RESTRUCTURING HEALTH INSURANCE FOR MEDICARE ENROLLEES

The Congress of the United States
Congressional Budget Office

NOTES

Throughout this study, spending figures are incurred values--that is, amounts payable for all services provided during the period examined. Unless otherwise specified, all years are calendar years.

See the glossary at the end of the paper for definitions of terms.

Also see the inside back cover for a list of Congressional Budget Office publications on health-related topics.

PREFACE

This report--requested by the late Senator John Heinz for the Senate Special Committee on Aging--examines a number of options by which Medicare's benefit structure could be enriched without increasing federal costs or enrollees' premiums. The primary focus is on two benefit improvements--a ceiling on enrollees' copayment liabilities and coverage for their prescription drug costs. In keeping with the Congressional Budget Office's (CBO) mandate to provide nonpartisan analysis, the report includes no recommendations.

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By itself, Medicare gives less protection against large out-of-pocket costs for acute health care needs than employment-based private health insurance plans typically provide. Its protection is less because Medicare does not cover prescription drugs and does not cap the copayment costs for which enrollees are liable on covered services. If Medicare were the only health insurance for enrollees, from 17 percent to 28 percent of them would face catastrophic out-of-pocket costs for acute care in 1991 (Summary Table 1). The lower figure would be appropriate if costs of $2,000 or more are defined as catastrophic; the higher figure would be appropriate if costs greater than 10 percent of per capita income are defined as catastrophic.

In fact, however, nearly 80 percent of enrollees have additional coverage to supplement Medicare. About 30 percent of Medicare enrollees have employment-based retiree health benefits, which generally provide coverage for prescription drugs and limit copayment costs. Another 31 percent purchase individual medigap policies, which usually cover nearly all of Medicare's copayment requirements but not prescription drug costs. Nearly 9 percent of enrollees are eligible for limited or "qualified" benefits under Medicaid, which means that Medicaid will pay their Medicare premiums and copayments, but not prescription drug costs. Another 9 percent receive full Medicaid benefits, so that virtually all of their health care costs are covered.

Because of this supplementary coverage, the risk of catastrophic out-of-pocket costs for Medicare enrollees is greatly reduced. Fewer than 6 percent of enrollees will actually incur out-of-pocket expenses for acute care of $2,000 or more in 1991, and 14 percent will have out-of-pocket costs that exceed 10 percent of their per capita income.

More than 20 percent of enrollees lack supplementary insurance, however, and are at risk for large out-of-pocket costs both for Medicare-covered services and for prescription drugs. Another 40 percent

SUMMARY TABLE 1. ESTIMATED IMPACT OF SUPPLEMENTARY COVERAGE ON ENROLLEES' EXPENSES FOR ACUTE HEALTH CARE, 1991

	Overall	By Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Ignoring Benefits from and Premiums for Supplementary Coverage						
Enrollees' Expenses (Dollars)						
SMI Premiums	342	337	340	342	359	351
Other	1,153	1,079	1,137	1,180	1,098	1,323
Total	1,495	1,416	1,477	1,521	1,457	1,673
Percentage of Enrollees with Other Expenses Greater Than 10 Percent of Income	27.6	24.4	21.0	23.7	51.5	47.7
Percentage of Enrollees with Other Expenses of $2,000 or More	16.6	14.7	16.6	17.3	14.0	20.7
Including Benefits from and Premiums for Supplementary Coverage						
Enrollees' Expenses (Dollars)						
Premiums	631	337	815	1,006	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total	1,274	1,416	1,351	1,687	540	0
Percentage of Enrollees with Out-of-Pocket Expenses Greater Than 10 Percent of Income	14.1	24.4	7.9	12.3	31.7	0
Percentage of Enrollees with Out-of-Pocket Expenses of $2,000 or More	5.5	14.7	0	6.3	4.8	0

SOURCE: Congressional Budget Office simulations from the Medicare benefits model.

NOTES: Enrollees' expenses for acute health care include their premiums for Medicare and supplementary insurance, plus out-of-pocket costs for Medicare-covered services and for prescription drugs.

RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits; SMI = Supplementary Medical Insurance.

are at risk for potentially unlimited prescription drug costs because their supplementary coverage excludes them. Even those who currently have good coverage through retiree health plans are at risk of losing this protection because of rapidly rising health care costs. Employers are responding to higher expenses by shifting a larger share of health plan costs to their workers and retirees, or even by terminating their plans.

There is another problem associated with the mix of public and private insurance coverage Medicare enrollees currently have. Use of services by those with supplementary coverage (when it eliminates nearly all of Medicare's copayment requirements, as medigap policies and Medicaid do) is higher than it would otherwise be. As a result, Medicare's costs are higher because Medicare, not the supplementary insurer, pays most of the additional costs.

One way to ensure that all enrollees are protected against very large out-of-pocket expenses for acute care would be to establish a copayment cap and a prescription drug benefit under Medicare. The pay-as-you-go provisions of the Budget Enforcement Act would require financing these improvements in benefits either by reducing other direct spending or by increasing federal receipts.

This study examines options that would pay for improving Medicare benefits from the federal savings expected to result if the nearly first-dollar coverage medigap plans provide was prohibited. (First-dollar coverage eliminates all copayment requirements on insured services.) Although it is beyond the scope of this paper, federal savings--and hence Medicare benefits--could be further increased if retiree health plans were also prohibited or otherwise discouraged from providing first-dollar coverage. This objective might be accomplished, for example, by denying tax deductibility to plans that coordinate with Medicare in such as way as to eliminate enrollees' out-of-pocket costs. Use by Medicaid beneficiaries is also higher than it would be if they had to pay part of the costs, but eliminating health care expenses for poor enrollees is a public decision expressly intended to ensure their access to care.

The effects shown for the options examined here depend critically on an estimate of how the use of Medicare-covered services by medigap enrollees would change in response to changes in the share of costs they must pay out of pocket. One recent study indicates that use of services by medigap enrollees is an estimated 24 percent higher than it would be if they had only Medicare coverage, implying that eliminating medigap coverage would reduce their use of services by about 20 percent. This estimate, however, could be either too large or too small. If it is too large, then some of the options examined in this paper might add to net federal spending and to the budget deficit. If it is too small, federal savings would be larger than shown. In addition, the impact on enrollees would be different.

EXAMINING THE OPTIONS

Each of the options examined in this study would put in place a cap on Medicare's copayment requirements, and each would prohibit medigap plans from paying any part of enrollees' remaining copayment costs. The first set of options would leave Medicare's copayment structure unchanged except for the cap, while the second set would change the copayment structure. Within each set, the options differ depending on whether and how coverage for the costs of prescription drugs would be provided.

For each option (described in the Summary Box), the copayment cap was set as low as possible (in multiples of $100) without adding to net federal spending for Medicare enrollees under the Medicare and Medicaid programs combined. Medicare's premiums (which are set in law through 1995) would not change under any of the options examined. To avoid adding to federal spending in years after 1991, the caps specified in the options would have to be indexed to the rate of growth in average (precap) copayment costs under Medicare. With this index, the real value of the copayment cap would increase over time because the growth rate for average copayment costs under Medicare is expected to exceed the rate of general inflation.

SUMMARY BOX
Description of Alternative Options

Options That Would Leave Medicare's Copayment Structure Unchanged

Option 1. $1,500 copayment under Medicare.
No coverage for prescription costs.
No other change in Medicare's copayment structure.
Medigap prohibited from covering any of Medicare's copayment costs.

Option 2. $3,200 copayment cap under Medicare.
Prescription costs would count toward cap.
No other change in Medicare's copayment structure.
Medigap prohibited from covering any of Medicare's copayment costs.

Options That Would Change Medicare's Copayment Structure

Option 3. $1,000 copayment cap under Medicare.
No coverage for prescription costs.
New copayment structure:
- $200 deductible for Supplementary Medical Insurance (SMI).
- 20 percent coinsurance rate on all services except outpatient psychiatric care.
- 50 percent coinsurance rate on outpatient psychiatric care.
- Covered stays in a skilled nursing facility (SNF) limited to 100 days a year.
- No Medicare payments for enrollees' bad debts.

Medigap prohibited from covering any of Medicare's copayment costs.

Option 4. $2,200 copayment cap under Medicare.
Prescription costs would count toward cap.
New copayment structure:
- $200 SMI deductible.
- 20 percent coinsurance on all services except outpatient psychiatric care.
- 50 percent coinsurance rate on outpatient psychiatric care.
- Covered SNF stays limited to 100 days a year.
- No Medicare payments for enrollees' bad debts.

Medigap prohibited from covering any of Medicare's copayment costs.

Option 5. $2,400 copayment cap under Medicare.
Standard coverage for prescription costs.
New copayment structure:
- $500 SMI deductible.
- 25 percent coinsurance rate on all services except outpatient psychiatric care.
- 50 percent coinsurance rate on outpatient psychiatric care.
- Covered SNF stays limited to 100 days a year.
- No Medicare payments for enrollees' bad debts.

Medigap prohibited from covering any of Medicare's copayment costs.

SOURCE: Congressional Budget Office.

COMPARING THE OPTIONS

None of the options examined here would increase total federal spending or significantly change federal spending for Medicare, but they would differ in their effects on Medicaid costs (Summary Table 2). Medicaid spending for the acute care costs of Medicare enrollees would fall by about 15 percent under the options that would provide no cov-

SUMMARY TABLE 2. ESTIMATED CHANGES IN FEDERAL COSTS, EMPLOYERS' RETIREE HEALTH PLAN COSTS, AND ENROLLEES' EXPENSES UNDER ALTERNATIVE OPTIONS, 1991

Option	Percentage Change in Net Federal Costs For:[a] Medicare	Medicaid	Total	Overall Percentage Change in Employers' Health Plan Expenses[b]
Cap Medicare's Copayments and Prohibit Medigap Coverage of Copayments				
1. $1,500 Cap, No Rx Benefit	0.5	-13.7	0	-25.5
2. $3,200 Cap, Rx Costs Count	-0.2	5.7	0	-24.8
Restructure and Cap Medicare's Copayments and Prohibit Medigap Coverage of Copayments				
3. $1,000 Cap, No Rx Benefit	0.4	-15.0	-0.2	-27.3
4. $2,200 Cap, Rx Costs Count	-0.8	4.1	-0.6	-30.4
5. $2,400 Cap, Full Rx Benefit	-0.6	2.2	-0.5	-35.5

(Continued)

SOURCE: Congressional Budget Office simulations from the Medicare benefits model.

NOTES: Enrollees' expenses for acute health care include their premiums for Medicare and supplementary coverage plus out-of-pocket costs for Medicare-covered services and for prescription (Rx) drugs.

erage for prescription drugs, because Medicare would assume a larger share of health care costs for dually eligible enrollees. Medicaid costs would increase--by 2 percent to 6 percent--under the options that would provide some coverage for prescription drugs, given the assumption that Medicaid benefits for qualified beneficiaries would then be expanded to include prescription drug costs.

SUMMARY TABLE 2. Continued

Option	Financial Effects on Enrollees				
	Percentage Change in Enrollees' Expenses	Gainers		Losers	
		Percentage of Enrollees	Average Gain (Dollars)	Percentage of Enrollees	Average Loss (Dollars)
Cap Medicare's Copayments and Prohibit Medigap Coverage of Copayments					
1. $1,500 Cap, No Rx Benefit	-14.3	27.6	719	4.8	515
2. $3,200 Cap, Rx Costs Count	-17.7	33.4	756	4.6	803
Restructure and Cap Medicare's Copayments and Prohibit Medigap Coverage of Copayments					
3. $1,000 Cap, No Rx Benefit	-14.9	30.1	683	20.2	107
4. $2,200 Cap, Rx Costs Count	-18.5	34.6	797	21.1	218
5. $2,400 Cap, Full Rx Benefit	-20.2	40.5	760	18.6	305

NOTES: Continued

a. The percentage change in federal costs for Medicaid is relative to current federal spending under Medicaid for Medicare enrollees' acute care expenses (including Medicare premiums).

b. Relative to current spending by employers for Medicare enrollees' acute care costs.

All of the options would reduce employers' spending for health benefits. Employers' costs for health benefits provided to retirees enrolled in Medicare would fall by 25 percent to 35 percent, as Medicare would assume a larger share of health care costs for those with retiree health benefits.

The options would differ significantly in their effects on enrollees. Enrollees' aggregate expenses would fall by 14 percent to 20 percent, with the larger drop occurring under the options that would provide some coverage for prescription drugs. Despite the overall reduction, some enrollees would face higher expenses. Under the first two options, which would leave Medicare's copayment structure unchanged, fewer than 5 percent of enrollees would face higher expenses. Four times as many enrollees--up to 21 percent--would face higher expenses under the last three options, which would change Medicare's copayment structure, although the increase would be small for most of them.

The effects of the alternative options can be compared by looking at the effects on enrollees grouped by the type of coverage they have to supplement Medicare (Summary Table 3). Under the first two options, the only enrollees at risk for higher expenses would be those who now have medigap plans, while those without supplementary coverage would unequivocally gain, as would those with limited Medicaid benefits if coverage for prescription drugs was provided. By contrast, all enrollees but those receiving full or qualified Medicaid benefits would be at risk for some increase in expenses under the last three options, as a result of the higher deductible and new coinsurance requirements that would be put in place.

Enrollees Without Supplementary Coverage

Enrollees without supplementary coverage would be the primary beneficiaries of the options examined, because their unlimited risk for both Medicare copayments and prescription drug costs would be reduced. Average expenses for this group would fall by 10 percent to 18 percent.

Under the first set of options, all enrollees in this group would either gain or be unaffected. Under the second set of options, up to half

of this group might face higher expenses because of the higher SMI deductible and the new copayment requirements on services currently without them, although the average increase would be relatively small. The copayment cap would determine the maximum potential increase in expenses under the second set of options, but the maximum increase would be incurred only in rare instances. For example, an enrollee currently using extensive home health services (which now have no copayment requirements) would pay 20 percent of the costs up to a ceiling of $1,000 under Option 3, $2,200 under Option 4, and $2,400 under Option 5.

Enrollees with Retiree Health Plans

The first set of options would have no effect at all on enrollees with retiree health plans, although their former employers' costs would fall. These enrollees would see their average expenses increase slightly under the second set of options, however. Among the 16 percent of enrollees who would face higher expenses under the second set of options, the average increase would be small (less then $85). The maximum potential increase in expenses would be set by the minimum copayment cap facing this group of enrollees--either Medicare's cap or the cap set by the retiree health plan (assumed here to be $1,500).

Nearly 4 percent would gain by an average of $242 under Option 3 because Medicare's copayment cap of $1,000 would be lower than the retiree health plan cap. Nearly 5 percent would gain by an average of $5 under Option 5, under the assumption that Medicare could negotiate a discount on prescription drugs for all Medicare enrollees if prescriptions were covered as a standard benefit.

Medigap Enrollees

Under all options examined here, average expenses for medigap enrollees would fall by about 30 percent because savings on medigap premiums would exceed the overall increase in their out-of-pocket costs. From 82 percent to 85 percent of these enrollees would see their ex-

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SUMMARY TABLE 3. ESTIMATED CHANGES IN ENROLLEES' EXPENSES UNDER ALTERNATIVE OPTIONS, BY TYPE OF SUPPLEMENTARY COVERAGE, 1991

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Cap Medicare's Copayments and Prohibit Medigap Coverage of Copayments						
Option 1. $1,500 Cap, No Prescription Benefit						
Percentage Change in Expenses	-14.3	-10.3	0	-29.1	0	0
Enrollees Who Would Gain						
Percentage of enrollees	27.6	8.1	0	84.3	0	0
Gain (Dollars)						
Average	719	1,768	0	652	0	0
Maximum	UL	UL	0	664	0	0
Enrollees Who Would Lose						
Percentage of enrollees	4.8	0	0	15.5	0	0
Loss (Dollars)						
Average	515	0	0	515	0	0
Maximum	736	0	0	736	0	0
Option 2. $3,200 Cap, Prescription Costs Count						
Percentage Change in Expenses	-17.7	-10.4	0	-28.5	-100.0	0
Enrollees Who Would Gain						
Percentage of enrollees	33.4	5.7	0	84.7	71.2	0
Gain (Dollars)						
Average	756	2,518	0	679	749	0
Maximum	UL	UL	0	UL	UL	0
Enrollees Who Would Lose						
Percentage of enrollees	4.6	0	0	15.1	0	0
Loss (Dollars)						
Average	803	0	0	803	0	0
Maximum	2,436	0	0	2,436	0	0

(Continued)

SOURCE: Congressional Budget Office simulations from Medicare benefits medel.

NOTES: Enrollees' expenses for acute health care include their premiums for Medicare and supplementary coverage plus out-of-pocket costs for Medicare-covered services and for prescription drugs.

RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits; UL = unlimited.

a. Maximum loss could be larger for those enrolled only under the Hospital Insurance program, who would not be protected by the copayment cap.

