CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

MEMORANDUM January 5, 1989

TO: Health Staff

FROM: Sandra Christensen

SUBJECT: **Impact of the Medicare Catastrophic Coverage Act on Enrollees by Selected Demographic Characteristics**

This memorandum is in response to a number of requests for additional information on the impact of the Medicare Catastrophic Coverage Act (Public Law 100-360). In particular, requests have been made for estimates of the impact of the Medicare provisions alone (without consideration of medigap and Medicaid coverage), shown by age, disability, and use of services.1/

The first section below summarizes briefly the new Medicare benefits that will be provided under the act. The second section presents impact estimates for enrollees by selected demographic characteristics.

OVERVIEW OF NEW MEDICARE BENEFITS

New Medicare benefits under the act are to be phased in over several years, with most new Hospital Insurance (HI) benefits to be effective for 1989, new Supplementary Medical Insurance (SMI) benefits to be effective for 1990, and new Catastrophic Drug Insurance (CDI) benefits to be fully effective by 1993.

Hospital Insurance

The act eliminated all enrollee cost-sharing for hospital inpatient stays except for a single inpatient deductible ($560 for 1989). It eliminated current limits on covered days both for hospital inpatient stays and for hospice benefits. Both coverage limits and coinsurance requirements for stays in skilled nursing facilities

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1. See CBO's October 1, 1988, working paper called "The Medicare Catastrophic Coverage Act of 1988" for a full description of the act, for CBO's cost estimate for the act, and for the impact on enrollees by income and poverty status. The main body of the working paper presents results that show the combined effects of Medicare, Medicaid, and medigap, while an appendix to the working paper shows the effects of Medicare alone, regardless of supplementary coverage.

(SNFs) were changed. The limit on SNF stays was changed from 100 days in each spell of illness to 150 days a year, with no prior hospital stay required. Coinsurance payments will be required only for the first 8 days each year, at 20 percent of average SNF costs per day ($25.50 for 1989). In 1988, coinsurance amounts of $67.50 were payable on days 21-100 in each spell of illness. Finally, (effective for 1990) the current requirement that limits coverage for home health care to intermittent visits will be relaxed, so that enrollees may receive up to 38 consecutive days of care, 7 days a week.

Supplementary Medical Insurance

Coverage will be expanded to include screening mammography for women. Each enrollee's liability for SMI copayments will be capped ($1,370 for 1990), with the cap adjusted each year to keep the proportion of enrollees affected by it at 7 percent. Once incurring sufficient costs to receive benefits either under the SMI copayment cap or the new drug provisions (explained below), enrollees will be eligible for a respite benefit. Under this benefit, Medicare will pay 80 percent of reasonable costs for up to 80 hours a year of in-home personal services, to give homebound enrollees' usual caretakers a respite.

Catastrophic Drug Insurance

By 1991, coverage under this new program will include all outpatient prescription drugs and insulin, subject to a deductible amount ($600 in 1991) that will be adjusted each year to keep the proportion of enrollees affected constant at 16.8 percent. Enrollees' coinsurance requirements will be 50 percent of reasonable charges above the deductible in 1991, 40 percent in 1992, and 20 percent in 1993 and subsequent years.

IMPACT OF NEW MEDICARE BENEFITS ON ENROLLEES BY DEMOGRAPHIC GROUP

The impact of the new Medicare benefits under the act was estimated for calendar year 1988, as though all provisions of the act had been fully effective during that year.2/ The advantage of this approach is that it permits assessment of the fully-implemented act in dollar values to which readers can easily relate. The alternative would have been either to simulate the provisions of the act only for 1993--the first year all provisions of the act will be fully effective; or to simulate the act for each year from 1989 through 1993, tracking the effects of fuller implementation each year.

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2. For the 1988 simulation, the SMI copayment cap was at $1,115; the drug deductible was $465; the new flat Part B premium was $6.60 a month; and the supplemental (surtax) rate was 30.5 percent with a ceiling on supplemental liability of $577.

While simulation of the act for each year over the implementation period could be interesting, it would be a much larger task.

Percent of Enrollees Affected by New Benefits

The SMI copayment cap is set to affect 7 percent of Part B enrollees.3/ Relative to the larger count of those who are enrolled under either Part A or Part B of Medicare (used for all of the results shown here), about 6.8 percent of enrollees would see their copayment costs reduced because of the copayment cap (Table 1). This incidence varies greatly, however, among different groups of enrollees. Nearly 70 percent of nonaged enrollees with renal disease will exceed the copayment cap, as will more than 80 percent of aged enrollees with renal disease.

Enrollees with one hospital stay during the year are twice as likely than average to exceed the cap, while those with multiple or long hospital stays are 6 to 10 times more likely to exceed the cap than average. Enrollees near death are 3 times more likely to exceed the cap than average.

About 22 percent of Part A and/or Part B enrollees will benefit in any given year from at least one of the new Medicare provisions--the SMI copayment cap (which benefits 7 percent of Part B enrollees), the drug benefit (which affects 16.8 percent of Part B enrollees), or the new HI copayment provisions (which benefit about 4 percent of Part A enrollees). This, too, varies across enrollee groups, although the variation is not as large as it is for the SMI copayment cap alone. One surprising result is that the oldest group--enrollees who are age 85 or more--are slightly less likely to benefit under the act than those age 80-84.

