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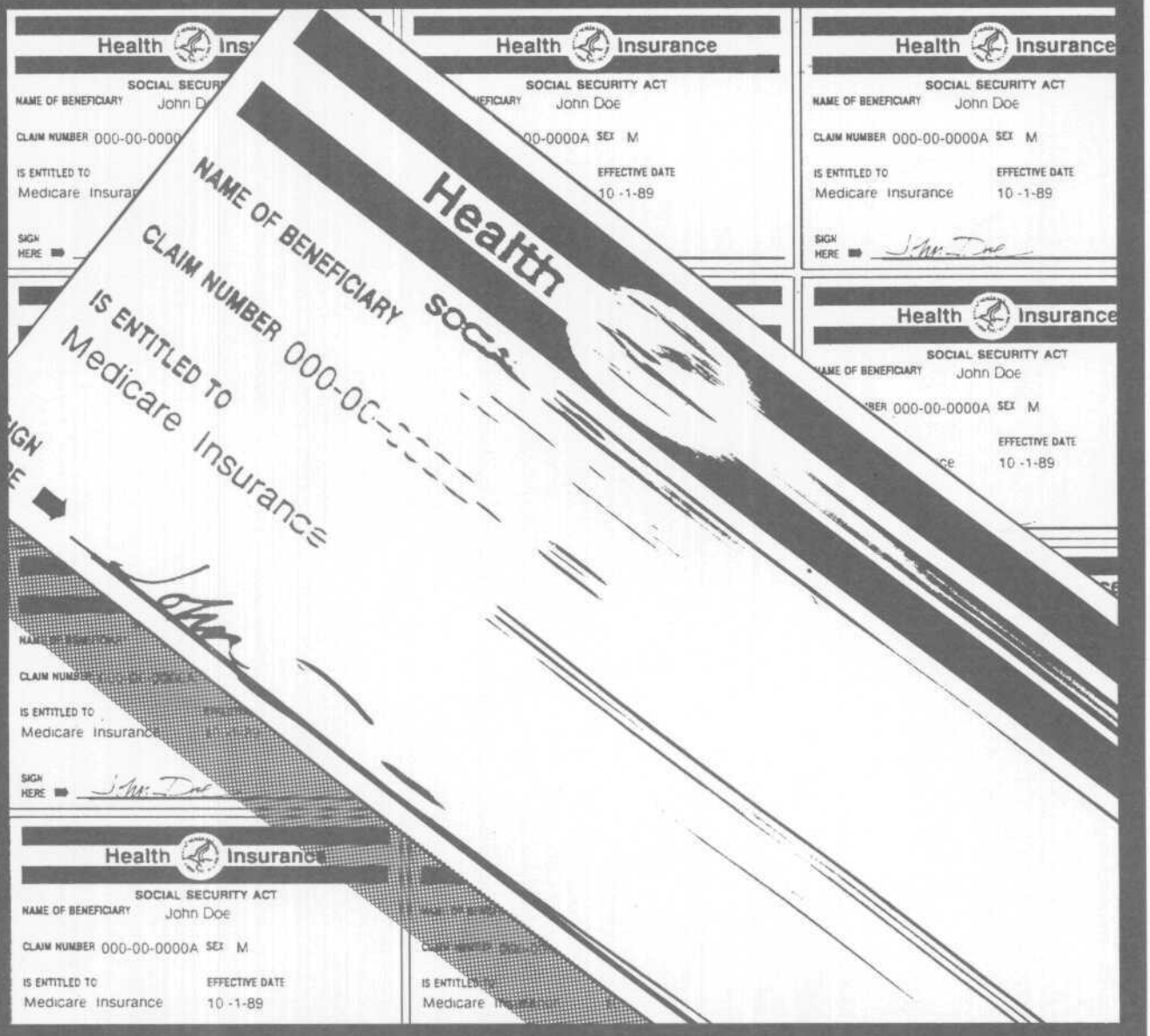
Subsidies Under Medicare and the Potential for Disenrollment Under a Voluntary Catastrophic Program



A SPECIAL STUDY

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S U M M A R Y

September 1989

CBO STUDY ON THE MEDICARE CATASTROPHIC COVERAGE ACT

The Medicare Catastrophic Coverage Act of 1988 (MCCA) expanded benefits, covering the additional costs through higher premiums paid by enrollees. Part of the new premiums are income-related through an income tax surtax called a "supplemental premium" that requires higher-income enrollees to pay more in new premiums than do lower-income enrollees. Recently, there have been calls to amend or repeal the MCCA, in part because of discontent among enrollees who will be liable for the supplemental premium.

Some of the proposals for change would permit those eligible for Medicare to avoid the supplemental premium by opting to refuse the new MCCA benefits, either alone or along with all Part B benefits. A special study by the Congressional Budget Office, *Subsidies Under Medicare and the Potential for Disenrollment Under a Voluntary Catastrophic Program*--which was prepared at the request of Senator Lloyd Bentsen, Chairman of the Senate Finance Committee--estimates the subsidy provided to enrollees under Medicare and assesses the likely responses by enrollees under alternative proposals that would permit enrollees to avoid the new premiums.

If the current MCCA package of benefits and income-related premiums was offered as a separate and voluntary program, most higher-income people would probably choose not to enroll because premiums would exceed the expected value of additional benefits for them. A separate MCCA program could be financially viable only if funded entirely by flat premiums, but lower-income people might be unable to afford it. If, instead, MCCA benefits and premiums were tied to the existing voluntary Part B program, probably fewer than 2 percent of current Part B enrollees would disenroll. This approach would be workable, largely because of the substantial subsidy enrollees receive on basic Part B benefits.

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SUBSIDIES UNDER MEDICARE AND THE POTENTIAL FOR DISENROLLMENT UNDER A VOLUNTARY CATASTROPHIC PROGRAM

The Congress of the United States
Congressional Budget Office

NOTE

The Congressional Budget Office made a substantial upward revision in its estimates of Medicare benefit costs in skilled nursing facilities (SNFs) at the time this paper was released. The higher SNF costs were not included in the subsidy values discussed in this paper, however, because the excess of benefit costs over premium receipts does not reflect the fully funded structure intended by the Congress when it enacted the Medicare Catastrophic Coverage Act. The July 1989 estimates used here reflect that structure for the MCCA benefit package as a whole. Subsidy values using September 1989 cost estimates are shown in Appendix B. Unless otherwise specified, benefits are defined throughout this paper to include related administrative costs.

PREFACE

This study--prepared at the request of Senator Lloyd Bentsen, Chairman of the Senate Finance Committee--was written by Sandra Christensen of the Congressional Budget Office's Human Resources and Community Development Division. Richard Kasten, of CBO's Tax Analysis Division, prepared the income and tax liability information. Susan Hilton and Jodi Korb provided programming assistance, while Eric Guille processed the graphics. Francis Pierce edited the manuscript. Ray Chesney, of the Department of Health and Human Services, assisted in locating cover materials. Jill Bury typed the many drafts and Kathryn Quattrone prepared it for publication.

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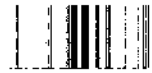

SUMMARY

The Medicare Catastrophic Coverage Act of 1988 (MCCA) expanded benefits, covering the additional costs through higher premiums paid by enrollees. Part of the new premiums are income-related, through an income tax surtax called a "supplemental premium" requiring higher-income enrollees to pay more in new premiums than lower-income enrollees do.

The incremental effect of the MCCA for most enrollees subject to the supplemental premium is negative, in that such enrollees will pay more in additional premiums each year than they can expect to receive in additional benefits because of the act.

Nevertheless, all current enrollees can expect to receive more benefits in total under Medicare than the value of their contributions. The excess of lifetime expected benefits over enrollees' contributions--the subsidy--will average more than $2,600 a year for all enrollees age 65 in 1989 (in dollars discounted to 1989). Even for those enrollees paying maximum supplemental premiums each year, the subsidy will be more than $1,300 a year.

Recently there have been calls for amendment or repeal of the MCCA, in part because of discontent among enrollees who will be liable for the supplemental premium. One of the changes under consideration in the Congress is to allow enrollees to avoid the new MCCA premiums by "opting out" of the catastrophic program. Currently, the MCCA flat premiums can be avoided by disenrolling from Medicare Part B (which covers the costs of physicians' and hospital outpatient services). But liability for the supplemental premium is based on eligibility for Medicare Part A (which covers the costs of hospital, nursing facility, and home health care), regardless of Part B enrollment.

One proposal would offer the MCCA benefit and income-related premium package under a separate and voluntary Medicare program, but a separate program would probably not be financially viable. Enrollment would be low initially, with most high-income enrollees choosing not to participate. In later years, as flat premiums had to be

increased to cover costs, enrollment rates would tend to fall ever lower. If the MCCA benefit package was funded entirely by flat premiums, however, a separate and voluntary program might be viable as an alternative to private-sector supplementary insurance. Lower-income Medicare enrollees would be less able to afford the additional coverage, though, compared to the current program structure.

