BACKGROUND INFORMATION ON OUT-OF-POCKET COSTS UNDER MEDICARE

Congressional Budget Office

March 18, 1987

This material was prepared by Sandra Christensen and Stephen H. Long, based on 1985 Medicare claims data. Baseline projections for Medicare spending through 1992 were provided by Hinda Ripps Chaikind, Holly Harvey, and Don Muse. Roald Euller's expert programming support was invaluable. Questions should be directed to Sandra Christensen (226-2665).

FACT SHEET 1

MEDICARE'S CURRENT COPAYMENT STRUCTURE:

UNDER PART A (HI):

- o First-day deductible of $520 (in 1987) paid for each hospital spell of illness (indexed to PPS update factor)
- o Hospital coverage limited to 90 days per spell of illness, plus an additional 60 lifetime reserve days
- o Coinsurance of $130 a day paid for days 61-90 per spell of illness
- o Coinsurance of $260 a day paid for each lifetime reserve day
- o Nursing home coverage limited to 100 days per spell of illness
- o Coinsurance of $65 a day paid for nursing home days 21-100
- o Small coinsurance requirements for certain home health and hospice benefits.

UNDER PART B (SMI):

- o Initial deductible of $75
- o 20 percent coinsurance on reasonable charges above the deductible

SOURCE: Congressional Budget Office.

FACT SHEET 2

DURING CALENDAR YEAR 1988, MEDICARE ENROLLEES WILL BE LIABLE FOR AN ESTIMATED $498 IN DEDUCTIBLE AND COINSURANCE AMOUNTS FOR MEDICARE-COVERED SERVICES, ON AVERAGE. ENROLLEES WILL PAY ANOTHER $264 IN MEDICARE PREMIUMS (FOR PART B, OR SMI, COVERAGE). COPAYMENT AND PREMIUM COSTS, TOGETHER, WILL REPRESENT ABOUT 6 PERCENT OF AVERAGE INCOME PER AGED MEDICARE ENROLLEE.

MORE THAN HALF OF MEDICARE COPAYMENTS WILL BE FOR PHYSICIANS' SERVICES. ANOTHER THIRD WILL BE FOR HOSPITAL INPATIENT CARE.

	Medicare Copayments (1988)	
	Dollars per Enrollee	Percent of Total
Total Medicare	498	100.0
Hospital Insurance		
Inpatient Stays	161	32.4
Other	9	1.8
Total HI	170	34.2
Supplementary Medical Insurance		
Physicians/Suppliers	255	51.1
Outpatient Departments	73	14.7
Total SMI	328	65.8

SOURCE: Congressional Budget Office.

NOTE: The costs shown here represent enrollees' liabilities. Amounts paid by enrollees may be less because some enrollees' liabilities are paid by Medicaid, or because some liabilities are not paid at all.

FACT SHEET 3

MEDICARE COPAYMENT COSTS ARE VERY UNEVENLY DISTRIBUTED ACROSS ENROLLEES, THOUGH, SO THAT THE AVERAGE AMOUNT OF $498 IS NOT REPRESENTATIVE FOR MOST ENROLLEES.

FOR EXAMPLE, NEARLY 27 PERCENT OF MEDICARE ENROLLEES WILL USE NO REIMBURSABLE SERVICES, AND WILL PAY NO MORE THAN THE $75 SMI DEDUCTIBLE IN COPAYMENT COSTS.

AT THE OTHER EXTREME, ABOUT 0.5 PERCENT OF MEDICARE ENROLLEES (157,000 PEOPLE WITH LONG HOSPITAL STAYS) WILL INCUR $7,619 IN COPAYMENT COSTS, ON AVERAGE, DURING 1988.

Enrollee Group	Percent of Enrollees in Group	Medicare Copayments (1988) Dollars per Enrollee	Medicare Copayments (1988) Percent of Total
All Enrollees	100.0	498	100.0
No Reimbursable Services	26.8	26	1.4
Reimbursable Services, With			
No inpatient stays	50.7	264	26.9
One stay	15.0	1,165	35.0
Two or more stays	7.1	2,053	29.2
One or more stays, with coinsurance days	0.5	7,619	7.5

LESS THAN 26 PERCENT OF MEDICARE ENROLLEES PAY THESE CO-PAYMENT COSTS OUT-OF-POCKET.