Percent Distribution of Enrollees by Copayment Liabilities

Under current law in 1988, 5.5 percent of enrollees will incur Medicare copayment costs or drug costs in excess of $2,500 (Table 2). If the act been fully effective for 1988, virtually no enrollees would have incurred such high copayment costs. This is so even though drug copayment costs--which do not count toward the SMI copayment cap--are potentially unlimited under the act.

On average, copayment liabilities would be reduced by $172 under the act, from $731 to $559. Benefits (Medicare reimbursement

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3. The probability of exceeding the cap in two successive years is low--only 1.8 percent. Multiyear simulations of the SMI copayment cap indicate that enrollees who exceed the cap in one year have a 25.7 percent chance of exceeding the cap again the following year, while those who do not exceed the cap have a 5.6 percent probability of exceeding the cap in the following year.

costs) would increase by $194, on average, from $2,801 to $2,995. While most of the new benefits under the act represent a transfer of copayment costs (defined to include drug costs prior to coverage by Medicare) from enrollees to Medicare, about 11 percent of new benefit costs is due to increased use of services by enrollees, the result of reduced cost-sharing and the elimination of certain limits on coverage.

Impact of the Act by Demographic Groups

The impact of the act--in terms of higher benefits and reduced copayment liabilities--varies greatly among different demographic groups. Enrollees with serious medical conditions receive higher benefits than other enrollees because this is the nature and the purpose of health insurance. Consequently, the allocation of new benefits is concentrated on enrollees with renal disease, or who are hospitalized, or who have terminal illnesses.

Disabled enrollees (the "under 65" group) would receive 16 percent of new benefits under the act, although they comprise less than 10 percent of the enrollee population (Table 3). Enrollees age 75 or more would also receive a disproportionately large share of new benefits under the act, while the share of new benefits going to enrollees age 65-74 would be disproportionately small.

Treatment for renal disease, however, is a more significant determinant of high benefit costs under Medicare than is disability. Average benefit costs for nonaged enrollees with renal disease are in excess of $25,000 under current law for 1988 (Table 4). New benefits under the act would exceed $4,000 for enrollees with renal disease, at least 22 times as large as the average new benefit for all enrollees. While enrollees with renal disease (whether aged or not) comprise 0.4 percent of the enrollee population, this group will receive nearly 9 percent of new benefits under the act. Average copayment costs for those with renal disease are nearly $5,000 (for the nonaged) and nearly $6,000 (for the aged) under current law. If the act had been in effect for 1988, these amounts would have been much lower--only $1,523 to $1,664.

Hospitalization, too, is an important determinant of high benefit costs under Medicare, especially for enrollees with more than one stay or with a very long stay (one that would involve coinsurance days under current law for 1988). For enrollees with a long hospital stay during the year, new benefit costs under the act would average $6,467, largely the result of a reduction in copayment liabilities by $6,103 (Table 5). While enrollees with long hospital stays comprise only 0.5 percent of the Medicare population, this group would receive more than 17 percent of new benefits under the act--more than 30 times the average new benefit.

About 5 percent of enrollees die each year and this group, too, uses a disproportionately large percent of Medicare benefits

-- about 16 percent of new benefits, or 3 times the average for all enrollees (Table 6). This group is probably less uniformly costly, however, than groups defined by renal disease or hospitalization.

TABLE 1. PERCENT OF ENROLLEES AFFECTED BY NEW MEDICARE PROVISIONS BY DEMOGRAPHIC CHARACTERISTIC BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

ENROLLEES AFFECTED BY:	New SMI Copayment Ceiling	Any New Medicare Provisions
AGE:		
Under 65	7.6%	21.4%
65-69	5.0%	18.5%
70-74	6.8%	21.8%
75-79	8.0%	24.6%
80-84	8.6%	26.2%
85 or more	7.4%	25.7%
REASON FOR ENTITLEMENT:		
Age--		
Without renal disease	6.6%	22.1%
With renal disease	81.4%	84.7%
Disability--		
Without renal disease	6.2%	20.4%
With renal disease	69.9%	75.3%
USE OF SERVICES:		
No reimbursable services	0.0%	5.0%
No stays, other services	3.7%	19.3%
One stay, no coinsurance days	13.7%	37.2%
Two+ stays, no coinsurance days	39.3%	77.3%
One+ stays, coinsurance days	65.7%	99.7%
YEAR OF DEATH:		
During benefit year	18.6%	40.4%
One year subsequent to benefit year	21.1%	41.5%
Two+ years subsequent to benefit year	5.8%	20.6%
All Enrollees /a/	6.8%	22.2%

SOURCE: Congressional Budget Office simulation.

a. Each year, 7 percent of SMI enrollees will benefit from the copayment ceiling. This is only 6.8 percent of the HI and/or SMI enrollment counts used here, however.