A second (and viable) proposal would tie MCCA benefits and premiums to the existing voluntary Part B program. Probably fewer than 2 percent of current Part B enrollees would disenroll under this approach, assuming that they based their decision on a comparison of benefits and costs.

SUBSIDIES UNDER MEDICARE
AND
THE POTENTIAL FOR DISENROLLMENT
UNDER A VOLUNTARY CATASTROPHIC PROGRAM

INTRODUCTION

The Congress is currently reconsidering the Medicare Catastrophic Coverage Act of 1988 (MCCA), in response to discontent among some groups of Medicare enrollees. Much of the dissatisfaction expressed by enrollees centers on the act's financing provisions, especially its income-related (or "supplemental") premium. Because the aggregate costs of new Medicare benefits under the act are fully financed by new premiums, and because part of those premiums are income-related, the result is that most enrollees liable for the supplemental premium will pay more in additional premiums than they can expect to receive in additional benefits under the act (while the reverse is true for other enrollees). Further, liability for the supplemental premium cannot be avoided, because it is payable by all Medicare-eligible people with at least $150 in income tax liability.

Some of the proposals for change would permit people eligible for Medicare to avoid the supplemental premium by opting to refuse the new MCCA benefits, either alone or along with all Part B benefits. This raises questions, however, as to whether sufficient premiums could be collected from those who remained to cover the benefit costs.

This paper assesses the likely responses by enrollees under two alternative proposals--one that would transfer all MCCA benefits and premiums to a separate and voluntary program, and one that would link MCCA benefits and premiums to enrollment in Part B so that MCCA premiums could be avoided only by forgoing all Part B benefits.

Enrollees' responses are assumed to depend on a comparison between the additional benefits and additional costs they can expect if they choose to be in the program. For most people eligible for Medicare, this comparison is favorable if the value of the subsidy they receive under the relevant Medicare program is positive, the subsidy being the difference between the total Medicare benefits enrollees can expect and the value of enrollees' contributions made in return for those benefits.[1] For those with employer-paid retiree health benefits, the comparison is favorable if the additional benefits they can expect from having Medicare coverage as well exceed their Medicare premium costs. The resulting estimates of disenrollment are probably an upper limit, because people are typically willing to pay somewhat more

1. The Medicare subsidy values presented here do not apply to "working Medicare" enrollees--those for whom employment-based insurance is the primary payer.

in premiums than the value of expected benefits to insure against the possibility of large and unplanned medical expenses.

The first section of this paper briefly describes the MCCA and the context in which it was developed.[2] The second section presents estimates of subsidy values under Medicare Parts A and B together, considering both new (MCCA) and preexisting (basic) benefits and premiums. The third section gives subsidy values considering only the MCCA benefits and premiums, and uses this information to assess what enrollees' responses might be to a separate and voluntary MCCA program. The fourth section shows subsidy values when only basic and MCCA benefits under Part B are considered, and estimates how large the potential Part B disenrollment would be if disenrollees were able to avoid liability for the supplemental premium. Implications drawn from the preceding sections are discussed in the final section.

DESCRIPTION OF THE MEDICARE CATASTROPHIC COVERAGE ACT

The primary goal of the MCCA was to improve the insurance protection provided under Medicare for acute-care services. This goal was achieved by introducing new limits on enrollee's liabilities for cost-sharing for services already covered by Medicare, and by expanding coverage to include prescription drugs.[3]

Before MCCA, there was no ceiling on expenses enrollees might incur because of Medicare's cost-sharing requirements, and the resulting potential for catastrophic out-of-pocket expenses induced more than two-thirds of enrollees to obtain private "medigap" insurance to supplement their Medicare coverage. Another 10 percent of enrollees were dually eligible for Medicaid, which paid their copayment costs.

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2. For a fuller description of the act and its impact, see Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988," Staff Working Paper (October 1988); or Sandra Christensen and Richard Kasten, "Covering Catastrophic Expenses Under Medicare," *Health Affairs*, vol. 3, no. 5 (Winter 1988), pp. 79-93.

3. Cost-sharing refers to the portion of charges for medical services that patients must pay, while the insurer pays the remainder. In Medicare, cost-sharing includes both deductible amounts and coinsurance. A deductible is an amount that patients must pay toward medical charges before Medicare will begin reimbursement. Once charges exceed the deductible, Medicare pays a percentage of charges above the deductible and patients pay the rest. The patients' portion is called coinsurance.

Nearly 25 percent of enrollees, however, had no supplementary coverage.

Under the act, cost-sharing in Part A's Hospital Insurance (HI) program is limited to at most one deductible a year for hospital inpatient stays ($560 in 1989), and to at most eight days of coinsurance for stays in skilled nursing facilities ($25.50 a day, or up to $204 in 1989). Under Part B's Supplementary Medical Insurance (SMI) program, deductible and coinsurance costs are limited by a ceiling (set at $1,370 for 1990, and adjusted to affect 7 percent of enrollees in subsequent years). Under Part B's new Catastrophic Drug Insurance (CDI) program, Medicare will pay 50 percent (increasing to 80 percent by 1993, if funding is sufficient to permit this) of outpatient drug costs above a deductible amount (set at $600 for 1991, and adjusted in later years to affect 16.8 percent of enrollees).[4] There is no ceiling on copayment costs under the CDI program.

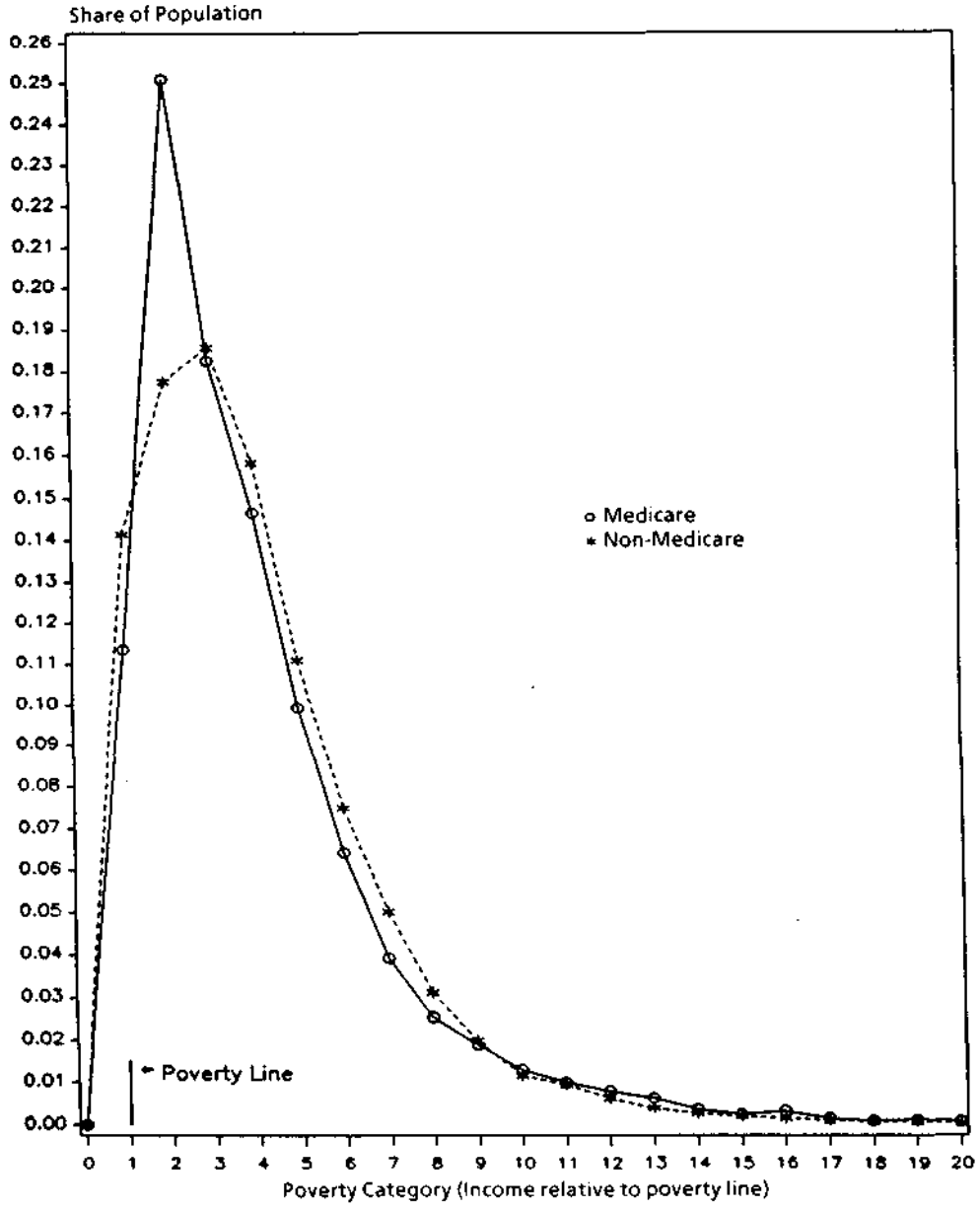
The Congress and the President decided in framing the legislation that the costs of new Medicare benefits would be paid by enrollees themselves, rather than by increasing the substantial transfers already made to this group from the working-age population. One reason for this position was recognition that the economic status of the Medicare population has improved dramatically in recent years so that it is no longer markedly below that of the working-age population, at least on average.[5]

At the same time, it was also recognized that financial well-being varies considerably among the Medicare population, with a substantial proportion of enrollees having low incomes--that is, with incomes less than twice the poverty line. As shown in the accompanying figure, the projected poverty rate for Medicare enrollees in 1990 is about 11 percent, while another 25 percent will have incomes less than twice the poverty line. Partly because of concern about low-income enrollees, the Congress rejected the Administration's original proposal to finance

4. According to CBO's July 1989 estimates, the CDI premium rates set through 1993 under the MCCA will be insufficient to cover benefit costs unless CDI benefits are reduced in one of the ways permitted under the law, which might include holding coinsurance rates at some level above 20 percent.