SUMMARY TABLE 3. Continued

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Restructure and Cap Medicare's Copayments and Prohibit Medigap Coverage of Copayments						
Option 3. $1,000 Cap, No Prescription Benefit						
Percentage Change in Expenses	-14.9	-12.0	0.2	-29.7	0	0
Enrollees Who Would Gain						
Percentage of enrollees	30.1	14.9	3.8	83.8	0	0
Gain (Dollars)						
Average	683	1,373	242	622	0	0
Maximum	UL	UL	500	664	0	0
Enrollees Who Would Lose						
Percentage of enrollees	20.2	50.2	15.5	16.0	0	0
Loss (Dollars)						
Average	107	71	72	233	0	0
Maximum[a]	1,000	1,000	1,000	336	0	0
Option 4. $2,200 Cap, Prescription Costs Count						
Percentage Change in Expenses	-18.5	-14.1	1.0	-29.3	-100.0	0
Enrollees Who Would Gain						
Percentage of enrollees	34.6	13.0	0	83.4	71.2	0
Gain (Dollars)						
Average	797	1,899	0	694	749	0
Maximum	UL	UL	0	UL	UL	0
Enrollees Who Would Lose						
Percentage of enrollees	21.1	52.7	16.2	16.5	0	0
Loss (Dollars)						
Average	218	98	82	657	0	0
Maximum[a]	2,200	2,200	1,500	1,536	0	0
Option 5. $2,400 Cap, Full Prescription Benefit						
Percentage Change in Expenses	-20.2	-17.7	1.0	-31.3	-100.0	0
Enrollees Who Would Gain						
Percent of enrollees	40.5	36.3	4.7	82.2	71.2	0
Gain (Dollars)						
Average	760	861	5	774	749	0
Maximum	UL	UL	90	UL	UL	0
Enrollees Who Would Lose						
Percentage of enrollees	18.6	39.0	16.1	17.7	0	0
Loss (Dollars)						
Average	305	166	83	753	0	0
Maximum[a]	2,400	2,400	1,500	1,736	0	0

penses fall by $622 or more, on average. Another 15 percent to 18 percent would face higher expenses, averaging $233 or more. The options that would provide some coverage for prescription drugs would eliminate the unlimited financial risk medigap enrollees currently face. However, the maximum financial risk for these enrollees on Medicare-covered services would increase to the value of Medicare's copayment cap.

Qualified Medicaid Beneficiaries

Enrollees receiving qualified Medicaid benefits would be affected only by those options that would provide some coverage for prescription drugs. If affected, their expenses would be reduced because Medicare and Medicaid, in combination, would pay all their prescription drug costs.

Full Medicaid Beneficiaries

None of the options would affect enrollees receiving full Medicaid benefits directly, because Medicaid already assumes virtually all of their health care expenses that Medicare does not pay. All of the options would reduce state and federal Medicaid costs for these enrollees, however.

CONCLUSION

Under the general approach examined here, enrollees without any supplement to Medicare would typically gain, while those with medigap plans would lose their nearly first-dollar coverage for Medicare-covered services. Some medigap enrollees might conclude that they would be better off, while others would decide that they would be worse off, as explained below.

Because few people know in advance what their medical needs will be for the coming year, most medigap enrollees might assume that their experience under any given option would be similar to the aver-

age effect for all medigap enrollees. If that is how medigap enrollees responded, then all of them could expect to be at least as well-off financially as they are now under these options because average expenses for this group would fall. In fact, because their premium costs would fall by more than their out-of-pocket costs would increase, more than 80 percent of medigap enrollees would actually have lower expenses during the year under this approach.

All medigap enrollees would have to assume a higher level of financial risk for Medicare-covered services than they do now, however, offset by a reduction in risk for prescription drug costs under some options. Because of greater uncertainty about their expenses, some enrollees might object to the elimination of their option to purchase first-dollar coverage for acute care costs even if, at the end of the year, they found they were financially better off because of it. Objections by enrollees would be stronger the larger the amount of additional financial risk they would have to assume, which would depend on the value of the copayment cap established under Medicare and on whether prescription drug costs counted toward the cap. Further, up to 18 percent of medigap enrollees would actually incur higher expenses in any given year. Those with expensive chronic medical problems could be worse off year after year, especially under the options that would exclude any kind of coverage for prescription drugs. Finally, the drop in the use of services by medigap enrollees might not be limited to "unnecessary" care, so that adverse effects on their health could result.

CHAPTER I

INTRODUCTION

While most working-age people have private employment-based insurance, those who have retired from the workforce because of age or disability typically have public insurance through Medicare as their primary payer. Medicare was established in response to the difficulties its target population had in obtaining affordable insurance in the private market, and guaranteed availability is one of its primary advantages. In other important ways, however, Medicare may be less satisfactory than the insurance typically provided through employment-based plans.

The fundamental purpose of health insurance is to reduce the risk of incurring high out-of-pocket expenses (costs for care that the patient pays directly), and Medicare does this less effectively than most employment-based plans. It does so because Medicare's copayment (deductible and coinsurance) requirements are subject to no limit, and because Medicare provides no coverage for most prescription drugs or for long-term care--items that account for a significant portion of the health care needs of the elderly and disabled.[1] Employment-based plans do not usually cover long-term care either, but the non-Medicare population rarely needs such care. Employment-based plans typically do provide coverage for prescription drugs, and they usually eliminate copayment requirements once the patient's copayment costs reach a specified amount, currently around $1,500 a year.

Out-of-pocket expenses enrollees incur for acute care (defined here as Medicare-covered services and prescription drugs) can be so large that many enrollees apparently believe Medicare alone provides insufficient financial protection. Consequently, most enrollees obtain secondary insurance from other sources, thereby reducing their out-of-pocket expenses while generally increasing their insurance pre-

1. Medicare covers home health and nursing home services only for short-term acute care needs.

mium costs. Enrollees' total expenses for acute health care are the sum of their out-of-pocket and premium costs. About 30 percent of enrollees have retiree health benefits that typically cover prescription drugs and cap their copayment costs; another 31 percent purchase individual "medigap" policies that pay nearly all copayment costs for Medicare-covered services ("first-dollar" coverage); 9 percent are eligible to have Medicaid pay all their Medicare copayments and premiums ("qualified" benefits); and another 9 percent have full Medicaid coverage for virtually all their health care costs.

More than 20 percent of Medicare enrollees lack any kind of supplementary coverage, however, and are at risk for large out-of-pocket expenses both for Medicare-covered services and for prescription drugs. Another 40 percent are at risk for potentially unlimited prescription drug costs because they have supplementary coverage that excludes them.[2] Even those who currently have good protection through retiree health plans are at risk of losing it if health care costs, and hence insurance premiums, continue to increase more rapidly than income.

SCOPE OF THE PAPER

One way to ensure that all Medicare enrollees are protected against very large out-of-pocket expenses for acute care would be to put in place a copayment cap and a prescription drug benefit under Medicare.[3] If these changes were made, Medicare's benefit structure would more closely resemble the benefits that employment-based health plans typically provide. These changes, though, would add substan-

2. Qualified Medicaid benefits do not include prescription drugs, but full Medicaid benefits do. Fewer than 5 percent of medigap policyholders have coverage for prescription drugs, while about 95 percent of those with retiree health benefits have such coverage.

3. An alternative way to ensure that all Medicare enrollees are protected against large out-of-pocket costs would be to expand medigap coverage to the 21 percent of enrollees who currently are without a supplement to Medicare. If this expansion was accomplished by federal subsidy of medigap purchase, however, it would increase federal costs substantially. If expansion was accomplished by changing medigap requirements--reducing benefits to only a copayment cap, for example--so that premiums would fall and coverage would be more affordable, it is uncertain how much expansion would occur. The estimated price elasticity of demand for insurance is only about -.16 (M. Holmer, "Tax Policy and the Demand for Health Insurance," *Journal of Health Economics* (1984), pp. 203-221). Hence, even with a large reduction in annual medigap premiums (from $664 to $100, for example), fewer than 20 percent of those who currently lack a supplement would be induced to purchase one.

tially to federal spending. Under the pay-as-you-go provisions of the Budget Enforcement Act, the Congress could enact new Medicare benefits only if the additional costs were financed either by reducing other direct spending or by increasing federal receipts.

This study presents options that would enrich Medicare's benefits but that would require no new Medicare funding--either from taxes or from enrollee premiums. The analysis was limited in this way because the costs of improving Medicare are unlikely to be imposed on the non-Medicare population in the current fiscal environment--massive federal debt, reluctance to increase taxes, and concern that federal transfers are tilted too heavily toward the aged at the expense of other public needs. Moreover, new benefits funded by premium increases would probably generate significant resistance among the 30 percent of enrollees who have retiree health benefits. These enrollees would pay the higher premiums but they would typically not receive more benefits. Instead, expanding Medicare benefits would probably just reduce health plan costs for their former employers.[4]

The options presented in this paper would finance a cap on copayments and (under some variations) provide a prescription drug benefit under Medicare by using the federal savings that would result if medigap policies were prohibited from paying any of enrollees' copayment liabilities under Medicare. With this prohibition, and before any improvement in benefits under Medicare, federal spending for Medicare would fall by an estimated $7.4 billion for 1991. This drop would occur because medigap enrollees would use fewer services if they were required to pay a larger portion of Medicare's statutory copayment requirements out of pocket.

Although it is beyond the scope of this study, federal savings, and hence improvements in Medicare benefits, could be increased if retiree health plans were also prohibited or otherwise discouraged from providing first-dollar coverage. For example, tax deductibility could be

4. While a portion of the savings to employers might ultimately be reflected in the premiums retirees paid for their health plan benefits, enrollees' savings on health plan premiums would fall short of the increase in Medicare premiums because employers pay about two-thirds of retiree health plan costs on average. In addition, any savings that were passed on to beneficiaries would typically be spread over both active and retired workers, rather than focused entirely on Medicare enrollees.

denied to plans that coordinate with Medicare in such a way as to eliminate enrollees' out-of-pocket costs. Use by Medicaid beneficiaries is also higher than it would be if they paid part of their health care costs, but eliminating health care expenses for poor enrollees is a public decision intended to ensure their access to care.

The approach examined in this study would improve insurance protection for enrollees who currently lack any supplement to Medicare, at the expense of those who currently have medigap insurance. At the same time, most other enrollees would be largely unaffected. Medigap enrollees would face higher (but limited) out-of-pocket costs for Medicare-covered services, offset by a reduction in risk for prescription drug costs under some variations. Average expenses would fall for medigap enrollees because the savings on medigap premiums would exceed the increase in out-of-pocket costs for most of them. Nevertheless, a minority of medigap enrollees would face higher expenses in any given year. The adverse effects of this approach would be particularly focused on medigap enrollees with chronic conditions who incur large out-of-pocket expenses year after year, but who rarely have expenses large enough to exceed the copayment ceiling.

LIMITATIONS

The estimated effects of the options discussed in this paper depend critically on the extent to which use of services by Medicare enrollees would change in response to changes in the portion of their acute health care costs that they must pay out of pocket. The estimates assume that use of acute care services, and the cost of those services, would fall by 20 percent for medigap enrollees if medigap coverage of Medicare's copayment requirements was prohibited, before any expansion of Medicare's benefits. The estimates also assume that use of Medicare-covered services would change if enrollees' out-of-pocket costs were altered by changes in Medicare's copayment structure--for example, use would increase among those who gained from a copayment cap.

The behavioral assumptions incorporated into the estimates are based on the results of a regression analysis using data Medicare enrollees provided in a 1984 survey of health insurance and use of medical services. The study found that enrollees who had supplementary private insurance used 24 percent more physician and hospital services than did enrollees who were otherwise similar (controlling for age, sex, race, health status, education, income, and geographic location) but who had only Medicare coverage.[5] This result implies that eliminating supplementary private insurance would reduce use of services among enrollees who have it to about 80 percent of current levels, if no other changes were made in their insurance coverage.[6]

Although there is little doubt that average use of services by enrollees (at least in the fee-for-service sector) is higher the better their insurance coverage, the magnitude of that response is much less certain, as explained below. Because of this uncertainty, the estimates presented in this study of the effects on federal spending under alternative options should be viewed with caution. A sensitivity analysis--showing how the effects on federal spending would change if the estimated use response was too high or too low--is discussed for the first option presented in Chapter III.

Uncertainty of Regression Estimates

Changes in the use of services by enrollees in response to changes in the share of health care costs they must pay out of pocket are unlikely to be precisely measured by the point estimate produced by the regression analysis cited. Apart from the range of uncertainty that is associated with any statistical estimate, measurement problems in the study may have led to results that are biased. Potential biases exist in

5. Sandra Christensen, Stephen H. Long, and Jack Rodgers, "Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options," *Milbank Quarterly*, vol. 65, no. 3 (Fall 1987), pp. 397-425.

6. These results are consistent with findings for the non-Medicare population. An experimental study found that health care spending was 24 percent higher for those who received free care, compared with those who paid 25 percent coinsurance (to a ceiling of $1,000). (See Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (June 1987), pp. 251-277.)

both directions, so that the response incorporated into the estimates of the options may be either an overestimate or an underestimate.

At least three factors would tend to generate an overestimate of the increased use resulting from medigap coverage:

- *Enrollees' Selectivity Bias.* One potential problem is the possibility that those expecting to use many services are more likely to purchase insurance to supplement Medicare. Although regression controls for age, sex, race, health status, education, income, and location were introduced to minimize this problem, they were unlikely to be completely effective. Further, none of the measures used would control for some individuals' greater propensity to use medical services regardless of health status.

- *Reduced Scope for Use Response.* The regression study used data for calendar year 1984, when Medicare's prospective payment system (PPS) for hospital reimbursement was just being established. Because the average number of hospital days Medicare enrollees use dropped substantially during and for a few years after the start of the PPS, the potential for reducing use of services may be smaller now than it was at the time of the study.

- *Spending Effects May Be Smaller Than Effects on Use.* The data for the study had information only on use of hospital and physician services, not on spending for those services. The reduction in spending resulting from eliminating medigap insurance might be smaller than the drop in the number of physician visits and hospital days used. This kind of result would occur if, for example, patients delayed treatment in instances where delay would lead to costly complications.

Other factors, however, would tend to generate an underestimate of the increased use resulting from medigap coverage:

- *Insurers' Selectivity Bias.* Selectivity bias may also be exercised by insurers who refuse to cover applicants they expect

to incur high costs. This may be a relatively unimportant factor, because the two largest medigap insurers (Blue Cross and the plans offered by the American Association of Retired Persons) guarantee issue nationwide. It is noteworthy, however, that those with private supplementary insurance in the regression study reported better health status than those without a supplement.

- *Inability To Distinguish Between Medigap and Retiree Health Plans.* About half of Medicare enrollees who have private supplementary insurance have medigap plans that pay nearly all their copayment costs under Medicare. The other half have retiree health plans, which typically do not eliminate their copayment costs for Medicare-covered services. Instead, most retiree health plans impose the same benefit and copayment structure (with 15 percent to 25 percent coinsurance) on active and retired beneficiaries; they coordinate with Medicare by reducing health plan payments dollar-for-dollar of Medicare reimbursements. Hence, the increase in cost-sharing that would occur for medigap enrollees under the options examined in this study is greater than the average difference observed in the regression study between those with private supplementary insurance and those without any supplement. Consequently, the difference in use observed between these two groups in the regression study may well be smaller than the difference that would be observed between those with true medigap coverage and those lacking any supplement.

Offsets to Savings As a Result of Responses by Providers

If medigap enrollees reduced their use of services, this might trigger responses by providers intended to offset the loss in their revenues. If providers increased the volume of services provided to Medicare enrollees in an effort to maintain revenues in the face of reduced use by medigap enrollees, some of the expected federal savings from eliminating medigap coverage would not occur.

Although there is evidence that physicians offset about half of the loss in their revenues that would otherwise occur in the face of reductions in Medicare's payment rates, any offset to revenue losses resulting from eliminating medigap coverage would probably be much smaller. There are several reasons for this expectation. First, physicians' services comprise only about 30 percent of Medicare costs, and few other providers have much ability to induce greater use of services by enrollees. Second, part of the offset to reductions in physicians' fees is the result of increased demand for services by patients in response to lower coinsurance and balance-billing costs.[7] But elimination of medigap would reduce demand for services among enrollees, not increase it. Third, the impact on revenues to providers from eliminating medigap might not be substantial enough to trigger an offsetting response. Medigap enrollees contribute only about 9 percent to physicians' revenues now, on average, so that a 20 percent reduction in their use of services would reduce physicians' revenues by less than 2 percent. For physicians with a disproportionately large share of Medicare patients, however, the impact would be larger.

Imminent Changes in Requirements for Medigap Plans

The estimates assume that medigap policyholders receive benefits that are typical of medigap plans offered now, although the typical plan might change over the next year or two as states adopt new standards recently developed by the National Association of Insurance Commissioners (NAIC). If a less generous plan becomes typical, then federal savings from eliminating medigap coverage would be lower, in percentage terms, than the estimates presented in this paper. Alternatively, if a more generous plan becomes typical, federal savings would be higher than shown.

Under current standards, insurance plans advertised as Medicare supplements or medigap policies are required to cover all coinsurance (but not deductible) costs under Medicare, excepting only coinsurance costs for stays in skilled nursing facilities (SNFs). Plans may provide

7. Balance-billing is the excess of a physician's actual charge on an unassigned claim over Medicare's payment rate. Balance-billing costs fall for enrollees when Medicare's payment rates are reduced because balance-billing charges may not exceed a set percentage of Medicare's payment rate for each service.

any other benefits they choose, and a confusing variety of alternatives have been offered.

