BACKGROUND MATERIAL ON

THE CATASTROPHIC DRUG INSURANCE PROGRAM

Prepared for the

Committee on Finance
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The Medicare Catastrophic Coverage Act of 1988 (MCCA) provided the largest expansion in Medicare benefits for enrollees since the program's inception. One major aspect of the expansion was to pay for a portion of catastrophically large expenditures on outpatient prescription drugs for enrollees. In calendar year 1990, the Catastrophic Drug Insurance (CDI) program will cover only immunosuppressive drugs and drugs administered intravenously at home. Beginning in 1991, however, Medicare will pay half of the allowed expenditures for all outpatient prescription drugs and insulin that exceed the $600 deductible amount and, in 1992, Medicare will pay 60 percent of expenditures over $652. In 1993 and beyond, provided that sufficient funding is available, Medicare will pay 80 percent of expenditures over deductible amounts that will be set by the Secretary of Health and Human Services (HHS) at levels required to provide benefits to 16.8 percent of enrollees each year.

These prescription drug benefits are to be paid from the Catastrophic Drug Insurance Trust Fund, which will be financed by portions of the flat premium and the income-related supplemental premium established in the MCCA. 1/ For 1991 and 1992, the law does not specify particular adjustments if funding from these sources is not enough to cover benefits and administrative costs. For 1993 and 1994, the Secretary of HHS has discretion to meet a shortfall by raising the deductible amount or the coinsurance rate paid by beneficiaries compared with the levels specified in the law. 2/ For 1995 and beyond, the Secretary may adjust the flat and supplemental premium rates to increase receipts.

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1. The MCCA also expanded catastrophic coverage under the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. To permit comparison of expenditures on these HI and SMI benefits with the portions of the new premiums not allocated to the CDI trust fund, the act created a "catastrophic account" for HI and SMI. Both spending and premiums for the additional HI and SMI benefits, however, will flow through the HI and the SMI trust funds.

2. The coinsurance rate cannot be set higher than its level in the preceding year, however.

At the time the Congress was considering the MCCA, a good deal of uncertainty surrounded the cost of covering catastrophic expenditures on prescription drugs. This uncertainty arose because the cost estimate had to be based on extrapolations of data from the late 1970s and early 1980s. Recognizing that a new source of information would be available when the 1987 National Medical Expenditure Survey (NMES) was prepared for analysis in 1989, the MCCA instructed the Congressional Budget Office (CBO) to reestimate the cost of the CDI program using these new data. CBO's reestimates, which are shown in the attached tables, also incorporate the new economic assumptions and baseline budget estimates that CBO will release in mid-August.

The top portion of Table 1 shows CBO's current estimates of benefits that would be paid under the CDI program and the cost of administering the program, if inadequate balances in the CDI trust fund do not constrain payments. Outlays are projected to total $2.2 billion in fiscal year 1991, rising to $5.1 billion in 1993. About $1.6 billion is expected to be paid in benefits in 1991, rising to $4.3 billion in 1993. Administrative costs are also expected to rise quickly, from $0.5 billion in 1991 to $0.8 billion in 1993. The bottom portion of Table 1 shows that receipts will grow from $2.4 billion in fiscal year 1991 to $3.3 billion in 1993. While receipts are projected to exceed outlays by $0.2 billion in 1991, there would be a shortfall of $1.8 billion in 1992, if outlays were not constrained. Over the 1990-1993 period, CDI outlays would exceed receipts by about $2.7 billion.

Table 2 contrasts CBO's current estimates with the ones prepared in June 1988 when the Congress enacted the MCCA, and with those released in February

1989. (The Appendix Table contrasts the estimates of outlays and receipts related to all the Medicare provisions enacted in the MCCA.) In June 1988, it appeared that receipts for the CDI program would total $7.5 billion over the 1990-1993 period, compared with expected outlays of $5.7 billion. By February 1989, it was apparent that receipts would be considerably higher -- an estimated $8.3 billion over the four-year period -- but estimated outlays were only slightly higher. Based on newly available information from the NMES, CBO has now substantially raised its estimates of outlays for both benefits and administrative costs to a total of $11.8 billion for the 1990-1993 period. Although receipts are also expected to be somewhat higher, CBO now projects that outlays will exceed receipts by $2.7 billion over the four years.

Revised estimates of the income-related premium accounted for almost all of the increase in estimated receipts, and two factors accounted for virtually all of this revision. First, current estimates are based on data reflecting higher incomes for elderly taxpayers than the information used at the time the MCCA was enacted. Second, taxpayers are expected to pay the premium on a more accelerated schedule than was expected in June 1988.