MORE THAN 9 PERCENT OF MEDICARE ENROLLEES ARE DUALLY ELIGIBLE FOR MEDICAID, WHICH PAYS COPAYMENT AND PREMIUM COSTS UNDER MEDICARE.

ABOUT 65 PERCENT OF MEDICARE ENROLLEES PURCHASE PRIVATE SUPPLEMENTARY INSURANCE--OR MEDIGAP--WHICH COVERS MOST OF THEIR COPAYMENT COSTS UNDER MEDICARE. THE AVERAGE MEDIGAP PREMIUM IN 1988 WILL BE AN ESTIMATED $598 ANNUALLY, OR $49.80 MONTHLY.

SOURCE: Congressional Budget Office.

NOTE: The costs shown here represent enrollees' liabilities. Amounts paid by enrollees may be less because some enrollees' liabilities are paid by Medicaid, or because some liabilities are not paid at all.

FACT SHEET 4

BOWEN PROPOSAL

COPAYMENT STRUCTURE UNDER PART A (HI):

- o First-day deductible of $520 (increased by PPS update factor) paid for each hospital stay up to two a year
- o No limit on covered hospital days
- o No hospital coinsurance
- o No coinsurance on nursing home stays
- o Nursing home coverage limited to post-hospital acute care, up to 100 days a year

COPAYMENT STRUCTURE UNDER PART B (SMI):

- o Initial deductible of $75
- o 20 percent coinsurance on reasonable charges above the deductible
- o Limit on each enrollee's annual liability for copayments under HI and SMI combined set at $2,000 in 1988, indexed to rate of program growth

FINANCING MECHANISM:

- o Additional premium under Part B

EFFECTS OF IMPLEMENTING THE BOWEN PROPOSAL

Calendar Years	1988	1989	1990
Per-enrollee cost to Medicare a/	73	81	87
Enrollees affected by cap			
Number (in thousands)	1,650	1,750	1,680
Percent	5.2	5.4	5.1
Average per-enrollee copayment			
Under proposal	432	467	512
Current law	498	542	591

SOURCE: Congressional Budget Office, preliminary estimates.

a. Amount to be financed through premiums or taxes.

FACT SHEET 5

STARK-GRADISON PROPOSAL:

COPAYMENT STRUCTURE UNDER PART A (HI):

- o First-day deductible of $520 (increased by COLA) paid for first hospital stay each year
- o No limit on covered hospital days
- o No hospital coinsurance
- o Coinsurance on nursing home stays of 20 percent of national average daily cost for first seven days each stay
- o Nursing home coverage limited to post-hospital acute care, up to 150 days a year
- o Lifetime limit of 210 days for hospice benefits eliminated
- o Blood deductibles reduced to three pints a year

COPAYMENT STRUCTURE UNDER PART B (SMI)

- o Initial deductible of $75
- o 20 percent coinsurance on reasonable charges above the deductible
- o Limit on each enrollee's annual liability for copayments under SMI set at $1,000 in 1988, indexed to COLA

FINANCING MECHANISM

- o Tax on the actuarial value of Medicare benefits

EFFECTS OF IMPLEMENTING THE STARK-GRADISON PROPOSAL

	1988	1989	1990
Per-enrollee cost to Medicare a/	139	154	180
Enrollees affected by cap			
Number (in thousands)	2,480	2,720	3,000
Percent	7.8	8.4	9.1
Average per-enrollee copayment			
Under proposal	371	400	427
Current law	498	542	591

SOURCE: Congressional Budget Office.

a. Amount to be financed through premiums or taxes.

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 31, 1987

1. BILL NUMBER: H.R. 1281

2. BILL TITLE:

   The Medicare Part B Catastrophic Protection Act of 1987.

3. BILL STATUS:

   As introduced on February 26, 1987.

4. BILL PURPOSE:

   To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under Part B of the Medicare program.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

	(By fiscal years, in millions of dollars)				
	1988	1989	1990	1991	1992
Direct Spending/ Offsetting Receipts					
Benefits from the Cap on Copayments					
Budget Authority	2,030	3,140	3,780	4,500	5,350
Outlays	1,710	2,930	3,620	4,310	5,130
Adjustment to SMI Premium					
Budget Authority	-380	-530	-565	-600	-640
Outlays	-380	-530	-565	-600	-640
Effects on Federal Medicaid Costs					
Budget Authority	-120	-215	-270	-325	-390
Outlays	-120	-215	-270	-325	-390
Amounts Subject to Appropriations					
Administrative Costs					
Budget Authority	0	0	0	0	0
Outlays	60	20	20	20	20
TOTAL BUDGET AUTHORITY	1,530	2,395	2,945	3,575	4,320
TOTAL OUTLAYS	1,270	2,205	2,805	3,405	4,120

Note: Components may not sum to total due to rounding.