The typical plan under current standards covers not only all coinsurance costs under Medicare (including those for SNF stays), but it also covers the Hospital Insurance (HI) deductible. Some cover the SMI deductible, too. In other words, the typical medigap plan currently eliminates nearly all copayment costs under Medicare. However, few policyholders have plans that cover balance-billing costs, prescription drugs, or other services not covered by Medicare.

TABLE 1. PROPOSED MEDIGAP POLICIES: PLANS APPROVED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Benefits	Plans									
	A	B	C	D	E	F	G	H	I	J
Core	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SNF Coinsurance	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HI Deductible	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SMI Deductible	No	No	Yes	No	No	No	No	Yes	No	Yes
Balance-Billing (Percent)	0	0	0	0	0	80	0	100	100	100
Foreign Travel	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
At-Home Recovery	No	No	No	Yes	No	Yes	No	No	Yes	Yes
Prescription Drugs, (B)asic or (E)xtended	No	No	No	No	B	No	No	No	B	E
Preventive Screening	No	No	No	No	No	No	Yes	No	No	Yes

SOURCE: Congressional Budget Office from information provided by the National Association of Insurance Commissioners (June 1991). NAIC assigned letters to identify each plan.

NOTES: SNF = skilled nursing facility; HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

Under the new standards the NAIC tentatively approved in June 1991, all medigap insurers will be required to offer a uniform "core" plan virtually identical to the minimum plan requirements currently in place (plan A in Table 1 on page 9). In addition, insurers may offer up to nine more generous plans, all incorporating the core benefits. The NAIC standards also specify the benefits each of the nine optional plans (B through J) are to provide. Plan D closely resembles the plan that is typical now, and it will probably become the typical plan under the new standards if the current norm meets the preferences of enrollees.

CHAPTER II

BACKGROUND ON THE MEDICARE PROGRAM AND SUPPLEMENTS TO IT

Medicare is the fourth-largest federal spending category (exceeded only by defense, Social Security, and interest payments), and it is one of the fastest-growing major items in the federal budget. In an effort to slow its growth, the Congress enacted a number of measures during the 1980s intended to reduce payments to providers under the program, with appreciable success in some areas. By 1991, total (federal and enrollee) spending for Medicare-covered services is expected to be less than 80 percent of what it would have been had the growth rate between 1975 and 1980 continued.

The Congress has generally sought to avoid shifting costs to Medicare enrollees as the means to achieving federal savings. Indeed, the many changes made to the Medicare program since 1980 have increased only slightly the share of costs under Medicare for which enrollees are liable--from 23.4 percent in 1980 to 23.9 percent expected for 1991. Despite this, because costs for Medicare-covered services have grown more rapidly than income, enrollees' liabilities under Medicare have increased relative to income by about 20 percent between 1980 and 1991. (See the Appendix for a description of major changes under the Medicare program, and for estimates from 1975 through 1991 of total costs for Medicare-covered services and of enrollees' statutory share of those costs.)

DESCRIPTION OF THE CURRENT MEDICARE PROGRAM

Medicare was enacted in 1965 and put in place on July 1, 1966. It is an insurance program that covers acute health care services for about 34 million enrollees. Medicare comprises two separate programs--Hospital Insurance (HI) authorized under Part A, and Supplementary Medical Insurance (SMI) authorized under Part B. The HI program pays for inpatient hospital care, some stays in skilled nursing facilities

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(SNFs), home health care, and hospice services. The SMI program pays for physicians' services and for charges by hospital outpatient departments, independent medical laboratories, and other medical suppliers.

The HI program is financed by a portion of the Social Security payroll tax levied on current workers and their employers. Benefits under the SMI program are financed partly from monthly premiums enrollees pay and partly from general revenues, which currently pay about 75 percent of costs.

Most people age 65 or more are eligible for Part A benefits based on previous Social Security or Railroad Retirement payroll tax payments. Those who are not already eligible may purchase coverage by paying a monthly premium ($177 in 1991). Coverage for Part B benefits is available to all people age 65 and older with payment of a monthly premium ($29.90 in 1991), and about 95 percent of those with Part A coverage also enroll under Part B. In addition to the aged, people receiving Social Security disability benefits for at least 24 months and people with end-stage renal disease are eligible for Medicare benefits.

Covered Services

Medicare is designed to cover acute care needs rather than to provide a comprehensive range of medical services. As such, it covers about 55 percent (and reimburses for about 45 percent) of total health care costs for the Medicare population. Medicaid and state/local health agencies pay a third of those costs Medicare does not pay, so that nearly two-thirds of enrollees' health costs are paid from public funds.[1]

The most important exclusion under Medicare is long-term nursing home care, which accounts for about 20 percent of total health care costs for Medicare enrollees, on average, although these costs are concentrated on about 5 percent of the aged population. Another major exclusion is outpatient prescription drugs, which represent about 7 per-

1. Daniel Waldo and others, "Health Expenditures by Age Group, 1977 and 1987," *Health Care Financing Review*, vol. 10, no. 4 (Summer 1989), pp. 111-120.

cent of total health care costs for the Medicare population. Additional excluded items include over-the-counter drugs and routine dental and eye care. Other health care costs not reimbursed by Medicare occur because of Medicare's cost-sharing requirements on covered services, which are discussed in the next section.

Medicare covers most hospital stays, although in rare instances the coverage can be exhausted. In a given spell of illness, Medicare will pay all or part of the hospital costs for the first 90 days.[2] Each enrollee has a lifetime reserve of an additional 60 days that can be used to extend Medicare coverage beyond 90 days if needed, although cost-sharing on those reserve days is substantial. Medicare also covers stays in a skilled nursing facility (SNF) for short-term rehabilitation following a hospital stay of at least three days. Coverage is limited to no more than 100 days in a given spell of illness. Medicare will cover home health care for home-bound enrollees so long as the services are medical and intermittent. As generally applied, the "intermittent" requirement limits care to no more than 21 consecutive days. Physicians' services both in and out of hospital are covered, excluding most preventive care and cosmetic procedures. Facility costs for services in hospital outpatient departments and in ambulatory surgical centers are also covered.

Cost-Sharing Requirements

Medicare's cost-sharing requirements are varied and confusing (Box 1). For hospital inpatient stays, enrollees are liable for the full HI deductible amount for the first day during a spell of illness ($628 for 1991), and for coinsurance amounts equal to one-fourth the deductible amount for days 61 through 90 and one-half the deductible amount for each subsequent day until the enrollee's lifetime reserve days are gone. No cost-sharing requirement exists for the first 20 days in a SNF during a spell of illness, but per-day copayments equal to one-eighth the HI deductible amount are required for days 21 through 100. No cost-sharing is required for home health visits, but enrollees must pay

2. A spell of illness begins with a hospital admission and ends 60 days after release from the hospital or from a skilled nursing facility entered immediately following the hospital stay.

20 percent coinsurance on medical equipment provided by home health agencies. Enrollees are liable for 20 percent of recognized charges above a $100 deductible for most services provided under the SMI program, although there are no cost-sharing requirements for clinical laboratory services. For outpatient psychiatric services, the coinsurance rate is 50 percent.

BOX 1
Medicare's Cost-Sharing Requirements, 1991

Medicare's requirements for cost-sharing by enrollees are outlined below.

For Each Spell of Illness Under the Hospital Insurance (HI) Program[a]

For Hospital Inpatient Stays	
First-day deductible	$628.00
Coinsurance for days 61 through 90	$157.00
Coinsurance for lifetime reserve days	$314.00
Coinsurance for Days 21 through 100 in Skilled Nursing Facilities	$78.50
Coinsurance Rate for Durable Medical Equipment	20 percent

Under the Supplementary Medical Insurance (SMI) Program

All services except home health and clinical laboratory services are subject to the SMI deductible and coinsurance requirements.

SMI deductible	$100.00
Coinsurance rate	
Outpatient psychiatric services	50 percent
Other services	20 percent

In addition, enrollees are liable for any excess charges above Medicare's allowed amounts on unassigned claims (balance-billing).

SOURCE: Congressional Budget Office.

a. A spell of illness begins with a hospital admission and ends 60 days after discharge from the hospital or from a skilled nursing facility entered immediately following the hospital stay.

In addition to deductible and coinsurance amounts, enrollees are liable for balance-billing amounts--physicians' charges in excess of Medicare's approved rates on unassigned claims. On assigned claims, patients transfer (assign) their right to reimbursement to the physician, who agrees to accept Medicare's approved rates in return for direct payment from Medicare. (In this instance, physicians collect only copayment amounts directly from the patient.) On unassigned claims, physicians are paid by their patients, who are liable for the entire billed amount but who may receive reimbursement from Medicare for a part of those costs. Currently, about 85 percent of SMI charges are assigned, and physicians' actual charges on unassigned claims may not exceed 125 percent of Medicare's fee for the service. By 1993, physicians' actual charges will be limited to no more than 115 percent of Medicare's fee.

Enrollees' cost-sharing amounts can be very large under Medicare. Unlike most private insurance plans, Medicare does not limit, or cap, each enrollee's liability for copayments. Because of the resulting risk of potentially catastrophic liabilities, most enrollees obtain supplementary coverage either through private insurance or Medicaid.

SUPPLEMENTS TO MEDICARE

In 1991, about 21 percent of enrollees lack any coverage to supplement Medicare. Some 61 percent have private supplementary insurance--either employment-based group retiree health benefits or individual medigap coverage. Another 18 percent are eligible for either full or qualified benefits under Medicaid.[3] Each type of supplement is described below.

Some 30 percent of enrollees have retiree health plans that coordinate with their Medicare benefits. About three-quarters of this group have "carve-out" plans, which means that plan benefits are reduced dollar-for-dollar for any reimbursements from Medicare to which enrollees are entitled. Hence, these retirees generally face the

3. Some enrollees eligible for Medicaid are also currently purchasing medigap policies, although there is little reason to do so; medigap insurers will be prohibited from selling to them as of 1992. Those with both Medicaid and medigap coverage are included in the Medicaid group.

cost-sharing requirements of their private health plans, and not those of Medicare. Most other enrollees with retiree health benefits have plans that coordinate with Medicare in such a way that all their cost-sharing expenses on Medicare-covered services are eliminated.[4]

Another 31 percent of enrollees purchase medigap insurance for themselves. Under standards developed by the National Association of Insurance Commissioners, medigap plans must cover all of Medicare's coinsurance requirements except those for SNF stays, but are not required to cover the HI or the SMI deductible amounts. In fact, most medigap policies purchased do cover the HI deductible, many cover SNF coinsurance amounts, and some cover the SMI deductible as well. They rarely pay for services not covered by Medicare, however, such as costs for outpatient prescription drugs and for long-term care. Few policies purchased cover balance-billing costs, although plans that provide coverage for these costs are offered.[5]

Charges for services not covered by Medicare, copayments Medicare requires for covered services, and Medicare premiums are generally paid by Medicaid for the 9 percent of Medicare enrollees who receive full Medicaid benefits. Another 9 percent of Medicare enrollees who are poor but ineligible for Medicaid under the eligibility conditions of their states may apply for qualified Medicaid benefits--payment of Medicare premiums and copayments. Balance-billing is prohibited on claims for all dually eligible enrollees.

Those who lack supplementary coverage have higher income, on average, than those who receive Medicaid benefits, but they are not as well-off as those with private supplementary coverage (Table 2). Average per capita income is less than $10,000 for those eligible for Medicaid, about $17,500 for those who lack supplementary coverage, and more than $20,000 for those with private supplementary insurance.

On average taking into account all enrollees, family income is 3.3 times the poverty threshold. For those eligible for qualified Medicaid

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4. Michael Morrisey, Gail Jensen, and Stephen Henderlite, "Employer-Sponsored Health Insurance for Retired Americans," *Health Affairs*, vol. 9, no. 1 (Spring 1990), pp. 57-73.

5. "Beyond Medicare," *Consumer Reports*, vol. 54, no. 6 (June 1989), pp. 375-391.

benefits, this ratio is only 0.8. For those eligible for full Medicaid benefits, the ratio of income to the poverty threshold is about 1.7. Family income is higher than the poverty threshold for some people eligible for Medicaid for two reasons: income eligibility standards are higher than the poverty thresholds in some states; and some enrollees are eligible for Medicaid for only part of the year, although income for the whole year is above the standard. Those with private supplementary coverage have income that is about four times the poverty threshold, on average, while those lacking supplementary coverage have income that is about three times the threshold.

TABLE 2. CHARACTERISTICS OF MEDICARE ENROLLEES BY TYPE OF SUPPLEMENTARY COVERAGE, 1991

		Type of Supplementary Coverage				
	Overall	None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Average Values For:						
Per capita income (Dollars)	18,279	17,486	22,464	20,919	5,172	9,385
Poverty status[a]	3.3	3.1	4.1	3.8	0.8	1.7
Percentage Who Are:						
Disabled under age 65	9.5	14.8	8.1	3.2	13.5	19.2
Impaired[b]	16.6	20.4	12.5	11.5	24.3	31.1
Users of HI services	19.8	17.4	19.0	20.7	21.1	23.8
Age 85 or older	9.0	10.2	5.5	9.8	10.5	13.5
Women	58.8	56.0	54.0	60.0	66.2	70.4

SOURCE: Congressional Budget Office tabulations from the Medicare benefits model.

NOTES: RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits; HI = Hospital Insurance.

a. Shows average value over enrollees in group for the enrollee's family income divided by the appropriate poverty threshold.

b. Limited in the ability to perform one or more activities of daily living.

Compared with those who have private supplementary coverage, enrollees who lack supplementary coverage are more likely to have disabilities of some kind. Nearly 15 percent of those without supplementary coverage are disabled enrollees under age 65, compared with only 8 percent of those with retiree health plans and only 3 percent of those with medigap policies. More than 20 percent of those lacking supplementary coverage have one or more functional limitations, while only about 12 percent of those with private supplementary insurance are so impaired.

Despite the greater prevalence of physical limitations among them, those individuals lacking supplementary coverage are less likely to use inpatient or nursing services than those with private supplementary insurance--reflecting the effect better insurance coverage has on increasing the use of services. About 17 percent of those with no supplementary coverage use HI services, compared with 19 percent of those with retiree health benefits and 21 percent of those with medigap plans.

ENROLLEES' OUT-OF-POCKET AND PREMIUM EXPENSES FOR ACUTE HEALTH CARE

In this section, two sets of estimates for enrollees' acute care expenses are discussed. (Enrollees' acute care expenses include health insurance premiums and out-of-pocket costs. Acute care services include all services covered by Medicare plus prescription drugs.) The first estimates presented ignore the benefits received from and premiums paid for supplementary coverage; they indicate how well Medicare would protect enrollees against out-of-pocket expenses for acute health care if it was their only insurance. The second estimates include the effects of supplementary coverage.

In reality, the supplementary coverage enrollees have varies considerably, even within each of the four major kinds. A representative prototype for each kind of coverage is used for results shown here and in the next chapter.

The prototype characteristics assumed here are:

- *Retiree Health Plan (RHP).* The plan uses the carve-out method of coordination with Medicare. In other words, benefits and copayment requirements under the private plan are generally the effective ones, and reimbursements from Medicare simply reduce health plan costs for employers. Enrollees' out-of-pocket expenses will rarely be lower than they would be under the retiree health plan alone.[6] The plan covers the same services as Medicare but covers prescription drugs as well. It also covers balance-billing costs under Medicare, because allowable charges under the plan are as high as the maximum actual charges permitted by Medicare. The plan has a $200 deductible per beneficiary. It requires 20 percent coinsurance on allowed charges above the deductible for all services except hospital stays, for which the coinsurance rate is 10 percent. Cost-sharing expenses are limited to $1,500 a year per beneficiary. Each enrollee pays an annual premium of $475 in 1991.[7]

- *Medigap Plan (MGP).* All copayment costs under Medicare are paid except for the $100 SMI deductible. No balance-billing or prescription drug costs are paid. The annual premium is $664 in 1991, equal to 133 percent of the average benefit paid per medigap policyholder nationwide. Thus, the plan's loss ratio (average benefit relative to premium) is 75 percent.[8]

- *Qualified Medicaid Benefits (QMB).* All copayment and premium costs under Medicare are paid, but other health care

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6. Medicare's coverage would reduce the enrollee's expenses when the enrollee has medical charges that fall short of the retiree health plan's deductible amount but exceed Medicare's $100 deductible, or that are not subject to copayment requirements under Medicare (such as home health services).

7. Description of the typical retiree health plan was obtained from the 1989 Employee Benefits Survey of medium and large firms conducted by the Bureau of Labor Statistics. The premium used is a weighted average: an estimated 35 percent of those in retiree health plans pay no premium; 45 percent pay an average annual premium of $450; and 20 percent pay a full-cost premium averaging $1,350. Premium estimates for 1988 were derived from Morrisey, Jensen, and Henderlite, "Employer-Sponsored Health Insurance for Retired Americans." Premium, deductible, and cap values were inflated to 1991 using the medical services component of the Consumer Price Index.

