medicare beneficiaries.

As noted earlier, the issue of whether the various proposals are "budget neutral" is outside the scope of our work.

The Definition of "Catastrophic Expense"

By one definition, a catastrophic expense is a person's annual out-of-pocket medical expense that exceeds a certain dollar amount. An insurance plan may protect an enrollee against catastrophe by paying expenses that exceed the limit. Medicare currently has no limit on out-of-pocket expenses—no copayment cap, in insurance terms—so that costs continue to accumulate. There is no protection against catastrophic expense.

H.R. 2470 and S. 1127 both provide catastrophic protection by setting copayment caps and insuring that Part B enrollees will not have out-of-pocket payments for specific categories of expense that exceed the cap. However, this is only one of several possible definitions and it tends to be hard on the elderly who are poor or "near-poor."

Research has shown that it is important to distinguish between illnesses that are high in cost and those that are financially catastrophic. They overlap but are not identical, as table III.1 illustrates.

Table III.1: A Matrix of Costs, Third-Party Coverage, and Financially Catastrophic Expenses

	Financially catastrophic		Not financially catastrophic	
Costs	Covered by third party	Not covered by third party	Covered by third party	Not covered by third party
High	A	B	C	D
Not high	E	F	Neither high nor catastrophic	Neither high nor catastrophic

Source L. Wyszewianski "Financially Catastrophic and High-Cost Cases Definitions, Distinctions, and Their Implications For Policy Formulation" Inquiry 23 (Winter 1986) 384

- Block A represents high-cost cases that are also financially catastrophic because Medigap coverage is inadequate and other resources are insufficient to cover costs.
- Block B represents high-cost cases that are financially catastrophic because there is no Medigap coverage and other resources are inadequate.
- Block C represents high-cost cases that are not catastrophic because the combination of Medigap coverage and other resources is adequate to cover expenses.
- Block D represents high-cost cases that are not catastrophic because, although there is no Medigap coverage, the other resources alone cover expenses.
- Block E represents cases that are not high in cost but are catastrophic because the combination of Medigap coverage and other resources is inadequate even for small expenses.
- Block F represents cases that do not have high cost but are catastrophic because there is no Medigap coverage and resources are inadequate to pay for even small expenses.

A major concern about the definition of catastrophic expense in the legislative proposals before the Congress is that, on the one hand, they would provide coverage for expenses for which many Medicare enrollees already have Medigap coverage while, on the other hand, they tend to ignore that the limited financial resources of other enrollees prevent them from paying out-of-pocket costs. A number of experts have proposed an alternative definition in which out-of-pocket expenditures are catastrophic relative to a family's or an individual's income, such as expenses greater than 5 percent or 10 percent of annual income.[1] The

[1] See S. E. Berki, "A Look at Catastrophic Medical Expenses and the Poor," Health Affairs, 5:6 (Winter 1986), 138-45, and J. Feder, M. Moon, and W. Scanlon, "Catastrophic Health Insurance for the Elderly: Options and Impacts," Georgetown Health Policy Associates, Washington, D.C., July 1987