5. See Congressional Budget Office, *Trends in Family Income: 1970-1986* (February 1988).

Figure
Projected Distribution of Medicare and Non-Medicare Populations by Poverty Category, 1990



SOURCE: Congressional Budget Office projections for 1990, based on tabulations from the Census Bureau's March 1986 Current Population Survey, with incomes adjusted for underreporting.

new Medicare benefits entirely by new monthly premiums paid by all enrollees. Instead, more than 60 percent of new receipts were to be income-related, in the form of an income tax surtax called a supplemental premium. Further, Medicaid coverage was expanded so that, by 1992, all poor enrollees could have their Medicare premiums and copayments paid in full by Medicaid.[6]

Under these funding arrangements, lower-income but nonpoor enrollees will see their premium costs increase somewhat, but their expected benefits will increase by nearly three times as much when the act is fully implemented. For about 30 percent of enrollees with high incomes (those liable for significant amounts in supplemental premiums), new premium costs will exceed the additional benefits they can expect to receive under the act.[7]

SUBSIDY VALUES UNDER MEDICARE PARTS A AND B TOGETHER

The subsidy values presented in this section are the difference between the expected value of an enrollee's Medicare (HI, SMI, and CDI) benefits and the expected value of contributions made by or on behalf of that enrollee to Medicare through flat and supplemental premiums and through HI payroll taxes.[8] HI payroll contributions include enrollees' taxes as workers, their employers' taxes, and interest earnings.

Although these overall Medicare subsidy values are not relevant to disenrollment decisions under either of the proposals considered here, they make a contribution to the debate about whether to alter the value of transfers to the Medicare population. Further, they facilitate

6. These and other new Medicaid benefits provided under the act are paid from general federal and state revenues. The premiums paid by Medicare enrollees are used only to pay for Medicare benefits.

7. See Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988," for more information about the distribution of benefits and premiums by income categories. The paper also examines the interaction between new MCCA benefits and benefits under enrollees' medigap policies.

8. The analysis assumes the efficacy of the provisions in the MCCA intended to insure that employment-based health plans use the savings they would otherwise realize because of the MCCA to provide Medicare enrollees with alternative benefits. If so, even enrollees with employer-paid medigap-type supplements will receive the additional benefits credited to the MCCA.

the analysis of employer responses to Medicare program changes in later sections.

The specific calculations presented here and in later sections are for enrollees who became 65 at the start of 1989. Age-adjusted calculations are presented for two alternative income levels. Two versions of the subsidy value are calculated--the present discounted value in 1989 of the lifetime average annual subsidy; and annual values of that subsidy for 1989 through 1993 in current dollars. Appendix A provides more detailed information about the assumptions behind the calculations.

Comparable estimates of subsidy values for disabled enrollees and for enrollees older than 65 in 1989 will be larger because such enrollees will have fewer years of contributions through HI payroll taxes.[9] Subsidy values for enrollees who will reach 65 after 1989 will be smaller because the number of years they contribute through HI payroll taxes will increase, eventually spanning their entire working life.[10]

For the average Medicare enrollee age 65 in 1989, the annual lifetime subsidy under Parts A and B combined will be an estimated $2,647 in dollars discounted to 1989 (see Table 1, top panel). This is essentially unchanged from what the subsidy would have been without passage of the MCCA, reflecting the financing provisions of the act. An average enrollee age 65 in 1989 can expect to contribute about 34 percent toward the costs of expected lifetime benefits through payroll taxes and Medicare premiums, while other sources will pay for the remaining 66 percent of costs.

For high-income enrollees who made maximum HI payroll tax contributions until their retirement at the end of 1988, and who will pay the maximum in supplemental premiums, the average annual lifetime subsidy will be lower, at $1,323 in dollars discounted to 1989

9. Disabled enrollees might also have more benefit years. Older aged enrollees might have fewer benefit years as a result of lower life expectancy, but life expectancy at age 65 has increased at only about 1 year each decade over the last 20 years.

10. In fact, if HI trust fund reserves accumulating during their working years are insufficient to finance the benefits of the baby-boom population when it retires, the Medicare subsidy value could become negative for post-baby-boom enrollees. Those enrollees might have to contribute enough not only to fund their own HI benefits, but also to cover some portion of benefits for older beneficiaries.

TABLE 1. ANNUAL SUBSIDY VALUES UNDER MEDICARE PARTS A AND B FOR ENROLLEES AGE 65 IN 1989
(By calendar year, in dollars per enrollee)

	1989	1990	1991	1992	1993	Lifetime Average[a]
Enrollees Who Made the Average Payroll Tax Contribution and Who Will Pay the Average Amount in Supplemental Premiums						
Pre-MCCA Benefits	2,423	2,768	3,117	3,524	3,964	3,676
HI Payroll Taxes	(461)	(522)	(575)	(638)	(704)	(563)
Basic Part B Premiums	(335)	(348)	(394)	(445)	(499)	(465)
Pre-MCCA Subsidy Value	1,627	1,897	2,148	2,441	2,761	2,649
Change Due to MCAA:						
Benefits	47	139	244	295	322	328
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(117)
Supplemental premiums	(125)	(174)	(187)	(203)	(224)	(213)
Current Benefits	2,469	2,907	3,361	3,819	4,286	4,004
Enrollee Contributions	(968)	(1,103)	(1,245)	(1,395)	(1,549)	(1,357)
Current Subsidy Value	1,501	1,803	2,116	2,423	2,737	2,647
Current Subsidy as Proportion of Pre-MCCA Subsidy	0.922	0.950	0.985	0.993	0.991	0.999
Current Subsidy as Proportion of Benefits	0.608	0.620	0.630	0.635	0.639	0.661
Enrollees Who Made the Maximum Payroll Tax Contribution and Who Will Pay the Maximum Amount in Supplemental Premiums						
Pre-MCCA Benefits	2,423	2,768	3,117	3,524	3,964	3,676
HI Payroll Taxes	(881)	(999)	(1,099)	(1,220)	(1,347)	(1,077)
Basic Part B Premiums	(335)	(348)	(394)	(445)	(499)	(465)
Pre-MCCA Subsidy Value	1,207	1,421	1,624	1,859	2,119	2,135
Change Due to MCCA:						
Benefits	47	139	244	295	322	328
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(117)
Supplemental premiums	(800)	(850)	(900)	(950)	(1,050)	(1,023)
Current Benefits	2,469	2,907	3,361	3,819	4,286	4,004
Enrollee Contributions	(2,064)	(2,256)	(2,482)	(2,725)	(3,018)	(2,681)
Current Subsidy Value	405	651	879	1,094	1,268	1,323
Current Subsidy as Proportion of Pre-MCCA Subsidy	0.336	0.458	0.541	0.588	0.599	0.620
Current Subsidy as Proportion of Benefits	0.164	0.224	0.261	0.286	0.296	0.330

SOURCE: Congressional Budget Office (July 1989 reestimate).

NOTE: Benefit values shown include related administrative costs. Values shown are age-adjusted. Unadjusted values are:

Pre-MCCA	3,114	3,473	3,818	4,213	4,627
MCCA	60	174	299	353	376
Current	3,174	3,647	4,117	4,566	5,003

a. In dollars discounted to 1989.

(see Table 1, bottom panel). About a third of lifetime benefits to these high-income enrollees will be paid from other sources (including their own income taxes), while their specific contributions to Medicare will cover 67 percent of the costs. Hence, even for this least-subsidized group of current enrollees, considerable subsidy will remain in every year of eligibility. Over their lifetimes, though, the subsidy will be only 62 percent of the subsidy to them before the MCCA.

MCCA SUBSIDY VALUES AND THE POTENTIAL FOR DISENROLLMENT UNDER A SEPARATE AND VOLUNTARY MCCA PROGRAM

If the MCCA package of benefits were offered under a separate and voluntary Medicare program, eligible people could choose whether they wanted to purchase the new MCCA benefits or not. For this decision, it would be appropriate to compare the additional benefits expected under the MCCA to the additional premiums for which MCCA enrollees would be liable, as well as to the premiums that enrollees would pay for a similar benefit package in the private sector. In addition, the decision not to enroll could be affected by the nature of any premium penalty that might be imposed on those who delayed enrollment, such as the current penalty for delayed Part B enrollment.[11]

Two voluntary options are discussed in this section: one that would use the current income-related premium structure; and one that would fund the MCCA benefit package entirely from flat premiums. The first approach would not be financially viable, but the second approach could be. Under either approach, however, lower-income enrollees would be less likely to obtain expanded coverage than under the current MCCA provisions. Most enrollees who lacked supplementary coverage before the MCCA--a group of particular concern to the act's framers--would still be without it.