The costs of this bill fall within function 570 and function 550.

BASIS OF ESTIMATE:

Part B of Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount. This bill would alter copayment requirements under Part B of Medicare by capping each enrollee's annual liability for copayments, first effective for calendar year 1988.

The additional benefits provided under this bill (and under the companion bill H.R. 1280) would be financed by imposing a tax on the actuarial value of Medicare benefits. Since the financing provision appears only in H.R. 1280, its effects are not shown in this estimate. The components of the estimate are explained in more detail below.

Direct Spending; Cap on Copayment Costs

Under Section 2 of the bill, each SMI enrollee's liability for copayments under the program would be limited to $1,000 in 1988. In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the SMI copayment cap would be $1,185 in 1992.

Estimates of the costs to Medicare from this new benefit were derived by simulating the effects of the proposed copayment cap on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline assumptions for SMI enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed cap to obtain the estimated costs of the benefit expansion.

Under current law, SMI reimbursements per enrollee are projected to increase by about 11.4 percent annually between 1987 and 1992. Under this bill, SMI reimbursements per enrollee would increase by an estimated 13.5 percent annually over the same period. About 86 percent of the additional costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 14 percent of estimated costs would be due to increased use of Medicare-covered services by enrollees affected by the cap. The utilization response assumed in the estimate was based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

About 8 percent (or 2.5 million) of SMI enrollees would be affected by the copayment cap in 1988. As a result, Medicare costs would increase by $1.7 billion in fiscal year 1988. By 1992, more than 10 percent of enrollees would be affected by the copayment cap, at a cost to Medicare of $5.1 billion during the fiscal year.

Offsetting Receipts: SMI Premium Increases

Under this bill, as under current law, the SMI premium would automatically increase to offset a portion of any increased benefits paid under Part B of Medicare. The SMI premium increase resulting from the copayment cap would finance nearly 25 percent of the new benefit costs for calendar year 1988, but the proportion of benefit costs financed by the SMI premium would be less than 20 percent by 1992 due to the limitation on premium increases that will become effective in 1989. (Under current law, the percentage increase in SMI premiums for 1989 and later years may not exceed the rate at which Social Security benefits are adjusted each year to offset cost-of-living increases, as measured by the change in the third-quarter Consumer Price Index.)

Direct Spending: Federal Medicaid Savings

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for dually-eligible enrollees, partially offset by increased Medicaid costs for the higher SMI premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $120 million in fiscal year 1988.

Amounts Subject to Appropriations; Administrative Costs

Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap proposed in this bill, comprehensive information about both deductible and coinsurance amounts paid under Part B would have to be compiled across all Medicare carriers for each SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

6. ESTIMATED SAVINGS TO STATE AND LOCAL GOVERNMENTS

This bill would have an effect on state and local government budgets, since states share in the financing of Medicaid—paying about 45 percent of outlays. CBO estimates the following effects:

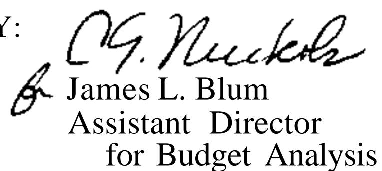
	(By fiscal years, in millions of dollars)				
	1988	1989	1990	1991	1992
Effects on State Medicaid Costs	-100	-175	-220	-265	-320

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE: None.

9. ESTIMATE PREPARED BY: Sandra Christensen (226-2665)
Holly Harvey (226-2820)

10. ESTIMATE APPROVED BY:



James L. Blum
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CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 2, 1987

1. BILL NUMBER: H.R. 1280

2. BILL TITLE:

The Medicare Part A Catastrophic Protection Act of 1987.

3. BILL STATUS:

As introduced on February 26, 1987.