8. Description of the typical medigap plan was obtained from *Consumer Reports* (June 1989).

costs are not. Hence, these enrollees are fully responsible for their prescription drug costs. No balance-billing is permitted for these enrollees. (The results shown in the tables here and in Chapter III assume that all those eligible for qualified benefits will apply, although currently fewer than half appear to do so.)

- *Medicaid (MCD).* All copayment and premium costs under Medicare are paid, as are all other health care costs including those for prescription drugs. No balance-billing is permitted for these enrollees.

Enrollees' Expenses When Benefits from and Premiums for Supplementary Coverage Are Ignored. On average, the sum of enrollees' statutory liabilities under Medicare and of prescription drug costs is an estimated $1,495 for 1991 (Table 3). Of this amount, 23 percent is for SMI premiums. The other 77 percent would be out-of-pocket expenses if Medicare were the only health coverage enrollees had.

These expenses vary depending on the type of supplementary coverage enrollees have. Those who lack supplementary coverage incur the lowest average costs, while those eligible for full Medicaid benefits have the highest. Those with medigap coverage tend to have higher costs than those with retiree health plans. These patterns reflect enrollees' use of services, which depends not only on their health status, but also on the out-of-pocket expenses for which they remain liable after payments by supplementary insurers (shown in the next section).

If Medicare were their only health coverage, nearly 28 percent of all enrollees would have out-of-pocket expenses that exceeded 10 percent of their per capita income. About 66 percent of enrollees would face out-of-pocket expenses of less than $1,000, but nearly 3 percent would have expenses of $5,000 or more and nearly 17 percent would have expenses of $2,000 or more.

TABLE 3. ESTIMATES OF ENROLLEES' OUT-OF-POCKET AND PREMIUM EXPENSES FOR ACUTE HEALTH CARE IN 1991, IGNORING BENEFITS FROM AND PREMIUMS FOR SUPPLEMENTARY COVERAGE

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Enrollees' Expenses (Dollars)						
SMI Premiums[a]	342	337	340	342	359	351
Other[b]						
Medicare copayments	571	525	553	578	558	716
Balance-billing	43	45	54	55	0	0
Prescription drugs	539	509	530	547	540	606
Subtotal	1,153	1,079	1,137	1,180	1,098	1,323
Total Expenses	1,495	1,416	1,477	1,521	1,457	1,673
Percentage of Enrollees' Expenses						
SMI premiums	22.9	23.8	23.0	22.5	24.6	21.0
Other	77.1	76.2	77.0	77.5	75.4	79.0
Percentage of Enrollees with Other Expenses Greater Than 10 Percent of per Capita Income	27.6	24.4	21.0	23.7	51.5	47.7
Percentage of Enrollees with Other Expenses						
Less than $1,000	65.7	69.4	66.1	64.2	67.2	59.3
$1,000 to $2,000	17.7	15.9	17.3	18.5	18.8	20.0
$2,000 to $5,000	13.7	12.3	13.6	14.2	11.6	17.3
$5,000 or more	2.9	2.4	3.0	3.1	2.4	3.4

SOURCE: Congressional Budget Office simulations from the Medicare benefits model.

NOTES: RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits; SMI = Supplementary Medical Insurance.

a. The annual SMI premium for 1991 is $358.80. Amounts shown are less than this amount because not all people with some Medicare coverage during the year have full-year SMI coverage.

b. These are out-of-pocket expenses for people who lack supplementary insurance coverage. For those with supplementary coverage, some portion of these liabilities are paid by the supplementary insurer.

Enrollees' Expenses When Benefits from and Premiums for Supplementary Coverage Are Included. The pattern above changes significantly when benefits from and premiums for supplementary coverage are factored into the analysis (see Table 4). Overall, average out-of-pocket and premium expenses for enrollees will be an estimated $1,274 in 1991. About half of these expenses will be out-of-pocket (compared with 77 percent if Medicare were the only insurer), while the other half will be for premiums (up from 23 percent if Medicare were the only insurer). About 14 percent of enrollees will have out-of-pocket expenses in excess of 10 percent of per capita income. Out-of-pocket expenses will be $2,000 or more for 5.4 percent of enrollees, and $5,000 or more for 0.7 percent of enrollees.

On average, enrollees' acute care expenses are lower than they would be if Medicare were the only insurer--primarily because of the costs that are picked up by Medicaid for eligible enrollees. For those receiving full Medicaid benefits, enrollees' health care expenses are zero. For those receiving qualified benefits, most acute care expenses except those for prescription drugs are eliminated.

Supplementary coverage for those with retiree health benefits reduces enrollees' average expenses, because these enrollees pay less in health plan premiums than the average value of the additional benefits they receive. The lower premiums are partly because employers pay a share of the premium costs, but also because the premiums are based on average costs per beneficiary in employment-based health plans--where most of the beneficiaries are workers and their families, who typically have fewer health care needs than retirees.

Supplementary coverage for enrollees with individual medigap policies increases their average expenses, since medigap premiums cover not only the average value of benefits but also administrative costs and profits for the insurers. The excess of the premium over the average value of benefits is a measure of the value enrollees place on protection from the risk of incurring large and unexpected health care costs. In fact, nearly 85 percent of those with medigap policies will lose financially from the purchase, because their medigap premiums will exceed the value of the additional benefits they receive. That is the

TABLE 4. ESTIMATES OF ENROLLEES' OUT-OF-POCKET AND PREMIUM EXPENSES FOR ACUTE HEALTH CARE IN 1991, INCLUDING BENEFITS FROM AND PREMIUMS FOR SUPPLEMENTARY COVERAGE

		Type of Supplementary Coverage				
	Overall	None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Enrollees' Expenses (Dollars)						
Premiums[a]	631	337	815	1,006	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total Expenses	1,274	1,416	1,351	1,687	540	0
Percentage of Enrollees' Expenses						
Premiums[a]	49.5	23.8	60.3	59.6	0	b
Out-of-pocket	50.5	76.2	39.7	40.4	100.0	b
Percentage of Enrollees with Out-of-Pocket Expenses Greater Than 10 Percent of per Capita Income	14.1	24.4	7.9	12.3	31.7	0
Percentage of Enrollees with Out-of-Pocket Expenses						
Less than $1,000	79.8	69.4	80.4	78.8	85.3	100.0
$1,000 to $2,000	14.8	15.9	19.6	14.9	10.0	0
$2,000 to $5,000	4.7	12.3	0	5.7	4.3	0
$5,000 or more	0.7	2.4	0	0.6	0.5	0

SOURCE: Congressional Budget Office simulations from the Medicare benefits model.

NOTES: RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits.

a. Assumes a medigap premium of $664, equal to 133 percent of the average medigap benefit. Assumes the enrollee's share of retiree health plan premiums is $475. The annual Supplementary Medical Insurance premium for 1991 is $358.80, but Medicaid pays this premium for dually eligible Medicare enrollees.

b. Not defined.

nature of insurance that is fully financed by premiums. The purpose of insurance is to have the relatively healthy majority subsidize the small minority with costly health problems--to protect the few who incur large health care costs by spreading the financial risks over the entire insured population.

A significant portion of the Medicare population will incur some risk of large out-of-pocket expenses for acute health care in 1991. For the 21 percent of enrollees who lack supplementary insurance coverage, that risk is substantial because they are liable without limit for Medicare's copayments, for balance-billing, and for prescription drug costs. For this group, more than 2 percent will face out-of-pocket expenses of $5,000 or more, and nearly 15 percent will incur out-of-pocket expenses of $2,000 or more. About 24 percent will have out-of-pocket expenses that consume more than 10 percent of their income. Some among this group, however, will become temporarily eligible for Medicaid benefits under state "medically needy" programs.

The risk is smaller for the 31 percent of enrollees with medigap coverage, because they face potentially unlimited expenses only for balance-billing and prescription drug costs. For this group, only 0.6 percent will face out-of-pocket expenses of $5,000 or more, but more than 6 percent will incur out-of-pocket expenses of $2,000 or more. About 12 percent will have out-of-pocket expenses greater than 10 percent of their income.

Nearly 5 percent of enrollees eligible for qualified Medicaid benefits would be expected to incur prescription drug costs of $2,000 or more based on their use of other services, although financial constraints may prevent the purchase of all prescribed drugs. Because their income is so low, out-of-pocket expenses would consume more than 10 percent of income for nearly a third of this group.

Based on the prototype plans used here, no enrollees with full Medicaid coverage would incur any out-of-pocket expenses; and none with retiree health plan benefits would incur out-of-pocket expenses in excess of $1,500. Still, nearly 8 percent of those with retiree health benefits will have out-of-pocket expenses greater than 10 percent of income.

CHAPTER III

OPTIONS TO RESTRUCTURE MEDIGAP AND MEDICARE INSURANCE

Apart from the lack of coverage for long-term care, two problems often cited with Medicare as protection against acute care costs are that:

- o It does not cover prescription drug costs; and
- o It fails to protect enrollees from catastrophic expenses even for the services it covers, since there is no ceiling on copayment costs under the program.

Because of their unlimited liability for copayment costs, enrollees ineligible for retiree health benefits or for Medicaid often purchase medigap insurance, with two results:

- o Use of services and, hence, Medicare costs are substantially higher than they would be if the nearly first-dollar coverage provided by medigap plans did not make Medicare's copayment requirements ineffective; and
- o Enrollees' total expenses for acute health care are higher, on average, than they would be if they did not purchase medigap.

Changes could be made in Medicare that would assure that all enrollees were protected against large out-of-pocket expenses, without increasing spending by the federal government or the premiums enrollees pay (amounts which are fixed in law through 1995). These changes would eliminate the nearly first-dollar coverage medigap policies now provide, and would use the resulting federal savings to finance an enrichment of Medicare's benefits. Without first-dollar coverage, the use of Medicare-covered services by medigap enrollees would fall, thereby reducing total costs under the program (before enrichment of Medicare's benefits). Because medigap premium expenses

would fall by more than medigap enrollees' out-of-pocket expenses would increase, their total expenses for health care would also fall, on average. However, 15 percent to 20 percent of them would face higher expenses in any given year. Medigap enrollees with expensive chronic conditions could be affected especially adversely. They might face higher expenses year after year under this approach (at least for options that would provide no coverage for prescription drugs) compared with continuing their medigap coverage.

This approach would eliminate the option that some enrollees might prefer--that of reducing the risk of large unexpected out-of-pocket costs (at least for Medicare-covered services) to nearly zero. But the insured non-Medicare population, which typically is already protected by a ceiling on copayment costs, does not seek out supplementary coverage for their copayment liabilities. The apparent preference of the Medicare population for first-dollar coverage is possibly an artifact of the choices they have been offered up to now: a public insurance program that leaves them at risk for catastrophic copayment costs, coupled with a private insurance supplement that is required to cover most Medicare copayment costs. However, Medicare enrollees may be more averse to the risks of large and unexpected health care costs than younger population groups because of the greater probability that they will have substantial health care needs.

One problem with eliminating medigap's nearly first-dollar coverage is that enrollees might forgo some necessary and appropriate services in response to higher out-of-pocket costs; that is, the drop in their use of services may not be confined to "unnecessary" care. If this resulted in more expensive care later on, federal costs might be higher in the long run despite immediate federal savings. The United States (along with France) is unusual among industrialized countries in its reliance on cost-sharing to control use of health care services. In Canada and the former West Germany, for example, cost-sharing by patients is virtually nonexistent precisely because it is effective at curtailing use and not always appropriately so, especially for lower-income people. Many countries prefer to rely instead on controls on providers to limit overuse of services, in the belief that providers are better able than patients to distinguish between necessary and unnecessary medical care. Controls on providers are more effective in

single-payer or all-payer systems, though, than in multipayer systems like ours.[1] The reason is that relatively strict controls by any one payer will threaten access for that payer's insured population if providers come to prefer other groups with less restrictive payers.

Another problem is that some low-income enrollees (those not eligible for Medicaid) may face unaffordably large expenses under the options discussed in this paper, just as they do under current law. This problem is difficult to address within the Medicare program because it would require either means-testing to determine eligibility for reduced copayment requirements (which would be administratively costly and stigmatizing) or virtual elimination of copayment requirements for all enrollees (which would increase federal Medicare costs by about 20 percent). The most feasible approach to this problem under the current patchwork might be to mandate "medically needy" benefits under all state Medicaid programs. (Medically needy people are those who become temporarily eligible for Medicaid benefits in some states when their income exceeds their health care costs by less than the state's income standard for eligibility.) Nationwide, Medicaid costs would increase by about 3 percent under this approach, with more than a third of the increase attributable to Medicare enrollees. But in the 15 states affected--those that do not currently have medically needy programs--Medicaid costs would rise by about 27 percent, and states are already struggling to meet the rapidly escalating costs of the Medicaid program.

Every option discussed here would establish a cap on copayment costs under Medicare and would prohibit medigap coverage of any of Medicare's copayment requirements. None of the options would include balance-billing costs in the copayment cap. Enrollees can avoid balance-billing costs by choosing physicians who agree to accept assignment on Medicare claims. Currently, about 85 percent of physicians' charges for Medicare-covered services are assigned.

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1. In a single-payer system, there is only one insurer. In a multipayer system, there are many different insurers each setting payment policies independently. In an all-payer system, the payment policies of the many different payers are coordinated by government regulation, rather than set independently.

In each option, the cap is set at the lowest value possible (using only multiples of $100) without increasing federal spending. In the first section below, the options would leave Medicare's copayment requirements unchanged except for introducing a copayment cap. In the second section, Medicare's copayment requirements would be redesigned.

Within each section, the options differ in how they treat costs for prescription drugs. The first variation addresses only copayment costs under Medicare, leaving enrollees fully at risk for prescription drug costs. (In 1991, expenses for prescription drugs are expected to average about $700 for the 80 percent of enrollees who use any, and will exceed $2,000 for 5 percent of enrollees.) The second variation addresses prescription drug costs as well, by counting them toward the copayment cap. A third variation (in the second section only) would cover prescription drug costs as a standard benefit under the SMI program. Although this would require a substantial increase in the copayment cap, the SMI deductible amount, or the coinsurance rate to avoid increasing federal costs, it might enable Medicare to reduce drug prices for enrollees by using its buying power to obtain discounts from suppliers. Estimates for the third variation assume that retail prices for prescription drugs would be lower by 6 percent for Medicare enrollees.

A combined cap on copayment costs incurred under either the Hospital Insurance or the Supplementary Medical Insurance program would be less expensive than separate HI and SMI caps providing the same overall ceiling on copayments--because separate caps necessarily set a lower copayment ceiling for those enrollees whose costs are concentrated in only one of the programs (see Box 2). Consequently, only combined caps are considered here.

The options presented would apply directly only to enrollees receiving care on a fee-for-service basis, and not to those enrolled in risk-based health maintenance organizations (HMOs). Enrollees in HMOs would be affected indirectly, however, under the options that would change Medicare's spending per enrollee in the fee-for-service sector, because Medicare's per enrollee payments to HMOs are proportional to per enrollee costs in the fee-for-service sector.

BOX 2
Illustrative Copayment Costs Under Alternative Copayment Caps (In dollars)

Separate caps effectively set a lower copayment ceiling for those enrollees whose costs are concentrated in either the Hospital Insurance (HI) or the Supplementary Medical Insurance (SMI) program, compared with enrollees who incur costs under both programs. For this reason, separate caps would be more expensive than a combined cap providing the same overall ceiling on copayments. This is illustrated below in a comparison for two enrollees under current law and under two alternative copayment caps.

Under current law (with no cap on Medicare's copayments) both enrollees incur total copayment costs of $3,000. For Enrollee 1, copayment costs are half for HI services, and half for SMI services. Enrollee 2, however, uses only SMI services and incurs all copayment costs under that program.

Under Current Law (No Copayment Cap)

	Enrollee 1	Enrollee 2
HI copayment costs	1,500	0
SMI copayment costs	1,500	3,000
Total	3,000	3,000

With a Combined Copayment Cap of $2,000

If Medicare introduced a $2,000 cap on copayments, whether for HI or SMI services, total copayment costs would be $2,000 for both enrollees.

	Enrollee 1	Enrollee 2
Total	2,000	2,000

With Separate Copayment Caps of $1,000 Each Under HI and SMI

If, instead, Medicare introduced separate copayment caps under the HI and SMI programs, with each cap set at $1,000, Enrollee 1 would be liable for $2,000 in copayment costs, and Enrollee 2 would be liable for only 1,000 in copayment costs.

	Enrollee 1	Enrollee 2
HI copayment costs	1,000	0
SMI copayment costs	1,000	1,000
Total	2,000	1,000

SOURCE: Congressional Budget Office.

ESTABLISH A MEDICARE COPAYMENT CAP AND PROHIBIT MEDIGAP COVERAGE OF MEDICARE'S COPAYMENT REQUIREMENTS

Both of the options in this section would introduce a copayment cap under Medicare without changing any other of Medicare's copayment provisions. Both options would also prohibit medigap coverage of any of Medicare's copayment requirements. The first option would exclude prescription drug costs from coverage under Medicare, while the second option would permit enrollees to count such costs toward the copayment cap.

As discussed in Chapter I, there is considerable uncertainty about the estimates presented in this chapter; the responses that would occur among enrollees and the providers of medical care are difficult to predict. For example, net federal spending under the first option might increase or fall by up to $0.8 billion in 1991--instead of being budget neutral--if the behavioral responses underlying the estimate are wrong by no more than 15 percent (Box 3).