11. Under current law, the Part B premium is increased by 10 percent for each year that enrollees could have been enrolled but were not, up to a maximum of 180 percent of the usual flat premium. This penalty is imposed over the entire enrolled lifetime of the delayed enrollee.

Under the Current Income-Related Premium Structure

Most of the 40 percent of enrollees who will be liable for the supplemental premium would probably opt out of a separate MCCA program. Premiums payable under the MCCA program would exceed expected benefits by a considerable margin for high-income enrollees (see Table 1, under "Change due to MCCA"). Consequently, private insurers could profitably compete with the MCCA program among those enrollees. In fact, private insurers could offer benefits equivalent to those under the MCCA program in 1990 for $221 or less, nationwide (see Table 2). By contrast, enrollees liable for maximum MCCA premiums will pay $909 in 1990; on average, enrollees liable for any supplemental premiums will pay $465. About 30 percent of enrollees will be liable for $221 or more in MCCA premiums (or more than $162 in supplemental premiums) and thus could buy the MCCA package (if offered) more cheaply from private insurers.[12]

About 20 percent of enrollees currently receive employer-paid retiree health benefits that may supplement basic Medicare benefits as well or better than the MCCA package does (see Table 3). Most of this group, too, might opt out of a separate MCCA program. Because there is considerable overlap between this group and the group with liability for the supplemental premium, however, total disenrollment would be higher by perhaps only eight percentage points (that is, those with retiree health benefits who will not be liable for supplemental premiums). However, this estimate assumes that the exclusionary clauses common in current retiree health plans--which deny payment for services that would have been reimbursed under Medicare for eligible enrollees had they enrolled--would not apply to the separate MCCA program. Further, it assumes there would be no penalty for delayed MCCA enrollment. Otherwise, fewer in this group might choose to opt out of the MCCA program.

Hence, a reasonable estimate is that from 30 percent to 40 percent of current enrollees might opt out of a separate MCCA program initially. As a result, the MCCA program would lose most of those liable for the supplemental premium. Those who enrolled would tend to be

12. The private sector looks especially competitive in the first two years of the MCCA program, when MCCA reserves are built up.

lower-income, and they would probably also be older and less healthy than average. Consequently, costs per enrollee under a separate MCCA program would be higher than under current provisions, while receipts per enrollee would be much smaller.

Thus, a separate MCCA program would not be financially viable under the current income-related premium structure. In order to maintain full funding of a separate MCCA program from enrollees' premiums, flat premiums would have to be increased substantially

TABLE 2. COMPARISON OF MCCA PREMIUMS AND PREMIUMS FOR EQUIVALENT PRIVATE-SECTOR COVERAGE
(By calendar year, in dollars per enrollee)

	1989	1990	1991	1992	1993
Private Insurance Premiums					
Average Premium[a]	71	221	362	433	461
Premiums Under MCCA Program					
Enrollees Paying Only Flat Premiums					
Premium	48	59	89	110	122
Proportion of enrollees paying	0.588	0.572	0.554	0.537	0.524
Enrollees Paying Flat and Any Supplemental Premiums					
Premiums (Average)	351	465	509	548	592
Proportion of enrollees paying	0.412	0.428	0.446	0.463	0.476
Enrollees Paying Flat and Maximum Supplemental Premiums					
Premiums (Maximum)	848	909	989	1,060	1,172
Proportion of enrollees paying	0.056	0.093	0.098	0.103	0.103

SOURCE: Congressional Budget Office (July 1989 reestimate).

a. Assumes that 25 percent of premiums pay administrative costs and profit, while 75 percent pay reimbursement for claims. Uses nationwide average benefit (without administrative) costs for all enrollees. Private insurance premiums could be lower than shown because enrollees dually eligible for Medicaid and Medicare--who are relatively high-cost--would not be included in the market.

TABLE 3. PROPORTION OF ALL ENROLLEES WITH EMPLOYMENT-BASED HEALTH INSURANCE AS PRIMARY OR SECONDARY PAYER, AND PROPORTION LIABLE FOR SUPPLEMENTAL PREMIUMS, 1990

Per Capita Income Quintiles	Enrollee Group, by Nature of Employment-Based Insurance				Liable for Supplemental Premiums
	Primary Payer Coverage	Employer-Paid Secondary Payer			
		Fully Paid	Partly Paid	Total	
First	0.000	0.005	0.005	0.010	0.000
Second	0.002	0.013	0.015	0.028	0.029
Third	0.004	0.021	0.025	0.046	0.325
Fourth	0.008	0.029	0.027	0.056	0.814
Fifth	0.019	0.027	0.033	0.060	0.954
Total	0.033	0.095	0.106	0.201	
Liable for Supplemental Premiums	0.026	0.057	0.062	0.119	0.428

SOURCE: Congressional Budget Office tabulations from the Census Bureau's March 1988 Current Population Survey, with incomes adjusted to 1990.

above the rates specified in current law. This increase would lead to further disenrollment among all income groups, a process that might continue until few enrollees remained.

Under a Flat Premium Structure

A separate program that was fully funded by flat premiums might be viable as an alternative to private-sector medigap coverage. A public medigap-type program could be provided at lower cost than private-sector policies with comparable benefits, because Medicare's administrative costs would be lower than those of private insurers and because no profits are claimed by Medicare.[13]

13. Medicare's administrative costs for a medigap-type plan would be lower than private insurers' costs for at least two reasons. First, Medicare's marketing costs would be negligible, because it already corresponds with the population who might purchase the medigap-type supplement. Second, the costs of processing medigap-type claims would be small, because those same claims must be processed by Medicare anyway to establish reimbursement for basic benefits.

If, however, the public medigap-type program accepted all applicants with no coverage restrictions on preexisting conditions--while private-sector insurers limited coverage based on medical condition (as most do now)--the public program might experience "adverse selection." That is, the public program might tend to enroll a relatively high-cost group, necessitating higher monthly premiums than would be required for a more representative group of enrollees.

Lower-income groups would be less likely to obtain expanded Medicare coverage under this approach than under the current MCCA program structure. Even if no adverse selection occurred, premiums would be higher for lower-income enrollees, compared to current provisions, because the premiums would not be income-related. If, in addition, premium rates were higher because of adverse selection, some groups would have insufficient incomes to purchase the additional coverage.

PART B SUBSIDY VALUES AND THE POTENTIAL FOR DISENROLLMENT UNDER A COMBINED MCCA-PART B PROGRAM

The subsidy values discussed in this section are the difference between the expected value of an enrollee's Medicare Part B (SMI and CDI) benefits and the expected value of contributions made by that enrollee through flat and supplemental premiums. If liability for the supplemental premium were made contingent on Part B enrollment, the decision to enroll would be based, in part, on a comparison between the benefits enrollees could expect under Part B and the amounts they would have to pay in premiums.[14]

For the average enrollee age 65 in 1989, the Part B subsidy value is substantial in every year of eligibility (see Table 4, top panel). The average lifetime subsidy under Part B is $1,399 a year, about 64 percent of expected benefits. In other words, enrollees' premiums will pay, on average, for about 36 percent of their Part B benefits.

14. In these calculations, it was assumed that new HI benefits provided under the MCCA would be available to all those eligible under Part A, regardless of Part B enrollment.

TABLE 4. ANNUAL SUBSIDY VALUES UNDER MEDICARE PART B FOR ENROLLEES AGE 65 IN 1989
(By calendar year, in dollars per enrollee)

	1989	1990	1991	1992	1993	Lifetime Average[a]
Enrollees Who Will Pay the Average Amount in Supplemental Premiums						
Pre-MCCA Benefits	1,008	1,162	1,347	1,556	1,790	1,915
Basic Part B Premiums	(335)	(348)	(394)	(445)	(499)	(465)
Pre-MCCA Subsidy Value	673	814	953	1,111	1,291	1,450
Change Due to MCAA:						
Benefits	4	92	193	239	260	279
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(117)
Supplemental premiums	(125)	(174)	(187)	(203)	(224)	(213)
Current Benefits	1,012	1,254	1,540	1,795	2,050	2,194
Enrollee Contributions	(508)	(581)	(670)	(758)	(845)	(795)
Current Subsidy Value	505	672	869	1,037	1,205	1,399
Current Subsidy as Proportion of Pre-MCCA Subsidy	0.749	0.827	0.913	0.933	0.934	0.965
Current Subsidy as Proportion	0.499	0.536	0.565	0.578	0.588	0.638
Enrollees Who Will Pay the Maximum Amount in Supplemental Premiums						
Pre-MCCA Benefits	1,008	1,162	1,347	1,556	1,790	1,915
Basic Part B Premiums	(335)	(348)	(394)	(445)	(499)	(465)
Pre-MCCA Subsidy Value	673	814	953	1,111	1,291	1,450
Change Due to MCCA:						
Benefits	4	92	193	239	260	279
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(117)
Supplemental premiums	(800)	(850)	(900)	(950)	(1,050)	(1,023)
Current Benefits	1,012	1,254	1,540	1,795	2,050	2,194
Enrollee Contributions	(1,183)	(1,257)	(1,383)	(1,505)	(1,672)	(1,605)
Current Subsidy Value	(171)	(4)	157	290	379	589
Current Subsidy as Proportion of Pre-MCCA Subsidy	-0.253	-0.004	0.164	0.261	0.293	0.406
Current Subsidy as Proportion of Benefits	-0.169	-0.003	0.102	0.161	0.185	0.268

SOURCE: Congressional Budget Office (July 1989 reestimate).