Three major factors contributed to the increase in estimated outlays for the CDI program between February 1989 and July 1989. First, the NMES indicated that both the average number of prescriptions used by enrollees and their average price had risen more by 1987 than CBO had expected based on data from the early 1980s. Consequently, the 1987 base for the projections is now higher than was assumed in June 1988. Moreover, CBO has incorporated a higher growth rate for spending on

prescription drugs than was used in June 1988. The annual growth rates used for the projection period are, however, lower than the average that actually occurred between 1980 and 1987. Finally, estimated administrative costs rose because of the larger projected number of claims to be processed and other factors.

The implications of these projections for the CDI trust fund, which uses a calendar year accounting period, are shown in the top panel of Table 3. The end-of-year balance will be positive only in 1990, and the shortfall will reach $4.7 billion by the end of 1993. In contrast, as shown in the middle panel, balances in the catastrophic account for the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) provisions will rise throughout the projection period, reaching $8.9 billion by the end of 1993. As a result, the combined balance would be $4.2 billion at the end of 1993, if spending for the CDI program were unconstrained. This amount would represent an overall contingency margin of about 33 percent, compared with the 31 percent level estimated at the time the MCCA was enacted. (The act does not, however, provide for transfers of funds between accounts.)

CBO's current estimates also indicate that many more enrollees will benefit from the CDI program in 1991 and 1992 than was expected when the MCCA was enacted, as shown in Table 4. Based on deductible amounts of $600 in 1991 and $652 in 1992, CBO's projections now show that 26 percent to 27 percent of enrollees will receive partial reimbursement of their prescription drug expenses in those years, compared with the original estimate of 16.8 percent. Because the act requires the Secretary of HHS to set the deductible amount for 1993 so that 16.8 percent of enrollees will benefit, the deductible will have to rise sharply, to $1,100 for that year.

A final observation is in order: although more information is available now from the NMES, estimates of outlays for the CDI program remain highly uncertain. Three of the most important reasons are mentioned here. First, spending on prescription drugs for enrollees rose much more quickly than CBO expected between 1980 and 1987, but the reasons for the fast growth are not clear. Thus, a wide range of assumptions about the rate of increase that will occur between 1987 and 1993 would be reasonable. Second, there is considerable disagreement about how enrollees, physicians, and pharmacists will respond to the introduction of catastrophic coverage for prescription drug expenses. Third, because the federal government has not run similar programs in the past, it is difficult to estimate the costs of administering the CDI program. Moreover, the Administration is unable to share its current estimates of these CDI costs, because it is currently in the process of contracting with firms to administer the program.

TABLE 1. OUTLAYS, RECEIPTS, AND THE NET EFFECT ON MEDICARE OF THE CATASTROPHIC DRUG INSURANCE PROGRAM (By fiscal year, in billions of dollars)

	1990	1991	1992	1993	Four-Year Total
Outlays					
Benefits	0.1	1.6	3.7	4.3	9.6
Administrative Costs	0.1	0.5	0.7	0.8	2.2
Total	0.2	2.2	4.4	5.1	11.8
Receipts					
Income-Related Premium	0.8	1.8	1.6	2.1	6.3
Flat Premium	a/	0.6	1.0	1.2	2.8
Total	0.8	2.4	2.6	3.3	9.1
Net Effect on Medicare b/	-0.7	-0.2	1.8	1.7	2.7

SOURCE: Congressional Budget Office, July 1989.

NOTE: Details may not add to totals because of rounding.

a. Less than $50 million.

b. Outlays less receipts for the Catastrophic Drug Insurance program. Note that these amounts do not represent the effect on the federal budget deficit because they do not take into account offsetting changes in outlays for other programs such as Medicaid.

TABLE 2. COMPARISON OF ESTIMATES OF OUTLAYS, RECEIPTS, AND THE NET EFFECT ON MEDICARE OF THE CATASTROPHIC DRUG INSURANCE PROGRAM (By fiscal year, in billions of dollars)

Date of CBO Estimate	1990	1991	1992	1993	Four-Year Total
Outlays					
Total					
June 1988	0.1	0.9	1.9	2.7	5.7
February 1989	0.1	1.0	1.9	2.8	5.9
July 1989	0.2	2.2	4.4	5.1	11.8
Benefits					
June 1988	a/	0.8	1.6	2.5	4.9
February 1989	a/	0.8	1.6	2.4	4.8
July 1989	0.1	1.6	3.7	4.3	9.6
Administrative Costs					
June 1988	0.1	0.2	0.2	0.3	0.8
February 1989	0.1	0.2	0.3	0.4	1.1
July 1989	0.1	0.5	0.7	0.8	2.2
Receipts					
Total					
June 1988	0.4	1.9	2.3	2.9	7.5
February 1989	0.5	2.2	2.5	3.1	8.3
July 1989	0.8	2.4	2.6	3.3	9.1
Income-Related Premium					
June 1988	0.4	1.3	1.3	1.7	4.7
February 1989	0.5	1.6	1.6	1.9	5.5
July 1989	0.8	1.8	1.6	2.1	6.3
Flat Premium					
June 1988	a/	0.6	1.0	1.2	2.8
February 1989	a/	0.6	1.0	1.2	2.8
July 1989	a/	0.6	1.0	1.2	2.8
Net Effect on Medicare b/					
June 1988	-0.3	-0.9	-0.4	-0.2	-1.8
February 1989	-0.4	-1.2	-0.6	-0.3	-2.4
July 1989	-0.7	-0.2	1.8	1.7	2.7

SOURCE: Congressional Budget Office, July 1989.