Option 1: Cap Copayments at $1,500; Prescription Drug Costs Would Not Count Toward Cap

If a $1,500 cap on Medicare (HI and SMI) copayments was added to the benefits provided under the SMI program, and if medigap plans were prohibited from covering any copayment costs, net federal spending would be virtually unchanged under the assumptions used here (see Table 5). Federal savings under Medicare from eliminating medigap coverage would be insufficient to offset the increase in benefit costs that would result from the copayment cap. However, higher costs under Medicare would be entirely offset by lower federal costs under Medicaid. Medicaid spending on acute care for dually eligible enrollees (eligible for either full or qualified benefits) would drop by about 14 percent under this option. In addition, employers' health plan costs for Medicare enrollees would fall by nearly 26 percent. Both Medicaid and employers would see their costs for Medicare enrollees

BOX 3
Estimated Effects on Spending Under Alternative Behavioral Assumptions for Option 1

The results shown here indicate the range of effects on Medicare benefits and on net federal spending that would occur under the first option if the estimates CBO uses for enrollees' behavioral responses to changes in their out-of-pocket costs are either too high or too low by up to 15 percent.

If the change in enrollees' use of services was 15 percent smaller than was assumed for the base estimate, then Medicare's benefit costs would increase by $1.3 billion, instead of $0.6 billion. Net federal spending would increase by $0.7 billion, instead of being virtually unchanged.

If the change in use of services by enrollees was 15 percent larger than was assumed, Medicare benefit costs would fall by $0.2 billion, and net federal spending would fall by $0.8 billion.

Hence, the estimated effects on net federal spending might differ from the overall percentage changes shown by no more than plus or minus 0.7 percentage points. The effects on (aggregate) net federal spending might be different (in either direction) by up to $0.8 billion for 1991.

	Behavioral Responses Assumed		
	0.85 of Base	Base	1.15 of Base
Per Enrollee Values for 1991 (Dollars)			
Medicare Benefits			
Current value	3,379	3,379	3,379
New value	3,415	3,396	3,374
Change	36	17	-4
Percentage change	1.1	0.5	-0.1
Net Federal Spending			
Current value	3,165	3,165	3,165
New value	3,184	3,164	3,143
Change	19	-1	-22
Percentage change	0.6	0	-0.7
Aggregate Values for 1991 (Billions of dollars)			
Medicare Benefits			
Current value	116.7	116.7	116.7
New value	118.0	117.3	116.5
Change	1.3	0.6	-0.2
Percentage change	1.1	0.5	-0.1
Net Federal Spending			
Current value	109.3	109.3	109.3
New value	110.0	109.3	108.5
Change	0.7	0	-0.8
Percentage change	0.6	0	-0.7

SOURCE: Congressional Budget Office simulations from Medicare benefits model.

TABLE 5. OPTION 1: CAP COPAYMENTS AT $1,500; PRESCRIPTION DRUG COSTS WOULD NOT COUNT TOWARD CAP

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Estimated Current Values (Dollars per enrollee)						
Net Federal Spending	3,165	2,626	3,046	3,039	3,545	4,813
Enrollees' Benefits						
Medicare	3,379	2,963	3,386	3,380	3,400	4,243
Supplementary	510	0	601	498	558	1,323
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	352	0	475	664	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total Expenses	1,274	1,416	1,351	1,687	540	0
Estimated New Values (Dollars per enrollee)						
Net Federal Spending	3,164	2,992	3,199	2,596	3,610	4,909
Enrollees' Benefits						
Medicare	3,396	3,329	3,539	2,938	3,544	4,456
Supplementary	276	0	448	0	413	1,110
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	145	0	475	0	0	0
Out-of-pocket	666	933	536	854	540	0
Total Expenses	1,091	1,270	1,351	1,196	540	0

(Continued)

SOURCE: Congressional Budget Office simulations from Medicare benefits model.

TABLE 5. Continued

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Estimated Percentage Change from Current Values						
Net Federal Spending	0	14.0	5.0	-14.6	1.8	2.0
Enrollees' Benefits						
Medicare	0.5	12.4	4.5	-13.1	4.2	5.0
Supplementary	-45.9	0.0	-25.5	-100.0	-25.9	-16.1
Enrollees' Expenses						
SMI premiums	0	0	0	0	0	0
Supplementary premiums	-58.6	0	0	-100.0	0	0
Out-of-pocket	3.7	-13.5	0	25.3	0	0
Total Expenses	-14.3	-10.3	0	-29.1	0	0
Estimated Financial Effects on Enrollees						
Enrollees Who Would Gain						
Percentage of enrollees	27.6	8.1	0	84.3	0	0
Gain (Dollars)						
Average	719	1,768	0	652	0	0
Maximum	UL	UL	0	664	0	0
Enrollees Who Would Lose						
Percentage of enrollees	4.8	0	0	15.5	0	0
Loss (Dollars)						
Average	515	0	0	515	0	0
Maximum	736	0	0	736	0	0

NOTES: Cap is for 1991. Cap value would be indexed to growth in average precap copayments for later years. Net federal spending refers to spending for Medicare enrollees' acute care costs under Medicare or Medicaid. Supplementary benefits are only for acute care costs for Medicare enrollees.

RHP=retiree health plan; MGP=individual medigap plan; QMB=qualified Medicaid benefits; MCD=full Medicaid benefits; UL = unlimited; SMI = Supplementary Medical Insurance.

fall because Medicare would pick up a larger portion of enrollees' health care costs as a result of the new cap on copayments under Medicare.

Over all groups, average expenses for enrollees would fall by about 14 percent, or $183. Enrollees with retiree health benefits and those eligible for Medicaid would be unaffected because these groups already have better protection than Medicare would provide under this option. Enrollees with no supplementary coverage would see their expenses fall by about 10 percent because of the new cap on copayments. Expenses would fall by 29 percent, on average, for enrollees who currently have medigap policies--the net result of an increase in out-of-pocket costs more than offset by a reduction in medigap premium costs.

About 28 percent of enrollees would be financially better off under this option, by an average of $719. Nearly 5 percent would be financially worse off, by an average of $515. All of the "losers" would be enrollees who previously had medigap coverage, but more than 84 percent of the medigap group would be financially better off. The 16 percent of medigap enrollees who would be financially worse off are those whose increase in out-of-pocket costs would exceed $664, which is the amount by which their medigap premium costs would fall for the typical plan. The maximum potential increase in expenses for medigap enrollees would be $736 (equal to the $1,500 cap less the $764 paid currently for medigap premiums and the SMI deductible amount). About 10 percent of medigap enrollees would incur the maximum loss under this option in 1991, but all medigap enrollees would be at risk for it.

Option 2: Cap Copayments at $3,200; Prescription Drug Costs Would Count Toward Cap

If the copayment cap included prescription drug costs, it would have to be increased to $3,200 to avoid additional federal spending (see Table 6 on page 36). Even this relatively high copayment cap would reduce

financial risks for most enrollees, because all except those receiving full Medicaid or retiree health benefits now face potentially unlimited expenses for prescription drugs. For those who do not incur large prescription drug costs, however, the maximum financial risk they would face under this option would be substantially larger (by $1,700) than under the previous option.

Under this option, net federal spending would be virtually unchanged. Medicaid costs would increase by nearly 6 percent, under the assumption that Medicaid would assume payment of prescription drug costs for qualified Medicaid beneficiaries. Employers' costs would fall by nearly 25 percent, because Medicare would pay a portion of both copayment and prescription drug costs that retiree health plans pay now.

On average, enrollees' expenses would fall by nearly 18 percent, or $225. Once again, enrollees with retiree health benefits or with full Medicaid benefits would be unaffected because the new benefits under Medicare would not improve on their supplementary coverage. All other groups would be financially better off on average. Average expenses would fall by more than 10 percent for those with no supplementary coverage, and there would be no losers among this group. Average expenses would fall by 29 percent for those who previously had medigap coverage, but about 15 percent of this group would face higher expenses averaging $803. The maximum potential increase in expenses for medigap enrollees who used no prescription drugs would be $2,436 (equal to the $3,200 cap less the $764 paid currently for medigap premiums and the SMI deductible), although fewer than 1 percent of medigap enrollees would incur the maximum increase. Acute care expenses for those receiving qualified Medicaid benefits would be eliminated under this option because Medicaid would assume their prescription drug costs, in addition to paying all other copayment costs under Medicare for them.

TABLE 6. OPTION 2: CAP COPAYMENTS AT $3,200; PRESCRIPTION DRUG COSTS WOULD COUNT TOWARD CAP

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Estimated Current Values (Dollars per enrollee)						
Net Federal Spending	3,165	2,626	3,046	3,039	3,545	4,813
Enrollees' Benefits						
Medicare	3,379	2,963	3,386	3,380	3,400	4,243
Supplementary	510	0	601	498	558	1,323
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	352	0	475	664	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total Expenses	1,274	1,416	1,351	1,687	540	0
Estimated New Values (Dollars per enrollee)						
Net Federal Spending	3,166	2,941	3,205	2,544	3,924	4,916
Enrollees' Benefits						
Medicare[a]	3,373	3,278	3,545	2,885	3,568	4,457
Supplementary	323	0	452	0	940	1,121
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	145	0	475	0	0	0
Out-of-pocket	624	932	536	865	0	0
Total Expenses	1,049	1,269	1,351	1,206	0	0

SOURCE: Congressional Budget Office simulations from Medicare benefits model.

NOTES: Cap is for 1991. Cap value would be indexed to average precap copayments for later years. Net federal spending refers to spending for Medicare enrollees' acute care costs under Medi-

(Continued)

TABLE 6. Continued

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Estimated Percentage Change from Current Values						
Net Federal Spending	0	12.0	5.2	-16.3	10.7	2.1
Enrollees' Benefits						
Medicare[a]	-0.2	10.6	4.7	-14.6	5.0	5.0
Supplementary	-36.7	0	-24.8	-100.0	68.5	-15.2
Enrollees' Expenses						
SMI premiums	0	0	0	0	0	0
Supplementary premiums	-58.6	0	0	-100.0	0	0
Out-of-pocket	-2.9	-13.6	0	26.8	-100.0	0
Total Expenses	-17.7	-10.4	0	-28.5	-100.0	0
Estimated Financial Effects on Enrollees						
Enrollees Who Would Gain						
Percentage of enrollees	33.4	5.7	0	84.7	71.2	0
Gain (Dollars)						
Average	756	2,518	0	679	749	0
Maximum	UL	UL	0	UL	UL	0
Enrollees Who Would Lose						
Percentage of enrollees	4.6	0	0	15.1	0	0
Loss (Dollars)						
Average	803	0	0	803	0	0
Maximum	2,436	0	0	2,436	0	0

NOTES: Continued

care or Medicaid. Supplementary benefits are only for acute care costs for Medicare enrollees.

RHP=retiree health plan; MGP=individual medigap plan; QMB=qualified Medicaid benefits; MCD=full Medicaid benefits; UL = unlimited; SMI = Supplementary Medical Insurance.

a. Includes costs of administering the prescription drug benefit.

RESTRUCTURE AND CAP MEDICARE'S COPAYMENT REQUIREMENTS AND PROHIBIT MEDIGAP COVERAGE OF THEM

The options in this section would restructure Medicare's copayment requirements in addition to putting in place a ceiling on each enrollee's liability for them. Medicare's current copayment requirements are hard to understand and do not encourage appropriate use of services. With a cap on copayment costs under Medicare, it would be possible to alter current copayment requirements without undue hardship on enrollees with large health care needs. The objective of the changes would be to simplify the requirements and to encourage enrollees to consider relative costs appropriately when choosing among treatment alternatives. The changes assumed here would also reduce Medicare's costs, thereby permitting a lower copayment cap than was possible under the first set of options.

The new copayment structure considered here would establish a uniform coinsurance rate of 20 percent (or 25 percent for the third variation) of reasonable charges for almost all Medicare services--all except outpatient psychiatric services, for which a 50 percent coinsurance rate would remain. The SMI deductible would be increased to $200 (or $500 for the third variation). Medicare would eliminate the current limit on covered hospital days, and would also eliminate payments now made by Medicare for enrollees' bad debts under the HI program. The limit on covered SNF days would be changed from 100 days per spell of illness to 100 days a year. The cumbersome spell of illness concept would be eliminated.

For some services, it would be most convenient to base coinsurance amounts on estimates of average costs, either nationwide (as is done now for the HI deductible amount) or locally. Compared with using a nationwide base, a base that varied with local costs would generally impose higher copayment costs (up to the copayment cap) on those in more urbanized areas.

The coinsurance rate could apply to the estimated average cost per day for skilled nursing facilities (SNFs), for example, and to the aver-

age cost per visit for home health services. For hospital outpatient services, the coinsurance rate (which currently applies to each hospital's actual charge) might apply to the hospital's actual charge reduced by the cost-to-charge ratio determined by Medicare's audit of that hospital's outpatient charges the previous year. For hospital stays, the coinsurance rate could apply to Medicare's diagnosis-based payment rate for each stay, so that enrollees admitted for a relatively expensive diagnosis would pay more than those admitted for an inexpensive diagnosis, up to the copayment ceiling. For physicians' services, the coinsurance rate would apply to Medicare's allowed amount, as it does now.

This approach would incorporate incentives for more prudent use of services by enrollees, while reducing the risk of catastrophic acute care expenses for enrollees. With a nearly uniform coinsurance rate, patients' expenses would mirror the actual costs of providing the services they use, encouraging them to consider relative costs when choosing among alternative treatments.

For example, patients would have a financial incentive to prefer less expensive home health services after a hospital stay rather than a brief stay in a nursing home. Under current law, which provides both home health visits and the first 20 days in a skilled nursing facility free of charge to enrollees, the patient is financially indifferent between the two alternatives. Patients also have no financial reason to refuse unnecessary home health visits or laboratory tests under current law, because neither service has a copayment requirement. In addition, basing copayments for hospital stays on their diagnosis might induce enrollees to monitor their classifications, perhaps constraining hospitals in their attempts to increase Medicare's payments to them by inflating their case mix. Further, the per-stay hospital copayment would work to reduce unnecessary admissions, while eliminating copayment requirements for long hospital stays would be unlikely to increase use of services. Under Medicare's prospective payment system, patients do not remain in hospital any longer than necessary, since hospitals have strong financial incentives to discharge them quickly.

TABLE 7. OPTION 3: RESTRUCTURE AND CAP COPAYMENTS AT $1,000; PRESCRIPTION DRUG COSTS WOULD NOT COUNT TOWARD CAP

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Estimated Current Values (Dollars per enrollee)						
Net Federal Spending	3,165	2,626	3,046	3,039	3,545	4,813
Enrollees' Benefits						
Medicare	3,379	2,963	3,386	3,380	3,400	4,243
Supplementary	510	0	601	498	558	1,323
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	352	0	475	664	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total Expenses	1,274	1,416	1,351	1,687	540	0
Estimated New Values (Dollars per enrollee)						
Net Federal Spending	3,159	2,973	3,201	2,589	3,605	4,913
Enrollees' Benefits						
Medicare	3,392	3,310	3,541	2,931	3,543	4,475
Supplementary	270	0	437	0	407	1,082
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	145	0	475	0	0	0
Out-of-pocket	659	909	538	845	540	0
Total Expenses	1,084	1,246	1,354	1,187	540	0

SOURCE: Congressional Budget Office simulations from Medicare benefits model.

NOTES: Cap is for 1991. Cap value would be indexed to average precap copayments for later years. Net federal spending refers to spending for Medicare enrollees' acute care costs under

(Continued)

TABLE 7. Continued

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Estimated Percentage Change from Current Values						
Net Federal Spending	-0.2	13.2	5.1	-14.8	1.7	2.1
Enrollees' Benefits						
Medicare	0.4	11.7	4.6	-13.3	4.2	5.5
Supplementary	-47.1	0.0	-27.3	-100.0	-27.0	-18.2
Enrollees' Expenses						
SMI premiums	0	0	0	0	0	0
Supplementary premiums	-58.6	0	0	-100.0	0	0
Out-of-pocket	2.6	-15.7	0.5	24.0	0	0
Total Expenses	-14.9	-12.0	0.2	-29.7	0	0
Estimated Financial Effects on Enrollees						
Enrollees Who Would Gain						
Percentage of enrollees	30.1	14.9	3.8	83.8	0	0
Gain (Dollars)						
Average	683	1,373	242	622	0	0
Maximum	UL	UL	500	664	0	0
Enrollees Who Would Lose						
Percentage of enrollees	20.2	50.2	15.5	16.0	0	0
Loss (Dollars)						
Average	107	71	72	233	0	0
Maximum[a]	1,000	1,000	1,000	336	0	0

NOTES: Continued

Medicare or Medicaid. Supplementary benefits are only for acute care costs for Medicare enrollees.

RHP=retiree health plan; MGP=individual medigap plan; QMB=qualified Medicaid benefits; MCD=full Medicaid benefits; UL = unlimited; SMI = Supplementary Medical Insurance.

a. Maximum loss could be larger for those enrolled only under the Hospital Insurance program, who would not be protected by the copayment cap.