NOTE: Benefit values shown include related administrative costs. Values shown are age-adjusted. Unadjusted values are:

Pre-MCCA	1,296	1,458	1,650	1,860	2,089
MCCA	5	115	236	286	304
Current	1,301	1,573	1,886	2,146	2,393

a. In dollars discounted to 1989.

For high-income enrollees who will be liable for the maximum amount in supplemental premiums each year, the average lifetime Part B subsidy is an estimated $589 a year (see Table 4, bottom panel). For these enrollees, about 27 percent of expected lifetime benefits will be subsidized, while they will pay 73 percent of the costs through premiums. For 1989, however, high-income enrollees will pay more in premiums than they can expect in Part B benefits. For 1990, with new SMI--but not CDI--benefits in place, premium costs and expected benefits will be nearly equal. The subsidy value will grow in subsequent years.

Would high-income enrollees drop out of Part B if they could avoid the supplemental premium by doing so? There are reasons to believe that few would, provided the decision was based on a comparison of the benefits and costs from doing so.

Medicare enrollees, especially those with high incomes, are not likely to do without comprehensive health insurance coverage. Such enrollees would probably not disenroll from (or refuse to enroll in) Part B of Medicare unless an alternative at least as good was available to them. Two potential alternatives are purchase of private insurance, or comprehensive coverage provided as a retiree health benefit.

Enrollees Without Retiree Health Benefits

Nearly 80 percent of Medicare enrollees are without access to comprehensive health coverage as a retiree benefit, and would have to purchase private insurance at full cost as a substitute for Part B if they disenrolled.

No private-sector alternative to Part B coverage developed before the MCCA, because private insurers could not provide the same benefit package profitably; private insurers would have had to charge a premium much higher than Part B enrollees paid. The difference reflects the financing of basic Part B benefits, in which about 75 percent of costs are currently paid from general revenues rather than enrollees' premiums.

The addition of MCCA benefits and premiums to Part B would reduce the competitive disadvantage for private insurers but would not

eliminate it, because Part B subsidy values would still be positive for most enrollees. For an average enrollee age 66 in 1990, premiums (including the supplemental premium) would cover only about 46 percent of benefit costs (see Table 5). For enrollees paying maximum premiums, payments would just cover costs in 1990, and would be less than benefit costs in later years. Over a lifetime, premiums would cover about 36 percent of costs for the average enrollee, and about 73 percent of costs for enrollees always paying maximum premiums.

Hence, private insurers would still be unable to compete profitably with Part B in 1990 or any later year, even for typical members of a group of relatively young, high-income enrollees. Insurers might be able to compete profitably only if they were able to select the healthiest members of this group, or members of this group living in the lowest-cost areas; but success through selective enrollment is also doubtful because this would increase insurers' marketing costs. Most enrollees would be better off financially by continuing to purchase the less expensive coverage provided under Part B of Medicare.

Enrollees With Retiree Health Benefits

About 20 percent of Medicare enrollees have access to retiree health benefits paid wholly or in part by former employers. These plans currently serve as secondary payers, or supplements to Medicare. Some of

TABLE 5. ENROLLEE PREMIUMS AS PROPORTION OF EXPECTED BENEFITS UNDER PART B, FOR ENROLLEES AGE 65 IN 1989 (By calendar year)

	1989	1990	1991	1992	1993	Lifetime Average
For Enrollees Who Will Pay:						
Flat premiums only	0.378	0.325	0.314	0.309	0.303	0.265
Average premiums[a]	0.501	0.464	0.435	0.422	0.412	0.362
Maximum premiums[a]	1.169	1.003	0.898	0.839	0.815	0.732

SOURCE: Congressional Budget Office (July 1989 reestimate).

a. Includes both flat and supplemental premiums.

these plans would be substitutes for Medicare Part B if retirees disenrolled, provided that employers did not modify them to exclude this possibility.

Enrollees with employment-based retiree health benefits include private-sector and some state and local government retirees (16.6 percent of enrollees) as well as federal government retirees (3.5 percent of enrollees). In addition, another 1 percent of Medicare enrollees are eligible for and use military retiree or veterans' health benefits.[15]

Nonfederal Retirees. Because of the subsidy by general taxpayers to Medicare, employment-based plans can provide retirees with comprehensive coverage at lower total cost if the plans are designed to supplement Medicare. For any fixed agreement about how total insurance costs are shared, both employers and retirees are financially better off with a health plan that wraps around Medicare, compared with standalone coverage.

Currently, about 50 percent of nonfederal retirees with employment-based health benefits have Part B coverage bought for them as a part of their retiree health plans. Most other nonfederal retirees with employment-based health benefits buy Part B coverage at their own expense, either because their health plans contain an exclusionary clause (perhaps another 45 percent of such retirees) or because they receive additional benefits from dual coverage (the remaining 5 percent of such retirees).[16]

Only the latter group (5 percent of nonfederal retirees with employment-based health benefits, or less than 1 percent of all Medicare enrollees) could drop Part B and still have comprehensive insurance coverage. Moreover, only about half of this group (0.5 percent of all Medicare enrollees) would find it financially advantageous to disenroll, because of the additional expected benefits that dual coverage provides them.

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15. Congressional Budget Office tabulations from the Census Bureau's March 1988 Current Population Survey.

16. Based on discussions with insurers and on preliminary results from a 1988 survey of employers conducted jointly by the Health Insurance Association of America and Johns Hopkins University, under a grant from the Health Care Financing Administration.

Even among the latter group, some might be reluctant to disenroll because of uncertainty that their retiree health benefits would continue to be available on favorable terms. Employers are increasingly concerned about the growing costs of health benefits, and their costs would be even greater if retirees converted their employment-based coverage from secondary payer to primary payer by disenrolling from Part B. Potential disenrollment among retirees would probably lead quickly to exclusionary clauses in retiree health plans that do not currently have them, effectively eliminating disenrollment--at least for future nonfederal retirees.

For current nonfederal retirees, however, there could be some impediments to employers who would seek to alter retiree health plans to prevent disenrollment from Part B. Collective bargaining agreements, requirements under the Employee Retirement Income Security Act, and emerging case law make it difficult for employers to change benefits for existing retirees, although retirees' premiums (if any) could be increased.

Federal Retirees. About 3.5 percent of retired Medicare enrollees are dually enrolled in Part B and in a plan under the Federal Employees' Health Benefits (FEHB) program. Unlike most private-sector retiree health benefit plans, FEHB plans have no exclusionary provisions, so that enrollees who choose not to enroll in Part B are reimbursed under their FEHB plan for services that Medicare would also have covered. For those who do enroll in Part B, FEHB plans serve as a Medicare supplement, generally eliminating all copayment costs.

If liability for the supplemental premium was made contingent on Part B enrollment, and if no exclusionary clauses were simultaneously added to FEHB plans, then about half of the FEHB retirees (or up to 1.6 percent of all Medicare enrollees) might disenroll. This estimate assumes that those disenrolling would be all those for whom Part B premium costs would exceed the value of the additional insurance benefits that dual coverage provides.

Military Retirees and Veterans. Military retirees may receive essentially free care at military installations, although access is restricted by available space, and active military personnel receive priority. Veterans may receive care at veterans' hospitals, but priority is given to low-income veterans with service-connected conditions. In both

cases, access is further limited by convenience, as many localities are not close to military or veterans' medical facilities. In 1988, a little over 1 percent of Medicare enrollees made some use of military or veterans' health services. Although some disenrollment under Part B of Medicare is a possibility for this group, its extent would probably be small because of current limitations on access.

IMPLICATIONS

A separate and voluntary MCCA program would not be financially viable under the current income-related financing provisions. Those choosing to enroll initially would tend to have lower incomes, and would probably also be older and less healthy than the average current enrollee. To maintain the program as a self-financing one, flat MCCA premiums would have to be increased so substantially that eventually few might choose to enroll. A separate program funded entirely by flat premiums might be viable, however. It could provide a lower-cost alternative to private-sector medigap insurance for many enrollees, but low-income enrollees not eligible for Medicaid might still be unable to afford it.

