

**CHANGING THE STRUCTURE OF MEDICARE BENEFITS:
ISSUES AND OPTIONS**

**The Congress of the United States
Congressional Budget Office**



PREFACE

The rapid growth of the Medicare program since its introduction in 1966 and the financing problem facing its Hospital Insurance trust fund in the next decade have focused attention on ways to control federal outlays in this area. This paper, prepared at the request of the Senate Finance Committee, explores potential changes in Medicare's benefit structure. It examines options for increasing the share of medical care costs paid by beneficiaries and changes that would improve the protection of the elderly and disabled against catastrophic medical expenditures. In addition to calculating the federal savings from each option, the paper estimates the impact of such changes on individual enrollees. In keeping with the mandate of the Congressional Budget Office (CBO) to provide objective and impartial analysis, this paper contains no recommendations.

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SUMMARY

Rapid growth of the Medicare program threatens the solvency of its Hospital Insurance trust fund. Since 1970, Medicare outlays have been increasing at an average annual rate of 17.7 percent and in fiscal year 1982 they were over \$50 billion. Current projections see the Hospital Insurance trust fund as depleted by 1987 or 1988 and running increasing deficits in the years afterward (see Summary Figure 1).

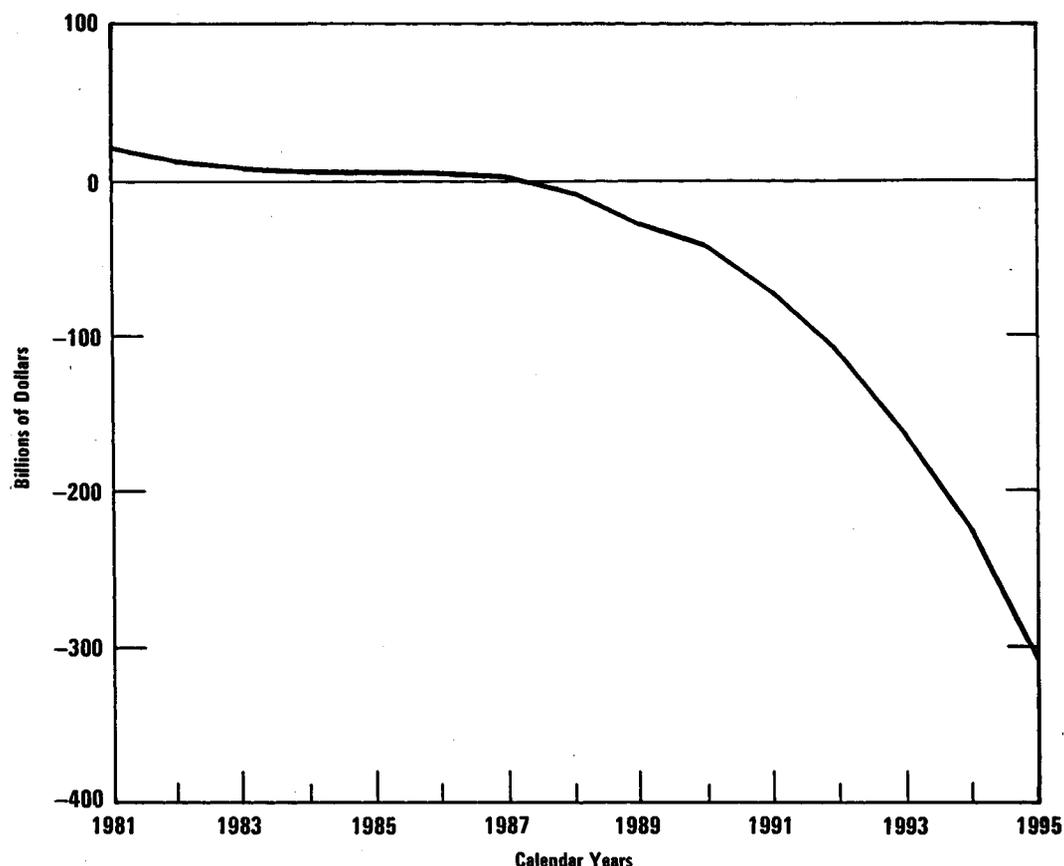
Although no single change is likely to be sufficient to solve the financing problem, one way to stem increasing outlays would be to require enrollees to pay a greater share of the costs of Medicare-covered services.¹ This could generate large savings, although it would do so by substantially increasing medical care costs to the elderly and disabled. For example, one of the broadest options considered here would reduce outlays by \$2.3 billion in 1984. It would add \$112 to the \$505 that the average elderly enrollee will contribute in 1984 for Medicare-covered services, and increase the cost of a hospital stay by \$463. Since the burden of these increased costs would tend to fall disproportionately on beneficiaries in poor health, many would prefer to combine any increase in cost-sharing with a limit on the amount that an individual enrollee would be required to pay.² Unless such a limit was set very high, however, it would eliminate much of the savings.