4. BILL PURPOSE:

The amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under Part A of the Medicare program.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(By fiscal years, in millions of dollars)	1988	1989	1990	1991	1992
DIRECT SPENDING/OFF-SETTING RECEIPTS					
Section 2 Provisions					
Eliminating the limit on covered hospital days					
Budget Authority	-10	-30	-60	-90	-130
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days					
Budget Authority	-15	-50	-95	-150	-210
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first-stay each year					
Budget Authority	-20	-60	-110	-160	-220
Outlays	395	530	550	595	655

	(By fiscal years, in millions of dolkrs)				
	1988	1989	1990	1991	1992
Indexing the first-stay hospital deductible amount to the COLA					
Budget Authority	*	-5	-15	-35	-65
Outlays	10	75	175	290	410
Changing the calculation of the Part A premium					
Budget Authority	15	25	25	25	25
Outlays	15	25	25	25	25
Effect on Trust Fund from Change in Part A Premium					
Budget Authority	-16	-27	-30	-30	-35
Outlays	0	0	0	0	0
Section 3 Provisions					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year					
Budget Authority	-10	-30	-55	-85	-120
Outlays	170	275	315	350	385
Section 4 Provisions					
Eliminating the 210 day limit on hospice benefits					
Budget Authority	*	*	*	*	*
Outlays	*	1	1	1	1
Section 5 Provisions					
Changing blood deductible requirements from 3 per spell to 3 a year					
Budget Authority	*	-1	-2	-5	-5
Outlays	5	8	10	10	11
Spending Under Medicaid					
Effects on federal Medicaid costs					
Budget Authority	-85	-140	-160	-185	-210
Outlays	-85	-140	-160	-185	-210

	(By fiscal years, in millions of dollars)				
	1988	1989	1990	1991	1992
REVENUES					
Section 6 Provisions					
Taxing a portion of Medicare's insurance value 1/					
Budget Authority	1,465	5,245	6,410	7,750	9,280
Revenues	1,400	4,900	5,600	6,400	7,300
TOTAL					
BUDGET AUTHORITY	1,324	4,927	5,908	7,035	8,310
OUTLAYS	990	1,565	1,815	2,090	2,375
REVENUES	1,400	4,900	5,600	6,400	7,300
CHANGE IN DEFICIT	-410	-3,335	-3,785	-4,310	-4,925

NOTE: Components may not sum to total due to rounding.

* Less than $0.5 million.

The effects of this bill fall within function 570 and function 550.

1. These revenue estimates are from the Joint Committee on Taxation. They are based on current law benefits under Part B of Medicare (SMI) and proposed Part A (HI) benefits as they would be under H.R. 1280. In a companion bill (H.R. 1281), the Committee has also proposed to expand Part B benefits, though. The total Medicare tax revenues that would be collected each year if H.R. 1280 also became law are shown below:

	(By fiscal years, in millions of dollars)				
	1988	1989	1990	1991	1992
Taxing a portion of Medicare's insurance value					
Budget Authority	1,570	5,465	6,750	8,120	9,780
Revenues	1,500	5,100	5,900	6,700	7,700

BASIS OF ESTIMATE:

Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). This bill would change the HI copayment requirements, effective January 1, 1988, with the result that Medicare's reimbursement costs would increase. It would also change the way in which the HI premium is calculated, which would affect only those enrollees not already entitled to HI benefits through previous payroll tax contributions. The additional benefits provided under this bill (and under the companion bill H.R. 1281) would be financed by imposing a tax on the actuarial value of Medicare benefits.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for HI enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

About 97 percent of the costs of the new benefits in the bill would result from reducing enrollees' copayment costs; the remaining 3 percent would result from increased use of services by enrollees. Because of controls on use imposed by Medicare's fiscal intermediaries and Peer Review Organizations, most of the increased use of services in the estimates occurred as a result of changes in coverage limits (for SNF stays and for hospice benefits) specified in the bill.

Under current law, HI reimbursements per enrollee are projected to increase by about 8 percent annually between 1987 and 1992. Under this bill, HI reimbursements per enrollee would increase by an estimated 9 percent annually over the same period.

The revenue estimates were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below.