Under this approach, however, the proportion of enrollees for whom expenses would increase would be about four times larger than under the options examined earlier, although the increase would be small for most of them. Expenses would increase by small amounts for a relatively large proportion of enrollees because of the higher SMI deductible amount and the new copayment requirements on services that currently do not have any. Because of the new copayment requirements, the maximum potential increase in expenses would be substantial for all except Medicaid enrollees, but very few enrollees would incur this maximum increase.

Option 3: Restructure and Cap Copayments at $1,000; Prescription Drug Costs Would Not Count Toward Cap

Under this option, the redesigned copayment requirements under Medicare would be capped for each enrollee at $1,000 and medigap plans would be prohibited from paying any of Medicare's copayment costs for covered services. Net federal spending would fall by 0.2 percent, or $0.2 billion for 1991 (see Table 7 on page 40). Medicaid costs would fall by 15 percent, and employers' costs would fall by about 27 percent.

Over all groups, average expenses for enrollees would fall by 15 percent, or $190. Although most enrollees would have expenses that were lower or unchanged by this option, about 20 percent would face somewhat higher expenses by an average of $107. In contrast to previous options, enrollees with retiree health benefits would also be affected. Further, the effects on those without supplementary coverage would differ from the effects under previous options because some of them would be financially worse off under this approach.

For those with no supplementary coverage, average expenses would fall by 12 percent. Among this group, expenses would fall by an average of $1,373 for nearly 15 percent, but would increase by an average of $71 for 50 percent. Enrollees who would be financially better off under this option are those with large costs, who would benefit because of the new cap on copayment costs under Medicare. Most enrollees who would be financially worse off are those with small costs, who would see their out-of-pocket expenses increase slightly because of

the higher SMI deductible and the new copayment requirements on some services that currently lack them. The maximum potential increase in expenses, however, would be set by Medicare's copayment cap and might affect enrollees with large costs for services (such as home health) that would be newly subject to coinsurance requirements.

For medigap enrollees, average expenses would fall by nearly 30 percent. Nearly 84 percent of enrollees would see their expenses fall by an average of $622, but 16 percent would face higher expenses averaging $233. The maximum potential increase in expenses for medigap enrollees under this option would be $336 (equal to the $1,000 cap less the $664 paid in medigap premiums), but fewer than 1 percent of them would incur the maximum increase.

Average expenses would increase by 0.2 percent for those with retiree health benefits, although the effects would be concentrated on the 16 percent of them with too few health care costs to exceed the deductible under their retiree health plan. For this group, the new copayment requirements under Medicare would increase expenses by $72 on average. The maximum potential increase would be $1,000, affecting only those with large costs for services not currently subject to copayment requirements under Medicare. Nearly 4 percent of those with retiree health benefits would see their expenses fall because--for those without prescription drug expenses--Medicare's $1,000 copayment cap would improve on the $1,500 cap provided under the typical retiree health plan.

Option 4: Restructure and Cap Copayments at $2,200; Prescription Drug Costs Would Count Toward Cap

If the costs of prescription drugs counted toward the copayment cap, it would have to be increased to $2,200 to avoid an increase in federal spending; instead, spending would fall by 0.6 percent, or $0.7 billion for 1991 (see Table 8). Medicaid costs would increase by 4 percent, because of newly covered prescription drug costs for qualified Medicaid beneficiaries. Employers' costs would fall by more than 30 percent, an

TABLE 8. OPTION 4: RESTRUCTURE AND CAP COPAYMENTS AT $2,200; PRESCRIPTION DRUG COSTS WOULD COUNT TOWARD CAP

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Estimated Current Values (Dollars per enrollee)						
Net Federal Spending	3,165	2,626	3,046	3,039	3,545	4,813
Enrollees' Benefits						
Medicare	3,379	2,963	3,386	3,380	3,400	4,243
Supplementary	510	0	601	498	558	1,323
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	352	0	475	664	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total Expenses	1,274	1,416	1,351	1,687	540	0
Estimated New Values (Dollars per enrollee)						
Net Federal Spending	3,146	2,880	3,231	2,488	3,919	4,939
Enrollees' Benefits						
Medicare[a]	3,355	3,217	3,571	2,830	3,560	4,507
Supplementary	309	0	419	0	947	1,073
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	145	0	475	0	0	0
Out-of-pocket	613	880	549	851	0	0
Total Expenses	1,038	1,217	1,364	1,193	0	0

(Continued)

SOURCE: Congressional Budget Office simulations from Medicare benefits model.

NOTES: Cap is for 1991. Cap value would be indexed to average precap copayments for later years. Net federal spending refers to spending for Medicare enrollees' acute care costs under Medicare or Medicaid. Supplementary benefits are only for acute care costs for Medicare enrollees.

TABLE 8. Continued

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Estimated Percentage Change from Current Values						
Net Federal Spending	-0.6	9.7	6.1	-18.1	10.6	2.6
Enrollees' Benefits						
Medicare[a]	-0.7	8.6	5.5	-16.3	4.7	6.2
Supplementary	-39.4	0	-30.4	-100.0	69.8	-18.8
Enrollees' Expenses						
SMI premiums	0	0	0	0	0	0
Supplementary premiums	-58.6	0	0	-100.0	0	0
Out-of-pocket	-4.6	-18.5	2.5	24.9	-100.0	0
Total Expenses	-18.5	-14.1	1.0	-29.3	-100.0	0
Estimated Financial Effects on Enrollees						
Enrollees Who Would Gain						
Percentage of enrollees	34.6	13.0	0.0	83.4	71.2	0.0
Gain (Dollars)						
Average	797	1,899	0	694	749	0
Maximum	UL	UL	0	UL	UL	0
Enrollees Who Would Lose						
Percentage of enrollees	21.1	52.7	16.2	16.5	0.0	0.0
Loss (Dollars)						
Average	218	98	82	657	0	0
Maximum[b]	2,200	2,200	1,500	1,536	0	0

NOTES: Continued

RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits; UL = unlimited; SMI = Supplementary Medical Insurance.

a. Includes costs of administering the prescription drug benefit.

b. Maximum loss could be larger for those enrolled only under the Hospital Insurance program, who would not be protected by the copayment cap.

TABLE 9. OPTION 5: RESTRUCTURE AND CAP COPAYMENTS AT $2,400 WITH SMI DEDUCTIBLE OF $500 AND COINSURANCE RATE OF 25 PERCENT; STANDARD BENEFIT FOR PRESCRIPTION DRUGS

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Percentage of Enrollees	100.0	21.1	30.4	30.7	8.7	9.1
Estimated Current Values (Dollars per enrollee)						
Net Federal Spending	3,165	2,626	3,046	3,039	3,545	4,813
Enrollees' Benefits						
Medicare	3,379	2,963	3,386	3,380	3,400	4,243
Supplementary	510	0	601	498	558	1,323
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	352	0	475	664	0	0
Out-of-pocket	643	1,079	536	682	540	0
Total Expenses	1,274	1,416	1,351	1,687	540	0
Estimated New Values (Dollars per enrollee)						
Net Federal Spending	3,149	2,871	3,267	2,459	3,936	4,950
Enrollees' Benefits						
Medicare[a]	3,360	3,207	3,607	2,801	3,595	4,528
Supplementary	295	0	388	0	915	1,054
Enrollees' Expenses						
SMI premiums	279	337	340	342	0	0
Supplementary premiums	145	0	475	0	0	0
Out-of-pocket	592	829	549	817	0	0
Total Expenses	1,017	1,166	1,364	1,159	0	0

SOURCE: Congressional Budget Office simulations from Medicare benefits model.

NOTES: Cap is for 1991. Cap value would be indexed to average precap copayments for later years. Net federal spending refers to spending for Medicare enrollees' acute care costs under Medicare or Medicaid. Supplementary benefits are only for acute care costs for Medicare enrollees.

(Continued)

TABLE 9. Continued

	Overall	Type of Supplementary Coverage				
		None	RHP	MGP	QMB	MCD
Estimated Percentage Change from Current Values						
Net Federal Spending	-0.5	9.3	7.2	-19.1	11.0	2.8
Enrollees' Benefits						
Medicare[a]	-0.6	8.3	6.5	-17.1	5.7	6.7
Supplementary	-42.2	0	-35.5	-100.0	64.0	-20.3
Enrollees' Expenses						
SMI premiums	0	0	0	0	0	0
Supplementary premiums	-58.6	0	0	-100.0	0	0
Out-of-pocket	-7.9	-23.2	2.4	19.9	-100.0	0
Total Expenses	-20.2	-17.7	1.0	-31.3	-100.0	0
Estimated Financial Effects on Enrollees						
Enrollees Who Would Gain						
Percentage of enrollees	40.5	36.3	4.7	82.2	71.2	0
Gain (Dollars)						
Average	760	861	5	774	749	0
Maximum	UL	UL	90	UL	UL	0
Enrollees Who Would Lose						
Percentage of enrollees	18.6	39.0	16.1	17.7	0	0
Loss (Dollars)						
Average	305	166	83	753	0	0
Maximum[b]	2,400	2,400	1,500	1,736	0	0

NOTES: Continued

RHP = retiree health plan; MGP = individual medigap plan; QMB = qualified Medicaid benefits; MCD = full Medicaid benefits; UL = unlimited; SMI = Supplementary Medical Insurance.

a. Includes the costs of administering a standard prescription drug benefit and assumes that Medicare could obtain a price discount of about 6 percent.

b. Maximum loss could be larger for those enrolled only under the Hospital Insurance program, who would not be protected by the copayment cap.

increase over their savings in the previous option because of Medicare's partial coverage of costs for prescription drugs.

Over all, average expenses for enrollees would fall by nearly 19 percent, or $236. About 21 percent of enrollees would see higher expenses by an average of $218, but nearly 35 percent would have lower expenses by an average of $797. The proportion of enrollees who would be financially better off is higher under this option primarily because those eligible for qualified Medicaid benefits would be affected--by the inclusion of prescription drug costs in the copayment cap--while they would not benefit under the previous option. Those without supplementary coverage would gain more under this option than under the previous one because of the cap on prescription drug costs. The maximum potential increase in expenses, however, would be larger for all enrollees except those receiving Medicaid benefits because of the higher Medicare cap on copayment costs. The maximum potential loss would be $2,200 for those without supplementary coverage, $1,500 for those with retiree health benefits, and $1,536 for medigap enrollees. (The maximum potential loss would be set by Medicare's copayment cap for those without supplementary coverage, by the lesser of Medicare's or the retiree health plan's cap for those with retiree health benefits, and by Medicare's cap less medigap premiums for medigap enrollees.)

Option 5: Restructure and Cap Copayments at $2,400 with SMI Deductible of $500 and Coinsurance Rate of 25 Percent; Standard Benefit for Prescription Drugs

If prescription drug costs were covered as a standard benefit under the SMI program, subject to deductible and coinsurance requirements, either the deductible amount, the coinsurance rate, or the copayment cap would have to be increased to avoid adding to Medicare costs.[2] With a deductible of $500, a coinsurance rate of 25 percent, and a cap of $2,400, net federal spending would fall by 0.5 percent, or $0.6 billion in

2. The estimates for a standard prescription drug benefit assume that Medicare could negotiate a reduction of about 6 percent on current retail prices for prescription drugs, which all Medicare enrollees could claim. No reduction in prescription drug prices was assumed for earlier options.

1991 (see Table 9 on page 46).[3] Medicaid costs would increase by 2 percent because of its new coverage of some prescription drug costs for qualified beneficiaries, and employers' costs would fall by nearly 36 percent.

Average expenses for enrollees would fall by more than 20 percent, or $257. About 19 percent of enrollees would have higher expenses, by $305 on average. But nearly 41 percent would have lower expenses, by $760. Average expenses would fall by 18 percent for enrollees with no supplementary coverage, but expenses would increase by an average of $166 for 39 percent of them and the maximum potential loss would be $2,400. Average expenses would increase by 1 percent for those with retiree health benefits. The 16 percent of this group with health care costs too low to exceed the retiree health plan deductible would be adversely affected; for them, average expenses would increase by $83, with a maximum potential increase of $1,500. Nearly 5 percent of those with retiree health benefits would be slightly better off--entirely as a result of the 6 percent discount on prescription drugs assumed for Medicare enrollees under this option. Average expenses would fall by 31 percent for those with medigap coverage. For the 18 percent of medigap enrollees who would see their expenses rise, the average increase would be $753, and the maximum potential increase (for those not requiring prescription drugs) would be $1,736. Acute care expenses would be eliminated for those receiving qualified Medicaid benefits.

3. Approximately the same net federal savings would result with a deductible of $500, a coinsurance rate of 20 percent, and a cap of $2,700.

APPENDIX

TOTAL COSTS AND ENROLLEES' LIABILITIES FOR MEDICARE-COVERED SERVICES, 1975-1991

During the 1980s, major changes occurred in the health care sector, both general and specific to Medicare. Advances in technology permitted a substantial shift in services from hospitals to the outpatient sector, while greatly increasing the services available. The growing number of physicians relative to the population improved access to care. But costs increased at rapid rates as well, inducing payers to move away from the cost-based reimbursement of the past toward greater cost-consciousness.

Medicare participated in this trend toward cost-consciousness. In 1983, it established the prospective payment system for hospitals, under which it eliminated cost-based reimbursement in favor of a case-based system intended to induce hospitals to eliminate unnecessary services during each admission. It also introduced peer review organizations whose task it was to prevent unnecessary admissions, as well as to ensure that appropriate care was provided. Further, since 1983, cumulative increases in payment rates for most providers under Medicare have been held below the increase in their costs.

After briefly reviewing the major changes made in Medicare in recent years, this appendix focuses on historical changes in total costs for Medicare-covered services and in enrollees' statutory share of those costs. Enrollees' statutory liabilities include the copayments Medicare requires (deductible amounts and coinsurance), balance-billing (the excess of actual charges over Medicare's payment rates), and premiums. In addition, rough estimates are presented of enrollees' expenses for all their health care needs, including those not covered by Medicare.

HISTORY OF CHANGES UNDER MEDICARE

Since the Medicare program was put in place in 1966, its benefit structure has changed little--apart from a temporary expansion of benefits in 1989 under the Medicare Catastrophic Coverage Act (MCCA) of 1988.[1] But the population covered by Medicare increased significantly in 1973 when eligibility--previously limited to those age 65 or more--was expanded to include those receiving Social Security disability benefits for the previous 24 months and those with end-stage renal disease. Further, the way Medicare sets payment rates for providers of services has changed. (See Table A-6 at the end of this appendix for a chronological list of major changes, by year of implementation.)

Eligibility and Premiums

Most enrollees are eligible for Hospital Insurance (HI) benefits because of payroll tax contributions during their working years. Beginning in 1973, those age 65 or more who were not eligible for HI benefits from payroll tax contributions were permitted to purchase HI coverage by paying a monthly premium. Initially, the premium was based on the HI deductible amount. By the mid-1980s, however, this amount exceeded the insurance value of HI benefits. Beginning in 1989, the premium was instead set by the projected insurance value of HI benefits. (The insurance value is the value per enrollee of benefits plus related administrative costs.)[2]

All enrollees are liable for a monthly premium for Supplementary Medical Insurance (SMI) benefits, although Medicaid pays it for some of them. From 1966 through 1972, the premium was set to cover 50 percent of the projected insurance value of SMI benefits. When eligibility was expanded to include the disabled in 1973, the basis for the premium was changed to the insurance value of SMI benefits for aged

1. For a description of this short-lived benefit expansion, see the CBO paper called "The Medicare Catastrophic Coverage Act of 1988" (October 1988).

2. Also in 1989 a "supplemental" income-related premium (an income tax surtax) was imposed on all higher-income Hospital Insurance enrollees to cover a portion of the costs of the new benefits under the Medicare Catastrophic Coverage Act. The supplemental premium was later repealed, and payments made by enrollees were refunded.

enrollees. As of 1975, the percentage increase in the premium each year was limited by the most recent cost-of-living adjustment (COLA) for Social Security benefits. Because SMI costs grew faster than the COLA, the percentage of the aged enrollee's insurance value covered by the premium fell from 50 percent to about 25 percent between 1974 and 1983. From 1984 through 1990, the premium was adjusted to cover 25 percent of the aged enrollee's expected insurance value for the year. Premiums are set in law for 1991 through 1995 at values that would cover 25 percent of the aged enrollee's insurance value if projections made by CBO in 1990 prove to be correct. Under current law, the COLA will once again limit growth in premiums for 1996 and later years.

Covered Services

Since its inception, there has been limited expansion of services covered by Medicare. In 1983, coverage was extended to include hospice care for enrollees with less than six months to live. Initially, Medicare covered no preventive services, but coverage for pneumococcal vaccine was added in 1981; coverage for pap smears in 1990; and coverage for mammograms in 1991.

Through 1989, reimbursement under Medicare for outpatient psychiatric services was limited to specified amounts a year, but thereafter reimbursement for such services was no longer limited. Through 1980, coverage for home health visits was limited to at most 100 visits a year, but this restriction was dropped beginning in 1981. In 1988, coverage was restricted to homebound enrollees. The definition of "intermittent" care was relaxed temporarily in 1989 under the MCCA to permit up to 38 consecutive days of care instead of the previous and current limit of 21 days.