Offering the MCCA benefit and premium package as an inseparable component of Part B would be a viable approach. Probably fewer than 2 percent of current Part B enrollees would opt out if no changes were made in benefits, premium rates, or penalties for late enrollment under Part B, and if the disenrollment decision was based on an informed comparison of Part B benefits and costs. Disenrollment would occur among those who had alternative coverage through employer-paid retiree health plans without exclusionary clauses.

Although about 2 percent of enrollees would have some financial incentive to disenroll, there are reasons to believe that actual disenrollment might be less. First, enrollees could not be certain that their alternative coverage would continue to be available on favorable terms; yet they would be penalized by higher premium costs if they delayed enrollment in Part B, or if they disenrolled and later reenrolled. Second, the Medicare population tends to be very risk-averse, with the result that they insure heavily even to the point of purchasing duplicative coverage.

In fact, as employers who do not currently have exclusionary clauses in their health plans became aware of the increased benefit costs they would incur if their retirees disenrolled from (or failed to enroll in) Part B, it seems probable that they would seek to modify their plans. If the basis for supplemental premium liability was changed to Part B enrollment and, at the same time, provision was made for alteration in private and FEHB health plans to permit the addition of exclusionary clauses where they do not now exist, disenrollment would probably be negligible.

This analysis is based on the assumption that enrollees, if able to avoid the supplemental premium by disenrolling from Part B, would base their decision on the expected benefits and costs of doing so. Some enrollees, however, might be mistaken as to the benefits and costs. If the Congress decided to change the MCCA so as to base liability on Part B enrollment rather than Part A eligibility, it would be important to ensure that accurate information was available to all enrollees.

For example, some enrollees may erroneously believe that they will be liable for the supplemental premium when, in fact, they will pay only the flat premiums. For 1990, enrollees will have no supplemental liability until their incomes exceed about $14,000 for those filing singly, or about $23,000 for couples filing jointly, so that only about 43 percent of enrollees will pay any supplemental premium (see Table 6). Liability will not reach the maximum of $850 per enrollee until incomes exceed $32,000 (for individuals) or about $56,000 (for couples filing jointly), affecting only about 9 percent of enrollees.

Another potentially incorrect belief that might result in disenrollment is the assumption by currently healthy people that their need for medical services in the future will continue to be small. In fact, most health care spending among any given age group is the unpredictable result of new-onset illness and accidents. While average spending for an age group is reasonably predictable, individual spending is not, even by the individuals themselves.

Further, enrollees might fail to assess correctly the implications of the premium penalty for late enrollment in Part B. For example, if a high-income couple--both age 65 in 1989--chose not to enroll in Part B until they were 70, based on the belief that they would have no significant medical costs before then, the maximum value of their pre-

mium savings would be a little over $11,000 (discounted to 1989). Their expected lifetime premium penalty under current law once they did enroll would be a little under $11,000 (discounted to 1989). If, for any year before they reached age 70, the couple incurred any health care costs that Medicare would have covered or if they would have been

TABLE 6. MINIMUM INCOMES AT WHICH ENROLLEES WILL BE LIABLE FOR SUPPLEMENTAL PREMIUMS, 1990

	Individuals	Couples
Minimum Income at Which There Will Be Any Supplemental Liability *(Tax liability of at least $150)*		
Taxable Income	1,000	1,000
Adjusted Gross Income[a]	7,100	11,850
Total Cash Income[b]	13,710	23,390
Minimum Income at Which There Will Be Maximum Supplemental Liability *(Tax liability of at least $3,400 for individuals; $6,800 for couples)*		
Taxable Income	21,196	39,375
Adjusted Gross Income[a]	27,296	50,225
Total Cash Income[b,c]	32,039	55,995
Maximum Supplemental Liability	850	1,700

SOURCE: Congressional Budget Office.

NOTE: The supplemental premium will be 25 percent of income tax liability for those with liability of $150 or more, to the indicated maximum.

a. Includes taxable income, plus exemptions and deductions as indicated below:

Exemptions	2,050	4,100
Standard/Extra deductions	4,050	6,750

b. Includes adjusted gross income, plus untaxed portion of average Social Security benefits. Average Social Security benefits will be:

6,610	11,540

c. The incomes at which enrollees reach the maximum liability are probably higher than shown here because most high-income enrollees itemize deductions, have above-average Social Security benefits, and have tax-free income other than Social Security.

liable for less than the maximum surtax, they would experience a net loss for failing to enroll at age 65.

Whatever Part B disenrollment did occur among retirees would probably result in net savings to Medicare, but would mean net overall costs to the federal budget. Even assuming that disenrollment would occur only among enrollees age 65 to 69 (with the lowest expected benefits), reduced Part B benefit costs due to disenrollment would often exceed losses from flat and supplemental premiums, so that net savings would accrue to Medicare. But most disenrollment would occur among FEHB enrollees, and federal FEHB benefit costs would increase as a result, typically by more than any Medicare savings.

Apart from disenrollment effects, basing liability for the supplemental premium on Part B enrollment would increase the deficit somewhat, as supplemental premium receipts would fall. This is because the number of Part B enrollees is about 1 percent less than the number eligible for Part A. People enrolled only in Part A (about 3 percent of enrollees) would no longer be subject to the supplemental premium, while those enrolled only in Part B (about 2 percent of enrollees) would be newly subject to the supplemental premium. Benefit costs would be essentially unchanged, however, unless new HI benefits provided under the MCCA were denied to those not enrolled in Part B.

Enrollees subject to the "working Medicare" provisions--under which employment-based insurance is the primary payer for Medicare enrollees who are working themselves or who are insured by a working spouse--would be major beneficiaries if the basis for supplemental liability was changed from Part A to Part B. Currently, about 3 percent of (typically Part A only) enrollees have employment-based insurance as their primary payer. Of these, nearly 80 percent (or 2.6 percent of all Medicare enrollees) are liable for the supplemental premium. Enrollees in this group receive few Medicare benefits and have little or no reason to be enrolled in Part B.

APPENDIXES

APPENDIX A

METHODOLOGY

This appendix presents detailed information about how the lifetime average subsidy values discussed in the text were derived, using CBO's July 1989 projections for benefit costs and premiums. The calculations vary by enrollees' incomes because payroll tax and supplemental premium contributions are based on income; by age because cumulative payroll tax contributions and benefits depend on age; and by sex because both average benefits per year and expected lifetimes (hence, years of Medicare eligibility) differ for men and women.

Positive subsidy values exist for Medicare as a whole and for Medicare Part B because of the financing provisions for "basic" benefits--that is, benefits that existed before passage of the MCCA. Because of the short contributory period (only since 1966), no current enrollees have contributed enough through payroll taxes to cover the costs of their expected basic HI benefits. Hence, current HI benefits are subsidized from current workers' payroll taxes. This subsidy will gradually be reduced for future retirees, as the contributory period eventually expands to cover the enrollee's entire working life. Currently under the SMI program, enrollees' premiums cover only about 25 percent of the costs of basic benefits, with the remainder funded from general revenues. This subsidy will remain unless the law is changed to require that enrollees' premiums cover the full cost of basic SMI benefits. In fact, the subsidy will grow under current law, because increases in the basic premium for 1990 and later years will be limited by increases in the cost-of-living adjustment made each year to Social Security benefit payments.

For the estimates presented in the text, it is assumed that all self-insured enrollees paid the statutory HI payroll tax rate for each year from 1966 (when the tax was initiated) through 1988 (when they reached age 65), either on average or maximum taxable earnings. Those insured through their spouses' earnings are assumed to have contributed nothing through the HI payroll tax, which overstates the

Medicare--but not the Part B--subsidy for this group to some extent.[1] Total payroll tax contributions at the start of 1989 include workers' contributions, those made by employers on their behalf, and accumulated interest earnings on those contributions--using the rate actually earned by the HI trust fund for each year from 1966 through 1988.

The insurance value of Medicare is the per-enrollee value for benefit and related administrative costs. These insurance values are adjusted to reflect the sex and age of the enrollee for each year in the enrollee's remaining lifetime. Based on tables of expected remaining life at age 65, men are assumed to receive 15 years of age-adjusted Medicare benefits and women to receive age-adjusted benefits for 19 years.

It is assumed that all enrollees pay Medicare's flat monthly premiums. In order to obtain conservative (understated) estimates of subsidy values, the basic monthly Part B premium ($27.90 for 1989) is set thereafter to cover 25 percent of the costs of basic Part B (SMI) benefits for the aged Medicare population.[2] The new monthly premiums under the MCCA are fixed in law through 1993. Thereafter, it is assumed that the monthly rate will be set to cover 37 percent of the costs of new benefits each year, where costs include specified contingency margins.

Two alternative assumptions are made concerning payment of supplemental premiums--that the enrollee will pay either the average liability (total liability divided by the number of HI enrollees) or the maximum supplemental premium. The maximum is set in law through 1993, and is indexed thereafter to growth in net outlays (outlays net of flat premium receipts) under Part B. The supplemental premium rate is also specified in law through 1993. It is assumed that the rate thereafter is set to cover 63 percent of the costs of new benefits, including specified contingency margins.