Section 2 Provisions

Section 2 of the bill contains five provisions, discussed in turn below. The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt--that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days. Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care. Only a fraction of a percent of enrollees (fewer than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs for Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days. Under current law, enrollees pay one-fourth of the first-day hospital deductible amount for days 61-90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees use coinsurance or reserve days each year, accounting for an estimated 2.3 million coinsurance days and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year. Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital in a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains a hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another

deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Indexing the first-stay hospital deductible to the COLA. Under current law, the first-day deductible is tied to increases in the index used to update payment rates under the prospective payment system. Under this bill, the deductible would instead be tied to increases in the (third-quarter) consumer price index (the Social Security COLA). This would slow the rate of growth in the deductible, because the update factor is projected to increase by 35 percent from 1987 to 1992, while the COLA will increase by only 23 percent over the same period. In 1988, the deductible would be $544 under current law, but would be $541 if indexed to the COLA instead. By 1992, the deductible would increase to $700 under current law, but would be only $641 if indexed to the COLA. The additional costs to Medicare of this provision (after implementing all of the inpatient copayment provisions discussed above, as well as the SNF copayment provision discussed below) would be $10 million in fiscal year 1988. The costs of this provision would be higher if current law copayment requirements for hospital and SNF stays were unchanged.

Changing the calculation of the Part A premium. Under current law, the premium charged to HI enrollees who are not entitled to benefits through previous payroll tax contributions is based on the first-day deductible amount. Under this bill, the method of determining the premium would be changed so that it would reflect the actuarial value of HI benefits. This would reduce the projected monthly premium amount for 1988 from $236 to $155, affecting about 23,000 enrollees. The costs to Medicare from this provision in fiscal year 1988 would be about $15 million.

Section 3 Provisions

Section 3 of the bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital deductible amount ($68 per day in 1988) are charged each day for days 21-100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 20 percent of Medicare's national average reasonable cost for the first seven days of each SNF stay; enrollees' coinsurance costs would be $23.50 per day in 1988 for each of the first seven days of each SNF stay.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $170 million in fiscal year 1988. About 80 percent of the costs would be

due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Section 4 Provisions

Section 4 of the bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospice benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small cost due to this provision, equal to about $0.4 million in fiscal year 1988.

Section 5 Provisions

Under current law, enrollees are required to replace or pay for the first 3 pints of blood used each spell of illness. Section 5 of the bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 than they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Federal Medicaid Savings

Some Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays their Medicare copayment liabilities. Consequently, HI benefit changes that would reduce enrollees' copayment costs would result in federal savings through the Medicaid program, which would incur lower costs for dually-eligible beneficiaries. Further, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Federal savings under the Medicaid program would be about $85 million in fiscal year 1988.

Section 6 Provisions

Under Section 6 of the bill, a portion of Medicare's insurance value would be included in enrollees' gross incomes beginning in 1988,

increasing income tax liability for some Medicare enrollees. Half of the insurance value of HI benefits, and that portion of the insurance value of SMI benefits that was financed from general revenues, would be added to each Medicare enrollee's gross income for each enrolled month during the calendar year. Revenues collected as a result of these additions to gross income would be transferred to the Hospital Insurance Trust Fund quarterly, or more often, as appropriate.

The revenue estimates shown in the table ($1.4 billion in fiscal year 1988) reflect the higher HI insurance values that would result under this bill, but reflect SMI insurance values under current law. If H.R. 1281 were passed along with H.R. 1280 (as the Committee envisions), the revenues collected from the Medicare tax provisions of this bill would be higher than shown in the table because of higher insurance values for SMI. The higher revenue estimates ($1.5 billion in fiscal year 1988) are shown in footnote 1.

6. ESTIMATED SAVINGS TO STATE AND LOCAL GOVERNMENTS:

This bill would have an effect on state and local government budgets, since states share in the financing of Medicaid—paying about 45 percent of outlays. CBO estimates the following effects:

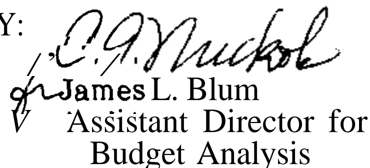
	(By fiscal years, in millions of dollars)				
	1988	1989	1990	1991	1992
Effects on state/local Medicaid costs	-70	-115	-130	-150	-170

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE: None.

ESTIMATE PREPARED BY: Sandra Christensen (226-2665)
Hinda Ripps Chaikind (226-2820)
Rick Kasten (226-2689)

10. ESTIMATE APPROVED BY:



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