NOTE: Details may not add to totals because of rounding.

a. Less than $50 million.

b. Outlays less receipts for the Catastrophic Drug Insurance program. Note that these amounts do not represent the effect on the federal budget deficit because they do not take into account offsetting changes in outlays for other programs such as Medicaid.

TABLE 3. RESERVES IN THE CATASTROPHIC DRUG INSURANCE TRUST FUND AND THE CATASTROPHIC ACCOUNT FOR HOSPITAL INSURANCE (HI) AND SUPPLEMENTARY MEDICAL INSURANCE (SMI) (By calendar year, in billions of dollars)

	1990	1991	1992	1993
Catastrophic Drug Insurance Trust Fund				
End-of-Year Balance a/	0.6	-0.3	-2.7	-4.7
Outlays	0.2	3.5	4.9	5.1
Estimated Contingency Margin b/ (in percent)	248	-9	-56	-93
Scheduled Contingency Margin (in percent)	n.a.	n.a.	75	50
Catastrophic Account for HI and SMI				
End-of-Year Balance a/	3.5	5.6	7.4	8.9
Outlays	4.7	6.0	6.8	7.7
Estimated Contingency Margin b/ (in percent)	75	93	109	116
Scheduled Contingency Margin (in percent)	n.a.	n.a.	20	20
Combined Funds				
End-of-Year Balance a/	4.1	5.3	4.7	4.2
Outlays	5.0	9.5	11.7	12.8
Estimated Contingency Margin b/ (in percent)	83	56	40	33
Contingency Margin Estimated in June 1988 b/ (in percent)	24	29	32	31

SOURCE: Congressional Budget Office, July 1989.

NOTE: n.a. = not applicable.

a. Balances reflect payment of estimated administrative expenses.

b. Contingency margins are defined as the balance at the end of the year over outlays during the same year.

TABLE 4. COST-SHARING PROVISIONS OF THE CATASTROPHIC DRUG INSURANCE PROGRAM AND THEIR EFFECTS ON ENROLLEES (By calendar year)

	1991	1992	1993
Cost-Sharing Provisions			
Deductible Per Year a/ (in dollars)	600	652	1,092
Coinsurance Rate b/ (in percent)	50	40	20
Effects on Enrollees			
Medicare Beneficiaries (in millions)	33.7	34.3	35.0
Enrollees Exceeding Deductible (in millions)	8.8	9.1	5.9
(in percent)	26.0	26.7	16.8

SOURCE: Public Law 100-360 and Congressional Budget Office estimates, July 1989.

a. In 1991 and 1992, the deductible is fixed by law at $600 and $652, respectively. For 1993 and after, the deductible is to be set by the Secretary of Health and Human Services (HHS) so that 16.8 percent of Medicare enrollees will exceed the deductible.

b. In 1991 and 1992, the coinsurance rate is fixed by law at 50 percent and 40 percent, respectively. For 1993 and after, it is set at 20 percent unless the Secretary of HHS raises it in order to ensure that financing will be sufficient to pay benefits.

APPENDIX TABLE — OUTLAYS, RECEIPTS, AND THE NET EFFECT ON MEDICARE OF THE HOSPITAL INSURANCE (HI), SUPPLEMENTARY MEDICAL INSURANCE (SMI), AND CATASTROPHIC DRUG INSURANCE (CDI) PROVISIONS OF THE MEDICARE CATASTROPHIC COVERAGE ACT (By fiscal year, in billions of dollars)

	1990	1991	1992	1993	Four-Year Total
Outlays					
June 1988	4.2	6.7	8.4	10.1	29.4
February 1989	4.2	6.8	8.7	10.5	30.1
July 1989	4.1	7.9	11.0	12.5	35.5
Receipts					
June 1988	6.1	7.6	9.2	10.6	33.6
February 1989	7.3	8.8	10.3	11.5	37.8
July 1989	8.3	9.9	10.4	11.7	40.3
Net Effect on Medicare a/					
June 1988	-1.8	-1.0	-0.8	-0.5	-4.1
February 1989	-3.1	-2.0	-1.6	-1.0	-7.8
July 1989	-4.2	-2.0	0.6	0.8	-4.8

SOURCE: Congressional Budget Office, July 1989.

NOTE: Details may not add to totals because of rounding.

a. Outlays less receipts. Note that these amounts do not represent the effect on the federal budget deficit because they do not take into account offsetting changes in outlays for other programs such as Medicaid.