Because projections (as of July 1989) indicate that CDI trust fund receipts will be insufficient to fund CDI benefits through 1993, but that the total of all new premiums imposed under the MCCA will be

1. For enrollees age 65 in 1989, HI payroll tax contributions must have been recorded for 36 quarters to be eligible for Part A on the enrollee's own work history.

2. This provision has been extended each year since 1983. Should it not be extended beyond 1989, subsidy values would be larger.

adequate to fund all new benefits, the analysis treats the CDI trust fund and the catastrophic account specified in the MCCA as a single fund. This implicitly assumes that reserves will be redirected as needed to the CDI trust fund. Although current law does not permit this, the Congress is considering alternative approaches that might resolve this problem.

The rate used to calculate present discounted values is 6.7 percent. This reflects current projections of 2.3 percent for the real rate of discount (which is set at the rate of growth in real income) and 4.4 percent for price inflation, on average.[3]

Appendix Table A-1 provides detailed information used to estimate lifetime Medicare subsidy values (Parts A and B combined) and lifetime MCCA subsidy values. Appendix Table A-2 provides comparable information for the calculation of Part B lifetime subsidy values.

3. If a discount rate of 4.7 percent had been used instead, the average lifetime subsidy value would have been $3,372 (instead of $2,647). With a rate of 8.7 percent, the average lifetime subsidy value would have been $2,089.

TABLE A-1. PRESENT DISCOUNTED VALUES IN 1989 OF CONTRIBUTIONS, BENEFITS, AND SUBSIDY UNDER MEDICARE, FOR ENROLLEES AGE 65 IN 1989 (In dollars per enrollee)

	Self-Insured		Spouse-Insured		Population-Weighted Average
	Men	Women	Men	Women	
Enrollees Who Made the Average Payroll Tax Contribution and Who Will Pay the Average Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	11,789	11,789	0	0	
Monthly premiums	6,523	9,321	6,523	9,321	
HI benefits	26,378	33,525	26,378	33,525	
Medicare benefits	52,950	72,253	52,950	72,253	
Lifetime subsidy	34,638	51,144	46,426	62,932	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	2,309	2,692	3,095	3,312	2,649
Ratio of:					
HI payroll taxes to HI benefits	0.447	0.352	0.000	0.000	0.320
Contributions to benefits	0.346	0.292	0.123	0.129	0.281
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	11,789	11,789	0	0	
Monthly and supplemental premiums	11,114	15,977	11,114	15,977	
HI benefits	27,115	34,452	27,115	34,452	
Medicare benefits	57,458	78,926	57,458	78,926	
Lifetime subsidy	34,556	51,160	46,344	62,949	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	2,304	2,693	3,090	3,313	2,647
Ratio of:					
HI payroll taxes to HI benefits	0.435	0.342	0.000	0.000	0.311
Contributions to benefits	0.399	0.352	0.193	0.202	0.341
Enrollees Who Made the Maximum Payroll Tax Contribution and Who Will Pay the Maximum Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	22,553	22,553	0	0	
Monthly premiums	6,523	9,321	6,523	9,321	
HI benefits	26,378	33,525	26,378	33,525	
Medicare benefits	52,950	72,253	52,950	72,253	
Lifetime subsidy	23,874	40,379	46,426	62,932	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,592	2,125	3,095	3,312	2,135
Ratio of:					
HI payroll taxes to HI benefits	0.855	0.673	0.000	0.000	0.611
Contributions to benefits	0.549	0.441	0.123	0.129	0.423
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	22,553	22,553	0	0	
Monthly and supplemental premiums	22,501	32,208	22,501	32,208	
HI benefits	27,115	34,452	27,115	34,452	
Medicare benefits	57,458	78,926	57,458	78,926	
Lifetime subsidy	12,405	24,165	34,957	46,717	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	827	1,272	2,330	2,459	1,323
Ratio of:					
HI payroll taxes to HI benefits	0.832	0.655	0.000	0.000	0.595
Contributions to benefits	0.784	0.694	0.392	0.408	0.673

SOURCE: Congressional Budget Office (July 1989 reestimate).

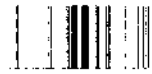
NOTE: Population proportions are: 0.431 0.361 0.032 0.176

TABLE A-2. PRESENT DISCOUNTED VALUES IN 1989 OF CONTRIBUTIONS, BENEFITS, AND SUBSIDY UNDER PART B, FOR ENROLLEES AGE 65 IN 1989 (In dollars per enrollee)

	Self-Insured		Spouse-Insured		Population-Weighted Average
	Men	Women	Men	Women	
Enrollees Who Will Pay the Average Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
Monthly premiums	6,523	9,321	6,523	9,321	
Part B benefits	26,572	38,728	26,572	38,728	
Lifetime subsidy	20,049	29,407	20,049	29,407	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,337	1,548	1,337	1,548	1,450
Ratio of:					
Contributions to benefits	0.245	0.241	0.245	0.241	0.243
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
Monthly and supplemental premiums	11,114	15,977	11,114	15,977	
Part B benefits	30,343	44,474	30,343	44,474	
Lifetime subsidy	19,229	28,497	19,229	28,497	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,282	1,500	1,282	1,500	1,399
Ratio of:					
Contributions to benefits	0.366	0.359	0.366	0.359	0.362
Enrollees Who Will Pay the Maximum Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
Monthly premiums	6,523	9,321	6,523	9,321	
Part B benefits	26,572	38,728	26,572	38,728	
Lifetime subsidy	20,049	29,407	20,049	29,407	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,337	1,548	1,337	1,548	1,450
Ratio of:					
Contributions to benefits	0.245	0.241	0.245	0.241	0.243
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
Monthly and supplemental premiums	22,501	32,208	22,501	32,208	
Part B benefits	30,343	44,474	30,343	44,474	
Lifetime subsidy	7,842	12,266	7,842	12,266	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	523	646	523	646	589
Ratio of:					
Contributions to benefits	0.742	0.724	0.742	0.724	0.732

SOURCE: Congressional Budget Office (July 1989 reestimate).

NOTE: Population proportions are: 0.431 0.361 0.032 0.176



APPENDIX B

SUBSIDY VALUES UNDER ALTERNATIVE PROJECTIONS

The subsidy values shown in this appendix reflect an updating of Medicare estimates between July and September 1989. The values differ from those shown in the text and in Appendix A principally because CBO's estimates of skilled nursing facility (SNF) costs both before and since MCCA have increased substantially. In addition, projected values for other pre-MCCA benefits have been reduced. Benefit costs are now expected to exceed premium receipts over the first five years of the MCCA program unless premium rates set by law through 1993 are increased.

The method used here to calculate lifetime subsidy values assumed that MCCA benefits would be paid through 1993 by borrowing from other funding sources as needed, but that MCCA premiums would be increased in later years to cover both benefit and borrowing costs.

In comparison with the estimates discussed in the text, MCCA benefits and subsidy values are higher for 1989 through 1993 by $60 or more a year (Appendix Table B-1). Inclusion of the higher SNF benefits has no appreciable effect on lifetime MCCA subsidy values for the average enrollee, however, because MCCA premiums would be increased in years after 1993 by enough to compensate for higher benefit costs.

Estimated Part B subsidy values for 1989 through 1993 are unaffected by the higher SNF costs, although they are lower than those shown in the text because projections for basic SMI benefits were reduced between the July and September estimates (Table B-2). Lifetime Part B subsidy values are reduced by more than those through 1993, because the higher SNF benefits would not be credited to Part B, while the higher premiums for years after 1993 would be.

Appendix Table B-3 provides detailed information underlying the estimates in Table B-1. Appendix Table B-4 provides comparable information underlying the estimates in Table B-2.

TABLE B-1. ANNUAL SUBSIDY VALUES UNDER MEDICARE PARTS A AND B FOR ENROLLEES AGE 65 IN 1989
(By calendar year, in dollars per enrollee)

	1989	1990	1991	1992	1993	Lifetime Average[a]
Enrollees Who Made the Average Payroll Tax Contribution and Who Will Pay the Average Amount in Supplemental Premiums						
Pre-MCCA Benefits	2,367	2,699	3,032	3,416	3,878	3,592
HI Payroll Taxes	(447)	(513)	(561)	(620)	(693)	(563)
Basic Part B Premiums	(335)	(340)	(383)	(432)	(485)	(450)
Pre-MCCA Subsidy Value	1,585	1,847	2,087	2,364	2,699	2,579
Change Due to MCAA:						
Benefits	72	204	310	368	397	408
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(149)
Supplemental premiums	(125)	(174)	(187)	(203)	(224)	(264)
Current Benefits	2,439	2,903	3,342	3,783	4,274	4,000
Enrollee Contributions	(954)	(1,086)	(1,221)	(1,365)	(1,524)	(1,426)
Current Subsidy Value	1,484	1,817	2,121	2,418	2,750	2,574
Current Subsidy as Proportion of Pre-MCCA Subsidy	0.936	0.984	1.016	1.023	1.019	0.998
Current Subsidy as Proportion of Benefits	0.609	0.626	0.635	0.639	0.643	0.644
Enrollees Who Made the Maximum Payroll Tax Contribution and Who Will Pay the Maximum Amount in Supplemental Premiums						
Pre-MCCA Benefits	2,367	2,699	3,032	3,416	3,878	3,592
HI Payroll Taxes	(855)	(982)	(1,074)	(1,187)	(1,327)	(1,077)
Basic Part B Premiums	(335)	(340)	(383)	(432)	(485)	(450)
Pre-MCCA Subsidy Value	1,177	1,378	1,575	1,797	2,066	2,065
Change Due to MCCA:						
Benefits	72	204	310	368	397	408
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(149)
Supplemental premiums	(800)	(850)	(900)	(950)	(1,050)	(995)
Current Benefits	2,439	2,903	3,342	3,783	4,274	4,000
Enrollee Contributions	(2,038)	(2,230)	(2,446)	(2,679)	(2,984)	(2,671)
Current Subsidy Value	401	673	896	1,104	1,290	1,329
Current Subsidy as Proportion of Pre-MCCA Subsidy	0.341	0.488	0.569	0.615	0.624	0.643
Current Subsidy as Proportion of Benefits	0.164	0.232	0.268	0.292	0.302	0.332

SOURCE: Congressional Budget Office (September 1989 reestimate).