There has been no lasting change in skilled nursing facility (SNF) or hospital coverage under Medicare, although coverage limits were briefly changed for 1989 under the MCCA. Under that act, coverage limits for SNF stays were changed from 100 days per spell of illness to 150 days per year, and the limit on days of coverage for inpatient hospital stays was temporarily dropped. A revision in 1988 of the

instruction manual administrative agents use to determine whether SNF stays are eligible for Medicare coverage had the effect of greatly relaxing the criteria applied, with the result that covered use expanded substantially.

Cost-Sharing Requirements

Copayments for both inpatient and SNF stays are based on the HI deductible amount. Although HI copayment requirements have not changed--apart from the MCCA provisions in place only for 1989--the calculation of the HI deductible amount has changed twice. Beginning in 1982, the Congress raised HI copayments by increasing the share of daily costs used in calculating the HI deductible, and by basing copayments on the deductible amount applicable at the time of service rather than at the time the spell of illness began. For 1987, HI copayments were reduced relative to previous law by overriding the increase in the deductible amount that would otherwise have occurred. For all subsequent years, increases in the HI deductible have been based on how much hospital payment rates were updated, instead of on increases in daily costs.

For 1989 only, HI copayment requirements were reduced under the MCCA. Copayment requirements for hospital stays were limited to at most one first-day deductible each year, with Medicare paying all other costs. Copayment requirements for SNF stays were imposed on the first eight days during the year, instead of on days 21 through 100 during each spell of illness. Further, the amount of cost-sharing required each day was greatly reduced, from one-eighth of the HI deductible amount ($70 in 1989) to 20 percent of per-day costs ($25.50).

The SMI deductible amount has changed three times since the inception of Medicare. It increased from $50 to $60 effective for 1973; to $75 as of 1982; and to $100 as of 1991. When adjusted for economywide inflation, however, the real value of the SMI deductible was nearly halved between 1967 and 1991. Relative to total approved charges per enrollee under the SMI program, the SMI deductible fell from about 45 percent in 1967 to only about 5 percent in 1991.

Some vacillation has occurred on copayment requirements for services the SMI program provides. Although such requirements were comprehensive at the program's inception, in 1968 an exception was made for inpatient services provided by radiologists and pathologists. This exception was reversed, and copayment requirements were restored in 1982. Copayment requirements were eliminated for home health services in 1973 and for clinical laboratory services in 1984; both of these exceptions continue. Copayment requirements were eliminated for physicians providing outpatient surgery on an assigned basis in 1981, but were restored in 1988.

Payment Rates to Providers

Initially, Medicare's payments to institutional providers--hospitals, nursing facilities, and home health agencies--were based on the cost of whatever covered services Medicare enrollees received. In 1982, Medicare imposed limits on the rate of growth in costs per day for these providers. In a phased implementation between October 1983 and October 1984, the prospective payment system (PPS) superseded the limits for hospitals. Under the PPS, hospitals were paid a set amount per discharge based on the patient's diagnosis, without regard to the services actually provided. Since then, automatic increases in hospital payment rates per case have been linked to the rate of increase in an index of hospital costs (the "market basket"), although legislation that set a different (typically lower) update has often superseded the automatic process (Table A-1).

In 1982, a prospective payment for facility fees in approved ambulatory surgical centers was established for selected surgical procedures. In 1987, payment of facility costs for these procedures when performed in hospital outpatient departments was changed to a blend of costs and the prospective rate; under previous law, payment had been based entirely on the hospital's costs.

Physicians' rates were initially based on their customary charges, subject to a ceiling typically set by the ninetieth percentile of the distribution of customary charges for all physicians in the locality. In 1971, this ceiling was reduced to the seventy-fifth percentile.

Beginning in 1975, increases in the ceiling in each locality were limited by an index of physicians' practice costs called the Medicare Economic Index (MEI). In 1984, Medicare's payment rates to physicians were frozen through April 1986. Each year since then legislation has held the update below the MEI increase for some or all

TABLE A-1. PERCENTAGE INCREASES IN MEDICARE'S INPATIENT PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM

	Percentage Increase in Market Basket[a]	Actual Average Update[b]
Annual Increase (By fiscal year)		
1984	4.90	4.70
1985	4.10	4.50
1986	2.90	0.50
1987	3.20	1.15
1988	4.70	1.50
1989	5.60	3.30
1990	4.80	6.00
1991	4.70	3.30
Cumulative Increases from Fiscal Year 1983 Through 1991		
Market Basket	1.41	
Actual Average Update		1.28
Ratio of cumulative increase in update to cumulative increase in market basket is 90.8.		

SOURCE: Congressional Budget Office from market basket information provided by the Health Care Financing Administration and average update information provided by the Prospective Payment Assessment Commission.

NOTE: Changes in payment rates do not necessarily reflect changes in payments per case, or changes in payments per enrollee. In fact, payments per case increased more rapidly than payment rates did over this period because of changes in case mix intensity. Changes in payments per enrollee increased less rapidly than payments per case because of a fall in admission rates.

a. Current estimates, which may differ from estimates made at the time of promulgation.

b. Payment-weighted average update effective by the end of the fiscal year.

TABLE A-2. PERCENTAGE INCREASES IN MEDICARE'S CEILINGS ON PREVAILING CHARGES FOR PHYSICIANS' SERVICES

12-Month Period Begins	Percentage Increase Promulgated	Service Category	Actual Update For: Participating Physicians	Actual Update For: Nonparticipating Physicians
Increases for 12-Month Period				
July 1976	8.23	All	n.a.	8.23
July 1977	6.35	All	n.a.	6.35
July 1978	5.08	All	n.a.	5.08
July 1979	7.50	All	n.a.	7.50
July 1980	8.15	All	n.a.	8.15
July 1981	7.96	All	n.a.	7.96
July 1982	8.88	All	n.a.	8.88
July 1983	5.85	All	n.a.	5.85
July 1984	3.34	All	0	0
October 1985	3.15	All	0	0
May 1986		All	4.15	0
January 1987	3.20[a]	All	3.20	c
January 1988	3.60[b]	Primary Care	3.60	d
		Other	1.00	
January 1989	4.10[a]	Primary Care	3.00	e
		Other	1.00	
January 1990	4.20[b]	Primary Care	4.20	e
		Other	2.00	
January 1991	4.60	Primary Care	2.00	e
		Other	0	
Cumulative Increases from Calendar Year 1983 Through 1991				
Medicare Economic Index (MEI)	1.30			
Actual Update				
Participating physicians			1.14	
Nonparticipating physicians				1.08
Average		1.12		
Ratio of cumulative increase in update to cumulative increase in MEI is 86.20.				

SOURCE: Congressional Budget Office from *Federal Register* and legislation.

NOTES: In addition, rates for certain overvalued procedures were reduced in some years.

Changes in payment rates do not necessarily reflect changes in payments per enrollee. In fact, payments per enrollee increased more rapidly than payment rates did because of increases in the volume of services provided per enrollee.

n.a. = not applicable.

a. Estimated by CBO.
b. Update delayed until April.
c. Ceiling set at 96.0 percent of that for participating physicians.
d. Ceiling set at 95.5 percent of that for participating physicians.
e. Ceiling set at 95.0 percent of that for participating physicians.

services, often including actual rate reductions for certain services considered to be overvalued (see Table A-2 on page 57). Fee schedules were put in place in 1984 for clinical laboratory services and in 1989 for radiology services, replacing Medicare's charge-based payment system for these services. In 1992, a resource-based fee schedule will be established for all physicians' services under Medicare.[3]

GROWTH IN TOTAL COSTS FOR MEDICARE-COVERED SERVICES

Average annual growth in total costs for Medicare-covered services was more than 14 percent from 1975 through 1988, but this amount includes economywide inflation and enrollment growth. The discussion here shows per enrollee costs in constant 1991 dollars to isolate that portion of cost growth not explained by general inflation and changes in enrollment. (The enrollment measure used is the unduplicated count of those enrolled under either the HI or the SMI program as of July 1 each year.)

The period from 1975 to 1980--when no major changes were made under Medicare--is used as a benchmark to provide an indication of how real costs per enrollee might have grown if Medicare legislation had not been enacted during the 1980s (see Box A-1). The benchmark period starts with 1975 instead of an earlier year for two reasons. First, the Medicare population changed significantly when coverage was extended to the disabled population in 1973, with full enrollment of the newly eligible population still incomplete in 1974. Second, national wage-price controls were in effect from August 1971 through April 1974.

Spending in 1988 is used for one comparison because it is the latest year for which complete information on incurred costs is available, and because new benefits briefly provided in 1989 under the Medicare

3. For a description of the forthcoming changes in physician payment, see Congressional Budget Office, *Physician Payment Reform Under Medicare* (April 1990).

BOX A-1
Choosing an Appropriate Benchmark

The assumption underlying the analysis in this appendix is that real growth in Medicare costs per enrollee would have continued at its 1975-1980 rate in the absence of legislation. If, instead, growth in costs under Medicare would otherwise have accelerated during the 1980s (as growth in the non-Medicare sector did), then recent legislation may have reduced costs under Medicare by more than the results shown indicate. It is likely, however, that growth in real per capita spending for non-Medicare services accelerated during the latter 1980s in part as a response to slower Medicare growth; that is, non-Medicare spending was probably affected indirectly by Medicare legislation through cost-shifting. Hence, changes in the rate of growth in non-Medicare spending cannot serve as an indicator of how growth in Medicare spending would have changed without legislation. Instead, growth in real per capita health spending nationwide is used as that indicator--implicitly assuming that no single payer can appreciably affect the total payments claimed by the health care sector. Because growth between 1980 and 1988 in real per capita health spending nationwide was similar to the rate between 1975 and 1980, it was assumed that the growth rate for Medicare spending would also have changed little in the absence of legislation.

Growth rates calculated for real spending differ depending on the deflator used to estimate real values, potentially affecting the conclusions that may be drawn. Real values shown in this appendix were obtained using the implicit price deflator for gross national product because it generates a conservative estimate of the effect of Medicare legislation during the 1980s when growth during the period from 1975 to 1980 is used as the benchmark. If the fixed-weighted deflator had been used instead, actual Medicare spending for 1988 would have been only 82 percent of the value predicted by continuing the trend between 1975 and 1980. With the fixed-weighted deflator, though, growth in real per capita health spending nationwide slowed during the 1980s compared with the period from 1975 to 1980. If the 1975-1980 rate of growth for Medicare spending is adjusted downward to mirror the deceleration in spending nationwide, actual Medicare spending in 1988 is 88 percent of the value projected by the adjusted trend--the same result obtained using the implicit price deflator.

Catastrophic Coverage Act did not affect 1988 spending.[4] A comparison using projected spending for 1991 is also shown, although projections are always uncertain.

Total costs per enrollee under Medicare in 1988 were about 88 percent of what they would have been had the trend in real per enrollee costs from 1975 to 1980 continued (Table A-3). In constant dollars, total costs per enrollee grew at an average annual rate of 6.8 percent between 1975 and 1980, but at a slower rate of 5.2 percent between 1980 and 1988. Growth was 7.4 percent a year between 1980 and 1984, but slowed dramatically--to about 3.0 percent a year--between 1984 and 1988, and this slower rate of growth is expected to continue through 1991. Actual spending is expected to be only about 78 percent of trend by 1991. Deceleration in the rate of growth in real costs per enrollee under the HI program was much more significant than the slowdown under the SMI program. By 1988, HI costs were only 81 percent of trend, while SMI costs were 98 percent of trend.

The decline during the 1980s in the rate of growth for real costs per enrollee under Medicare, compared with growth between 1975 and 1980, contrasts with the experience of the rest of the health care sector. For health care services not covered by Medicare, growth in real per capita spending accelerated during the latter 1980s, coincident with the large drop in growth for Medicare spending. These events are consistent with the common view that Medicare's recent success at slowing growth in its costs has come at the expense of other payers in the health care sector. Apparently, there has been little effect on growth in real per capita health care costs overall, however.

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4. Spending can be presented either as incurred costs or outlays. Incurred costs are costs for all services provided during the year. Outlays are amounts paid during the year. Outlays may include payments for some services provided (costs incurred) in previous years, and may exclude payments for some costs incurred during the year. Year-to-year changes in outlays can be misleading because outlays are affected by variation in the lags between the time of service and the date on which Medicare pays for the service.

TABLE A-3. TOTAL COSTS FOR PERSONAL HEALTH CARE UNDER MEDICARE BY SERVICE CATEGORY

Calendar Year	Medicare Costs			Costs by Service Category					
				Hospitals				HH and Hospice	Physician and Lab
	Total	HI	SMI	Total	INP	OPD	SNF		
	Values (1991 dollars per enrollee)								
1975	1,764	1,125	639	1,141	1,076	65	32	28	562
1976	1,940	1,230	711	1,256	1,173	84	35	35	612
1977	2,072	1,313	759	1,351	1,254	97	33	39	647
1978	2,173	1,371	802	1,418	1,312	106	31	41	681
1979	2,282	1,429	853	1,483	1,369	114	29	44	725
1980	2,457	1,534	922	1,594	1,471	123	29	46	786
1981	2,629	1,648	980	1,706	1,573	134	28	53	840
1982	2,872	1,792	1,080	1,848	1,698	150	30	64	929
1983	3,095	1,903	1,192	1,964	1,795	169	32	78	1,022
1984	3,263	2,013	1,250	2,078	1,892	186	33	89	1,063
1985	3,330	2,017	1,312	2,106	1,897	209	32	90	1,102
1986	3,485	2,036	1,448	2,162	1,919	243	31	88	1,204
1987	3,575	2,022	1,553	2,181	1,909	272	30	85	1,279
1988	3,679	2,049	1,630	2,212	1,917	295	46	88	1,333
1991[a]	3,992	2,215	1,777	2,312	1,968	344	129	120	1,431
	Annual Growth Rates								
1975-1980	6.8	6.4	7.6	6.9	6.5	13.6	-1.9	10.3	7.0
1980-1984	7.4	7.0	7.9	6.9	6.5	10.9	3.4	17.6	7.8
1984-1988	3.0	0.4	6.9	1.6	0.3	12.2	8.4	0.0	5.8
1988-1991	2.8	2.6	2.9	1.5	0.9	5.2	41.3	10.9	2.4
1980-1988	5.2	3.7	7.4	4.2	3.4	11.6	5.9	8.4	6.8
1980-1991	4.5	3.4	6.1	3.4	2.7	9.8	14.5	9.1	5.6
	Values Relative to Trend for 1975-1980								
1988	88.2	81.3	98.2	81.2	78.9	86.5	184.1	87.1	99.0
1991[a]	78.5	73.0	86.0	69.5	67.2	68.7	549.9	88.5	86.9

SOURCE: Congressional Budget Office.

NOTES: Total costs include Medicare's reimbursements plus enrollees' copayment and balance-billing costs. Administrative costs are not included here. The implicit price deflator for gross national product was used to get constant 1991 dollars.

HI = Hospital Insurance; SMI = Supplementary Medical Insurance; INP = hospital inpatient; OPD = hospital outpatient department; SNF = skilled nursing facility; HH = home health.

a. Projected.

Growth in HI Costs

Slower growth in HI costs--especially for hospital inpatient services--was responsible for most of the slowdown in the growth of total Medicare costs. Under the HI program, real costs per enrollee grew at an average annual rate of 7.0 percent between 1980 and 1984, but growth fell to only 0.4 percent a year between 1984 and 1988.

Real costs per enrollee for hospital inpatient care increased by only 0.3 percent a year between 1984 and 1988, although these costs had previously grown by 6.5 percent a year. Peer review of hospital admissions under Medicare was in place by July of 1984, and this review may have played a part in the significant reduction in admission rates for Medicare enrollees that took place after 1983. In addition, the prospective payment system (PPS) was fully in place by October of 1984, and this led to a substantial reduction in the average length of stay.[5] In an effort to claim some of the savings from reduced lengths of stay for the federal government, Medicare's cumulative updates in hospital payment rates in subsequent years were less than the growth in hospitals' costs. (Lower updates also helped to compensate for an initial miscalculation in hospital payment rates resulting in overpayments under the prospective payment system.) Although increases in the complexity of the average case mix reported by hospitals offset federal savings per admission from update reductions, growth in inpatient costs per enrollee fell relative to trend.

Growth in combined home health and hospice costs also slowed after 1984. The slowing occurred apparently because of stricter application by administrative agents of Medicare's criteria for home health coverage during the mid-1980s. Medicare's coverage for hospice care began in 1983, and payments grew rapidly thereafter. Currently, hospice services account for about 9 percent of combined home health and hospice payments under Medicare.

Growth in costs under Medicare for skilled nursing facilities differs from the pattern for other HI services. Between 1975 and 1980,

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5. Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System: Report to the Congress* (June 1990), pp. 65-66.

real costs per enrollee fell, but were roughly constant from 1980 through 1987. In 1988, growth in SNF costs accelerated sharply because of a revision in the guidance manual administrative agents use to determine Medicare coverage. This revision greatly relaxed the definition of covered care to make it conform with legislative language. Because costs for SNF services are a small part of total costs under the HI program, however, even the very large percentage increases in SNF costs that occurred had little effect on overall costs under the HI program.