This paper focuses on a variety of options that would increase cost-sharing by enrollees, with and without limits on liability. These options would vary in their effects. The savings to the government would also vary, depending upon the proportion of costs shifted to enrollees and the extent to

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1. None of the options considered in this paper would generate enough savings to do more than postpone the onset of the problem for one or two years. To eliminate the deficit through greater cost-sharing would require a very large increase in costs to beneficiaries. Alternatively, reimbursements to physicians or hospitals could be cut or taxes could be increased. For more discussion of this issue and of other alternatives to improve the financial outlook of the Hospital Insurance trust fund, see Special Committee on Aging, U.S. Senate, Prospects for Medicare's Hospital Insurance Trust Fund, 98:1 (March 1983).
 2. In this paper the term "enrollees" refers to all elderly and disabled persons covered by Medicare, while the term "beneficiaries" refers to those receiving benefits in the form of covered services.

Summary Figure.

End-of-Year Balances in the Hospital Insurance Trust Fund



SOURCE: Preliminary CBO estimates.

NOTE: The figures presented here assume that the hospital reimbursement payment rates created under the Social Security Amendments of 1983 will be updated yearly so as to maintain the same level of stringency as would have occurred if the Tax Equity and Fiscal Responsibility Act of 1982 had been extended. See Appendix A for additional information.

which beneficiaries would be induced to lower their use of Medicare-covered services. To understand these effects, it is necessary to examine the structure of the Medicare program and its patterns of use.

THE CURRENT STRUCTURE OF MEDICARE

Medicare serves as the principal insurer of acute health care expenditures for 29 million elderly and disabled persons. The program is divided

into two parts: Hospital Insurance (HI), which is dominated by short-stay hospital inpatient care, and Supplementary Medical Insurance (SMI), which covers physician visits and other ambulatory care. The HI portion is supported almost entirely by part of the Social Security payroll tax. SMI, on the other hand, is an optional insurance plan requiring a monthly premium (currently set at \$12.20) that covers about 25 percent of program costs. The remainder of SMI outlays are financed from general revenues.

Medicare reimburses hospitals and most other providers directly for the costs of covered services used by enrollees. In cases where physicians and other SMI providers decline to accept the charges established as reasonable by Medicare, beneficiaries pay them directly and then seek partial reimbursement from Medicare.³

Medicare now requires its beneficiaries to pay a considerable share of the costs of covered services. The HI portion charges a first-day deductible amount for short-stay inpatient care, plus coinsurance on days 61 through 150 of a hospital stay during one benefit period and on days 21 through 100 for stays in a skilled nursing facility (SNF).⁴ SMI assesses an annual deductible amount of \$75 and coinsurance of 20 percent of allowed charges on all covered services except home health care.⁵

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3. The allowed or reasonable charges for SMI are established as the lowest of the rate prevailing in a given area for that service, the usual charge by the provider, and the actual bill submitted. Enrollees may also be liable for additional charges in excess of the allowed amounts if physicians and other providers choose to bill for such amounts. It is not known whether beneficiaries actually pay these excess costs.
 4. Coinsurance refers to the percentage of the costs of each unit of care that beneficiaries are required to pay. In some cases--for example, for hospital coinsurance--coinsurance is expressed as a percent of the deductible amount for hospital care. A benefit period begins with the first day of hospitalization and ends when the beneficiary has not been a bed patient in a hospital or a SNF for 60 consecutive days. The deductible amount for 1983 is \$304. The hospital coinsurance is 25 percent of the deductible amount for days 61 through 90 and one-half of the deductible for lifetime reserve days (91 through 150). The SNF coinsurance charge is set at one-eighth of the hospital deductible amount.
 5. For purposes of this analysis, additional charges passed on to beneficiaries when providers do not accept assignment are not included in cost-sharing estimates.