TABLE 2. PERCENT DISTRIBUTION OF ENROLLEES BY COPAYMENT CATEGORY BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

Copayment Category /a/	Percent Distribution		Average Copayment	
	Before	After	Before	After
All Medicare Enrollees	100.0%	100.0%	731	559
$0	2.2%	2.2%	0	0
$1-500	57.8%	57.8%	159	160
$501-1,500	25.1%	29.3%	926	909
$1,501-2,500	9.3%	10.7%	1921	1861
$2,501 or more	5.5%	0.0%	4104	--

SOURCE: Congressional Budget Office simulation.

a. Enrollees' drug costs are counted as copayments, both before and after act.

TABLE 3. NET CHANGE IN ENROLLEES' BENEFITS AND COPAYMENT LIABILITIES BY AGE BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of enrollees in group	Before	Change	After	Percent of New Benefits Received
		MEDICARE BENEFITS			
AGE:					
Under 65	9.9%	3366	313	3679	16.0%
65-69	28.1%	1982	140	2122	20.3%
70-74	23.4%	2624	173	2797	20.9%
75-79	17.5%	3096	205	3301	18.5%
80-84	11.4%	3476	222	3698	13.0%
85 or more	9.7%	3690	234	3924	11.8%
Total	100.0%	2801	194	2995	100.0%
		MEDICARE COPAYMENTS			
AGE:					
Under 65	9.9%	827	-261	566	
65-69	28.1%	585	-133	452	
70-74	23.4%	702	-159	543	
75-79	17.5%	795	-183	612	
80-84	11.4%	854	-191	663	
85 or more	9.7%	867	-186	681	
Total	100.0%	731	-172	559	

SOURCE: Congressional Budget Office simulation.

a. Enrollees' drug costs are counted as copayments, both before and after act.

TABLE 4. NET CHANGE IN ENROLLEES' BENEFITS BY REASON FOR ENTITLEMENT
BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of enrollees in group	Before	Change	After	Percent of New Benefits Received
			MEDICARE BENEFITS		
REASON FOR ENTITLEMENT:					
Age--					
Without renal disease	90.4%	2694	175	2869	81.6%
With renal disease	0.1%	30221	4654	34875	3.1%
Disability--					
Without renal disease	9.2%	2800	202	3002	9.5%
With renal disease	0.3%	25640	4304	29944	5.8%
Total	100.0%	2801	194	2995	100.0%
			MEDICARE COPAYMENTS		
REASON FOR ENTITLEMENT:					
Age--					
Without renal disease	90.4%	715	-156	559	
With renal disease	0.1%	5938	-4274	1664	
Disability--					
Without renal disease	9.2%	689	-170	519	
With renal disease	0.3%	4992	-3469	1523	
Total	100.0%	731	-172	559	

SOURCE: Congressional Budget Office simulation.

a. Enrollees' drug costs are counted as copayments, both before and after act.

TABLE 5. NET CHANGE IN ENROLLEES' BENEFITS BY USE OF SERVICES BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of enrollees in group	Before	Change	After	Percent of New Benefits Received
			MEDICARE BENEFITS		
USE OF SERVICES:					
No reimbursable services	28.3%	0	36	36	5.3%
No stays, other services	50.2%	869	98	967	25.4%
One stay, no coinsurance days	14.1%	7076	248	7324	18.0%
Two+ stays, no coinsurance days	6.9%	17430	972	18402	34.3%
One+ stays, coinsurance days	0.5%	33129	6467	39596	17.3%
Total	100.0%	2801	194	2995	100.0%
			MEDICARE COPAYMENTS		
USE OF SERVICES:					
No reimbursable services	28.3%	125	-36	89	
No stays, other services	50.2%	532	-93	439	
One stay, no coinsurance days	14.1%	1540	-195	1345	
Two+ stays, no coinsurance days	6.9%	2486	-817	1669	
One+ stays, coinsurance days	0.5%	7923	-6103	1820	
Total	100.0%	731	-172	559	

SOURCE: Congressional Budget Office simulation.

NOTE: Use groups defined by use before Public Law 100-360.

a. Enrollees' drug costs are counted as copayments, both before and after act.

TABLE 6. NET CHANGE IN ENROLLEES' BENEFITS BY YEAR OF DEATH
BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of enrollees in group	Before	Change	After	Percent of New Benefits Received
			MEDICARE BENEFITS		
YEAR OF DEATH:					
During benefit year	5.5%	9390	586	9976	16.5%
One year subsequent to benefit year	2.3%	7916	645	8561	7.7%
Two+ years subsequent to benefit year	92.2%	2283	160	2443	76.1%
Total	100.0%	2801	194	2995	100.0%
			MEDICARE COPAYMENTS		
YEAR OF DEATH:					
During benefit year	5.5%	1602	-507	1095	
One year subsequent to benefit year	2.3%	1537	-540	997	
Two+ years subsequent to benefit year	92.2%	660	-144	516	
Total	100.0%	731	-172	559	

SOURCE: Congressional Budget Office simulation.

a. Enrollees' drug costs are counted as copayments, both before and after act.