Growth in SMI Costs

In contrast to experience under the HI program, total costs under the SMI program for 1988 were about 98 percent of the trend value. Although growth in costs was reduced relative to trend for SMI services, the drop was far less striking than it was for HI services. Between 1980 and 1988, the annual rate of growth in SMI costs was 7.4 percent, compared with a trend rate of 7.6 percent.

Per enrollee costs for hospital outpatient departments were about 87 percent of trend for 1988, but most of the drop in the rate of growth occurred in the early 1980s. In the latter 1980s, the growth rate accelerated from 10.9 percent a year to 12.2 percent. Growth in costs for hospital inpatient and outpatient services combined fell from 6.9 percent between 1980 and 1984, to 1.6 percent between 1984 and 1988. For 1988, these combined costs were only 81 percent of trend. This indicates that hospital inpatient costs were not simply shifted to outpatient facilities as a result of the PPS.

Per enrollee costs for physician and clinical laboratory services were 99 percent of trend for 1988. Growth accelerated between 1980 and 1984, despite the elimination of the normal update to payment rates for 1984. Between 1984 and 1988, the growth rate dropped to 5.8 percent. During this time, Medicare's payment rates were frozen through April 1986, and substantial rate reductions were imposed for selected services in 1987 and 1988. In addition, balance-billing costs fell substantially under Medicare's new participating physician program.

Medicare's constraints on payment rates for physicians were apparently largely offset by increases in the volume (either the number or complexity) of services billed. This increase in volume reflected at least three elements, although it is not known how much to attribute to each factor. First, advances in medical technology increased the types of services that physicians could provide. Second, physicians evidently provided or billed for more services to offset the reduction in real practice receipts that would otherwise have resulted from Medicare's less generous payment provisions.[6] Third, a reduction in out-of-pocket expenses for enrollees (especially in balance-billing costs, which are typically not covered by medigap insurance) probably increased patients' demand for services.[7]

GROWTH IN ENROLLEES' LIABILITIES FOR MEDICARE-COVERED SERVICES

In 1988, enrollees' contributions through copayments, balance-billing, and premiums covered 24.9 percent of total costs for Medicare-covered services (Table A-4). This was an increase from 1980 (when enrollees' contributions paid 23.4 percent of costs), but a fall from 1975 (when they paid 27.7 percent of costs).

The increase between 1980 and 1988 in the share of total costs under Medicare for which enrollees were liable was because of premiums, and not the result of increases in overall cost-sharing requirements through copayments and balance-billing. Between 1980 and 1988, the share of total costs paid through SMI premiums increased from 6.9 percent to 8.2 percent, while the share of costs paid by copayments and balance-billing changed little. The share of total Medicare costs paid by enrollees' premiums increased (even though the

6. Center for Health Economics Research, "Impact of the Medicare Fee Freeze on Physician Expenditures and Volume, Final Report," December 1988, Cooperative Agreement No. 17-C-98758/1-03 with the Health Care Financing Administration.

7. John Holahan, Avi Dor, and Stephen Zuckerman, "Understanding the Recent Growth in Medicare Physician Expenditures," *Journal of the American Medical Association*, vol. 263, no. 12 (March 23/30, 1990), pp. 1658-1661.

share of SMI costs covered by them fell) because SMI costs increased as a proportion of total costs under Medicare.

Between 1980 and 1988, growth in copayment costs for enrollees under the HI program exceeded growth in total costs, so that the share of HI costs paid by enrollees increased. This increase was primarily because of the way in which the HI deductible was calculated. Annual increases in the HI deductible amount were initially based on increases in the average cost to Medicare of a hospital day. Under the PPS, however, the average cost per day jumped substantially as length of stay fell, while costs per stay did not. As a result, the HI deductible grew at a very rapid rate until the method of calculating it was changed for 1987 and subsequent years.

The share of SMI costs for which enrollees were directly liable through cost-sharing fell during the 1980s. The share represented by enrollees' copayment costs fell slightly, while the share accounted for by balance-billing fell substantially. The reduction in balance-billing was the result of two factors: the much higher assignment rates induced by the participating physician program put in place in 1984, together with limits on actual charges on unassigned claims initiated during the freeze period and continued in modified form thereafter.

Between 1988 and 1991, the share of total costs under Medicare for which enrollees will be liable through cost-sharing and premiums is expected to fall slightly, from 24.9 percent to 23.9 percent. This drop will be primarily the result of further reductions in balance-billing costs, as Medicare's limits on physicians' actual charges are tightened.

Although enrollees' liabilities under Medicare fell as a share of total costs between 1975 and 1988, these liabilities consumed a growing share of enrollees' income (Table A-5). In 1975, enrollees' liabilities under Medicare were about 4.1 percent of per capita income, on average. By 1988, liabilities consumed 5.4 percent of income. Between 1988 and 1991, enrollees' liabilities are expected to increase at nearly the same rate as per capita income so that costs as a share of income will change little.

TABLE A-4. ENROLLEES' COPAYMENT, BALANCE-BILLING, AND PREMIUM LIABILITIES UNDER MEDICARE
(In 1991 dollars per enrollee)

Calendar Year	Copayments		Balance-Billing for SMI	Copayments and Balance-Billing[a]	
	HI	SMI		Amount	As a Percentage of Medicare Costs
1975	78	184	49	310	17.6
1976	85	193	60	338	17.4
1977	95	198	62	356	17.2
1978	103	203	64	370	17.1
1979	107	207	73	387	17.0
1980	104	214	87	405	16.5
1981	107	226	94	428	16.3
1982	132	251	106	489	17.0
1983	148	276	110	533	17.2
1984	150	283	114	547	16.8
1985	143	294	104	541	16.3
1986	166	319	110	595	17.1
1987	171	344	91	606	17.0
1988	178	360	77	615	16.7
1991[a]	188	383	43	613	15.4

(Continued)

SOURCE: Congressional Budget Office.

NOTES: Medicare costs include Medicare's reimbursements plus enrollees' copayment and balance-billing costs and are shown in Table A-3.

GROWTH IN ENROLLEES' EXPENSES FOR ALL HEALTH CARE

Annual data on enrollees' expenses for services not covered by Medicare are unavailable, but there are estimates of their total health care costs for 1977 and 1987, disaggregated between public and private

TABLE A-4. Continued

Calendar Year	Annual SMI Premiums		Enrollees' Liabilities	
	Amount	As a Percentage of Medicare Costs	Amount	As a Percentage of Medicare Costs
1975	178	10.1	488	27.7
1976	175	9.0	513	26.4
1977	173	8.4	529	25.5
1978	173	8.0	543	25.0
1979	171	7.5	558	24.4
1980	169	6.9	574	23.4
1981	187	7.1	615	23.4
1982	172	6.0	661	23.0
1983	187	6.0	720	23.3
1984	216	6.6	763	23.4
1985	223	6.7	765	23.0
1986	217	6.2	812	23.3
1987	267	7.5	874	24.4
1988	301	8.2	916	24.9
1991[a]	341	8.5	955	23.9

NOTES: Continued.

The implicit price deflator for gross national product was used to get constant 1991 dollars.

HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

a. Projected.

sources of payment.[8] These data were used to obtain rough estimates of enrollees' out-of-pocket and premium expenses for all health care (not just Medicare-covered services).

Enrollees' overall expenses for health care were an estimated $2,868 in 1988, in 1991 dollars (Table A-5). This amount was 17.0 per-

8. Daniel Waldo and others, "Health Expenditures by Age Group, 1977 and 1987," *Health Care Financing Review*, vol. 10, no. 4 (Summer 1989), pp. 111-120. Improved estimates should be available within the year from the 1987 National Medical Expenditure Survey.

TABLE A-5. ENROLLEES' LIABILITIES UNDER MEDICARE AND OVERALL HEALTH CARE EXPENSES RELATIVE TO INCOME (In 1991 dollars per enrollee)

Calendar Year	Per Capita Income	Enrollees' Liabilities Under Medicare		Enrollees' Overall Health Care Expenses[a]	
		Value Per Enrollee	Percentage of Income	Value Per Enrollee	Percentage of Income
1975	11,945	488	4.1	1,378	11.5
1980	13,504	574	4.3	1,885	14.0
1984	15,443	763	4.9	2,495	16.2
1988	16,911	916	5.4	2,868	17.0
1991[b]	18,272	955	5.2	2,829	15.5

SOURCE: Congressional Budget Office.

NOTES: Enrollees' liabilities include their premium, copayment, and balance-billing costs under Medicare. The implicit price deflator for gross national product was used to get constant 1991 dollars.

a. This is a rough estimate of enrollees' out-of-pocket and premium expenses for all health care, based on the relationship between total costs, Medicare benefits, and other public health benefits as estimated by Medicare's actuaries (*Health Care Financing Review*, Summer 1989, pp. 115-117). The projections for 1991 assume that only 25 percent of eligible enrollees will apply for the qualified benefits available to them under Medicaid.

b. Projected.

cent of average per capita income for enrollees, up from 11.5 percent in 1975. For 1991, however, qualified Medicaid benefits (payment of copayment and premium costs under Medicare) are available to all poor Medicare enrollees who apply. As a result of this, enrollees' expenses are expected to fall relative to income, on average, to 15.5 percent by 1991. (This decline assumes that only 25 percent of eligible Medicare enrollees will apply for the qualified Medicaid benefits.)

The growth in health care expenses relative to income observed for the Medicare population is not unique to them, but is instead a reflection of a nationwide phenomenon affecting all age groups. During the same period that enrollees' total health care expenses increased from 11.5 percent to 17.0 percent of income, national health expenditures grew from 8.3 percent to 11.2 percent of gross national product.

TABLE A-6. MAJOR CHANGES UNDER THE MEDICARE PROGRAM, BY YEAR OF IMPLEMENTATION

Calendar Year	Change
1966	Established health insurance coverage for the aged (if entitled to monthly Social Security or Railroad Retirement benefits); Part A provided Hospital Insurance (HI) and Part B provided Supplementary Medical Insurance (SMI). SMI premium set to cover 50 percent of costs.
1968	Eliminated copayment requirements for inpatient services provided by radiologists and pathologists (later restored).
1971	Set maximum payment rate for physicians' services at the seventy-fifth percentile of customary charges in each locality.
1972	Put in place Professional Standards Review Organizations, intended to monitor unnecessary hospital care--admissions and length of stay--and inappropriate care (replaced in 1984 by Peer Review Organizations).
1973	Extended coverage to disabled persons (after 24 months' entitlement to disability benefits) and to insured workers (or family members) with end-stage renal disease. Permitted otherwise ineligible persons age 65 or older to enroll in Part A by paying a premium if they also enrolled in Part B.
	Increased SMI deductible from $50 to $60 a year.
	Eliminated coinsurance requirements for home health services provided under the SMI program.
1975	Imposed cost-based ceiling (the Medicare Economic Index) on annual increases in maximum approved payment rate for physicians' services.
	Limited annual SMI premium increases to the most recent cost-of-living adjustment (COLA) for Social Security benefits (superseded by law for 1983 through 1995).
1981	Eliminated annual 100-visit limit on home health services; also eliminated SMI deductible requirements for home health services.
	Increased reimbursement ceiling on outpatient psychiatric services from $50 to $250.
	Eliminated copayment requirements on physicians' fees on assigned claims for outpatient surgery (later restored).
	Restored copayment requirements on unassigned claims for inpatient services that radiologists and pathologists provide.
	Extended coverage to include vaccine for pneumococcus.

(Continued)

TABLE A-6. Continued

Calendar Year	Change
1982	Increased share of per-day costs used to calculate HI deductible and based HI copayments on deductible applicable at time of services, rather than at start of benefit period.
	Increased SMI deductible from $60 to $75 a year.
	Imposed new limits on growth in payments to HI providers (superseded for hospitals by prospective payment system in 1984).
	Put in place fixed facility rates for certain surgical procedures in ambulatory surgical centers, with no copayment requirements.
	Restored copayment requirements on all inpatient services that radiologists and pathologists provide.
1983	Established prospective payment system for hospital inpatient services (completed by October 1984).
	Extended coverage to include hospice care.
	Made Medicare second payer for enrollees entitled by age or renal disease who have employment-based (nonretiree) group health benefits. Originally applied only to aged enrollees under age 70, but later expanded to all aged enrollees.
1984	Set SMI premium to cover 25 percent of expected costs per aged enrollee (extended through 1990); included hold-harmless provision that ensured that no Social Security benefit check would fall because of premium increase.
	Put in place new Peer Review Organizations, intended to monitor unnecessary or inappropriate care in hospitals.
	Established participating physician program, under which physicians who agreed to accept assignment on all Medicare claims were to receive higher payment rates at a later date.
	Froze payment rates for physicians' services (until May 1986 for participating physicians; until January 1987 for nonparticipating physicians).
	Established fee schedule for clinical laboratory services. Required assignment for all lab claims (effective by 1988), and eliminated copayment requirements for lab claims.
	Extended coverage to include vaccine for hepatitis-B for high- or intermediate-risk enrollees.

(Continued)

TABLE A-6. Continued

Calendar Year	Change
1987	Reduced normal increase in HI deductible for 1987 and based future increases on rate of increase in update factor for hospital payment rates, instead of basing it on increases in per-day costs.
	Replaced cost-based reimbursement for surgery in hospital outpatient departments with blend of prospective and cost-based facility fee. Imposed 20 percent coinsurance on facility fees for surgery in ambulatory surgical centers.
	Put in place limits on maximum allowable actual charges (MAACs) for nonparticipating physicians.
	Made Medicare second payer for enrollees entitled by disability who have employment-based (nonretiree) group health benefits.
1988	Restored copayment requirements on physicians' fees for outpatient surgery.
	Restricted coverage for home health services to home-bound enrollees.
	Increased reimbursement ceiling on outpatient psychiatric services from $250 to $450.
	Manual revised to relax restrictions on coverage for stays in skilled nursing facilities.
1989	Increased reimbursement ceiling on outpatient psychiatric services from $450 to $1,100.
	Established fee schedule for radiology services and relative value guide for anesthesiology.
	Relaxed coverage limitations for some HI benefits, and reduced HI copayment requirements (repealed as of 1990).
	Imposed new monthly SMI and supplemental (income-related) HI premiums (repealed as of 1990; income-related premiums refunded).
	Reduced HI premium (for those otherwise ineligible) and set it to reflect expected value of HI benefits each year.
	Required Medicaid programs to pay Medicare premium and copayment costs for poor enrollees: all applicants up to 85 percent of poverty in 1989; 90 percent in 1990; 95 percent in 1991; 100 percent thereafter. (The 100 percent coverage requirement was advanced to 1991 in 1990 legislation.)

(Continued)

TABLE A-6. Continued

Calendar Year	Change
1990	Replaced benefit expansion and associated premiums that were in place only for 1989.
	Eliminated reimbursement ceiling on outpatient psychiatric services.
	Extended coverage to include nondiagnostic pap smears.
	Required physicians to submit all (not just assigned) claims to Medicare for payment.
1991	Wrote SMI premium amounts into law for 1991 through 1995 at values intended to collect 25 percent of costs for an aged enrollee (using CBO's 1990 projections).
	Increased SMI deductible from $75 to $100 a year.
	Extended coverage to include screening mammograms.
	Replaced MAACs (established in 1987) with uniform limit on actual charges for nonparticipating physicians, set at 125 percent of applicable prevailing charge.
	Advanced to 1991 from 1992 the requirement that Medicaid cover Medicare premium and copayment costs for all poor enrollees who apply.
1992	Medicare fee schedule (MFS) to be put in place, with fees to be entirely resource-based by 1996. Limiting charge to be set at 120 percent of MFS amounts for nonparticipating physicians.
1993	Limiting charge to be set at 115 percent of MFS amounts for this and all subsequent years.
	Medicaid programs required to pay Medicare premium (but not copayment) costs for applicants with incomes between 100 percent and 110 percent of poverty.
1995	Medicaid programs required to pay Medicare premium (but not copayment) costs for applicants with incomes between 100 percent and 120 percent of poverty.

SOURCE: Congressional Budget Office.

Premium: A monthly or annual amount paid to purchase insurance coverage.

PPS: Prospective Payment System.

QMB: Qualified Medicaid beneficiary, eligible for coverage of Medicare's premiums and copayment requirements but not for other Medicaid benefits.

RHP: Retiree health plan beneficiary.

SMI: The Supplementary Medical Insurance program--Part B under Medicare.

GLOSSARY

Balance-Billing: The excess of a physician's actual charge over Medicare's payment rate on unassigned claims only.

Coinsurance: A copayment calculated as a percentage of the cost of the service.

Copayment: A generic term used here to apply to both deductible and coinsurance amounts under an insurance plan.

Cost-Sharing: A generic term used here to apply to both copayment and balance-billing amounts under an insurance plan.

Deductible: An initial amount payable by the patient before insurance begins to share the costs.

Expense: All costs ultimately payable by the consumer of care--the Medicare enrollee in this study. Includes both out-of-pocket and premium costs.

HI: The Hospital Insurance program--Part A under Medicare.

HCFA: Health Care Financing Administration.

MCD: Medicaid beneficiary.

MGP: Medigap policyholder.

Out-of-Pocket: Any costs for services payable directly by the patient with no insurance reimbursement. Includes cost-sharing amounts for covered services and the costs of noncovered services.

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