NOTE: Benefit values shown include related administrative costs. Values shown are age-adjusted. Unadjusted values are:

Pre-MCCA	3,042	3,387	3,714	4,084	4,526
MCCA	92	255	380	440	463
Current	3,134	3,642	4,094	4,524	4,989

a. In dollars discounted to 1989.

TABLE B-2. ANNUAL SUBSIDY VALUES UNDER MEDICARE PART B FOR ENROLLEES AGE 65 IN 1989
(By calendar year, in dollars per enrollee)

	1989	1990	1991	1992	1993	Lifetime Average[a]
Enrollees Who Will Pay the Average Amount in Supplemental Premiums						
Pre-MCCA Benefits	972	1,133	1,310	1,510	1,738	1,851
Basic Part B Premiums	(335)	(340)	(383)	(432)	(485)	(450)
Pre-MCCA Subsidy Value	637	793	926	1,079	1,253	1,401
Change Due to MCAA:						
Benefits	4	89	191	236	257	273
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(149)
Supplemental premiums	(125)	(174)	(187)	(203)	(224)	(264)
Current Benefits	976	1,222	1,501	1,747	1,995	2,124
Enrollee Contributions	(508)	(573)	(659)	(745)	(831)	(863)
Current Subsidy Value	468	649	841	1,002	1,164	1,260
Current Subsidy as Proportion of Pre-MCCA Subsidy	0.735	0.818	0.909	0.929	0.929	0.900
Current Subsidy as Proportion of Benefits	0.480	0.531	0.561	0.574	0.583	0.594
Enrollees Who Will Pay the Maximum Amount in Supplemental Premiums						
Pre-MCCA Benefits	972	1,133	1,310	1,510	1,738	1,851
Basic Part B Premiums	(335)	(340)	(383)	(432)	(485)	(450)
Pre-MCCA Subsidy Value	637	793	926	1,079	1,253	1,401
Change Due to MCCA:						
Benefits	4	89	191	236	257	273
Monthly premiums	(48)	(59)	(89)	(110)	(122)	(149)
Supplemental premiums	(800)	(850)	(900)	(950)	(1,050)	(995)
Current Benefits	976	1,222	1,501	1,747	1,995	2,124
Enrollee Contributions	(1,183)	(1,249)	(1,372)	(1,492)	(1,657)	(1,595)
Current Subsidy Value	(207)	(27)	129	255	338	529
Current Subsidy as Proportion of Pre-MCCA Subsidy	-0.325	-0.034	0.139	0.236	0.269	0.378
Current Subsidy as Proportion of Benefits	-0.212	-0.022	0.086	0.146	0.169	0.249

SOURCE: Congressional Budget Office (September 1989 reestimate).

NOTE: Benefit values shown include related administrative costs. Values shown are age-adjusted. Unadjusted values are:

Pre-MCCA	1,249	1,422	1,604	1,806	2,029
MCCA	5	111	234	282	300
Current	1,254	1,533	1,838	2,088	2,329

a. In dollars discounted to 1989.

TABLE B-3. PRESENT DISCOUNTED VALUES IN 1989 OF CONTRIBUTIONS, BENEFITS, AND SUBSIDY UNDER MEDICARE, FOR ENROLLEES AGE 65 IN 1989 (In dollars per enrollee)

	Self-Insured		Spouse-Insured		Population-Weighted Average
	Men	Women	Men	Women	
Enrollees Who Made the Average Payroll Tax Contribution and Who Will Pay the Average Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	11,789	11,789	0	0	
Monthly premiums	6,325	9,018	6,325	9,018	
HI benefits	26,017	33,173	26,017	33,173	
Medicare benefits	51,731	70,579	51,731	70,579	
Lifetime subsidy	33,617	49,773	45,406	61,561	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	2,241	2,620	3,027	3,240	2,579
Ratio of:					
HI payroll taxes to HI benefits	0.453	0.355	0.000	0.000	0.324
Contributions to benefits	0.350	0.295	0.122	0.128	0.284
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	11,789	11,789	0	0	
Monthly and supplemental premiums	12,098	17,330	12,098	17,330	
HI benefits	27,959	35,849	27,959	35,849	
Medicare benefits	57,369	78,870	57,369	78,870	
Lifetime subsidy	33,482	49,751	45,271	61,540	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	2,232	2,618	3,018	3,239	2,574
Ratio of:					
HI payroll taxes to HI benefits	0.422	0.329	0.000	0.000	0.300
Contributions to benefits	0.416	0.369	0.211	0.220	0.358
Enrollees Who Made the Maximum Payroll Tax Contribution and Who Will Pay the Maximum Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	22,553	22,553	0	0	
Monthly premiums	6,325	9,018	6,325	9,018	
HI benefits	26,017	33,173	26,017	33,173	
Medicare benefits	51,731	70,579	51,731	70,579	
Lifetime subsidy	22,853	39,009	45,406	61,561	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,524	2,053	3,027	3,240	2,065
Ratio of:					
HI payroll taxes to HI benefits	0.867	0.680	0.000	0.000	0.619
Contributions to benefits	0.558	0.447	0.122	0.128	0.428
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
HI payroll taxes	22,553	22,553	0	0	
Monthly and supplemental premiums	22,358	32,008	22,358	32,008	
HI benefits	27,959	35,849	27,959	35,849	
Medicare benefits	57,369	78,870	57,369	78,870	
Lifetime subsidy	12,458	24,310	35,010	46,862	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	831	1,279	2,334	2,466	1,329
Ratio of:					
HI payroll taxes to HI benefits	0.807	0.629	0.000	0.000	0.575
Contributions to benefits	0.783	0.692	0.390	0.406	0.671

SOURCE: Congressional Budget Office (September 1989 reestimate).

NOTE: Population proportions are: 0.431 0.361 0.032 0.176

TABLE B-4. PRESENT DISCOUNTED VALUES IN 1989 OF CONTRIBUTIONS, BENEFITS, AND SUBSIDY UNDER PART B, FOR ENROLLEES AGE 65 IN 1989 (In dollars per enrollee)

	Self-Insured		Spouse-Insured		Population-Weighted Average
	Men	Women	Men	Women	
Enrollees Who Will Pay the Average Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
Monthly premiums	6,325	9,018	6,325	9,018	
Part B benefits	25,714	37,407	25,714	37,407	
Lifetime subsidy	19,389	28,389	19,389	28,389	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,293	1,494	1,293	1,494	1,401
Ratio of:					
Contributions to benefits	0.246	0.241	0.246	0.241	0.243
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
Monthly and supplemental premiums	12,098	17,330	12,098	17,330	
Part B benefits	29,410	43,021	29,410	43,021	
Lifetime subsidy	17,312	25,690	17,312	25,690	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,154	1,352	1,154	1,352	1,260
Ratio of:					
Contributions to benefits	0.411	0.403	0.411	0.403	0.407
Enrollees Who Will Pay the Maximum Amount in Supplemental Premiums					
Under Pre-MCCA Benefit/Premium Structure					
Present Discounted Value of:					
Monthly premiums	6,325	9,018	6,325	9,018	
Part B benefits	25,714	37,407	25,714	37,407	
Lifetime subsidy	19,389	28,389	19,389	28,389	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	1,293	1,494	1,293	1,494	1,401
Ratio of:					
Contributions to benefits	0.246	0.241	0.246	0.241	0.243
Under Current Benefit/Premium Structure					
Present Discounted Value of:					
Monthly and supplemental premiums	22,358	32,008	22,358	32,008	
Part B benefits	29,410	43,021	29,410	43,021	
Lifetime subsidy	7,052	11,013	7,052	11,013	
Expected lifetime (Years)	15	19	15	19	
Average annual subsidy	470	580	470	580	529
Ratio of:					
Contributions to benefits	0.760	0.744	0.760	0.744	0.752

SOURCE: Congressional Budget Office (September 1989 reestimate).

NOTE: Population proportions are: 0.431 0.361 0.032 0.176