If SMI premiums are considered part of cost-sharing, a Medicare enrollee will pay on average \$505 in cost-sharing in calendar year 1984, 80 percent of which will be for SMI deductible amounts, coinsurance, and premiums. In addition, enrollees will also be liable for health expenses not covered by Medicare or Medicaid (the major federal health care program for the poor). The amount of this additional liability for noninstitutional care is likely to be about \$550 in 1984, for the average elderly beneficiary.⁶ Altogether, these expenditures on noninstitutional care will range from an average of 21 percent of income for those with family income under \$5,000 to 2 percent for those with family income above \$30,000.

SOURCES OF FEDERAL SAVINGS FROM INCREASED MEDICARE COST-SHARING

Increases in Medicare cost-sharing would cut federal spending primarily by shifting liability to enrollees, but might also reduce enrollees' use of covered services. In addition, the cost-sharing could be structured to encourage enrollees to use less expensive providers.

The Direct Impact of Increased Enrollee Liability

Increased cost-sharing would directly shift responsibility for additional expenses from the federal government to individual enrollees except for those who participate in other programs such as Medicaid. The impact on individuals would depend on the extent of their private insurance coverage and the particular form of the cost-sharing change.

For the more than 60 percent of Medicare enrollees with private insurance supplementing Medicare, the cost of higher deductible amounts and coinsurance would be reflected in higher premiums on their private insurance--amounting to approximately the average increase in cost-sharing (plus any increased administrative costs of such insurance). But those without private coverage would have to pay additional costs directly. For those with high medical charges--for example, for a long hospital stay--the added burden would be considerable.

The Indirect Effects of Lower Health Care Use

Cost-sharing might achieve additional reductions in outlays if it led to lower use of Medicare-covered services. While studies on Medicare enrol-

6. The average projected cost for nursing home care will add almost another \$650 to the total.

ees have been limited, results for the younger population suggest that cost-sharing--and particularly coinsurance on physician services--lowers use.

These indirect effects would be relatively small, however, because private supplemental insurance insulates the majority of beneficiaries from increases in costs associated with use of services. Only about one-fourth of Medicare enrollees have neither private insurance nor Medicaid, and would feel the impact in the form of higher out-of-pocket costs for medical care services.⁷

SPECIFIC OPTIONS FOR INCREASED COST-SHARING

This study presents options illustrating the many changes possible in Medicare's benefit structure. They would generate changes ranging between a cost of \$1.9 billion and savings of \$2.6 billion in fiscal year 1984 (see Summary Table 1). The average increase in individual liability for elderly, noninstitutionalized enrollees would also vary substantially among the options.⁸

These options highlight important tradeoffs. The broad-based ones would spread the costs among the largest number of enrollees, ensuring that no one enrollee faced a large increase in cost-sharing. On the other hand, increases tied directly to use of Medicare-covered services would burden a small proportion of enrollees, but would be more likely to result in somewhat lower use of Medicare-covered services.

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7. It is not known whether those who are not covered by private insurance have chosen not to purchase it or have been rejected by insurers, but this would be an important issue in evaluating the impact of cost-sharing options. There is some evidence to indicate that, the higher the family income, the more likely the person will have private insurance.
 8. To estimate precisely what enrollees would pay requires additional information about Medicaid coverage and private insurance paid for by others, which reduce actual liability. Insurance purchased by the family to supplement Medicare might actually raise average liability somewhat to cover added administrative costs, but it would protect against extraordinary increases resulting from an extended hospital stay, for example. Such adjustments are discussed in more detail in Chapter V.

Options Affecting a Large Percentage of Enrollees

Options tied directly to use of medical services would not spread costs widely, since in any one year relatively few enrollees would be affected. Consequently, the broadest-based cost-sharing change would be to increase the SMI premium, which is assessed against enrollees even when they have no medical expenditures, or to introduce an HI premium. An increase in SMI premiums to cover 35 percent of the per capita program costs for aged enrollees would raise annual costs to enrollees by \$68 in 1984, yielding total federal savings in fiscal year 1984 of \$1.4 billion. The broad-based option, an HI premium of \$10 per month, would provide savings of \$2.5 billion in fiscal year 1984. There would be no indirect savings from either of these options, since the premiums would not be tied to use of health care services.

A somewhat less broad-based change would be an increase in the deductible amount charged enrollees before Medicare begins to pay for covered services--for example, a deductible of \$100 for SMI. This option would reduce federal spending by \$0.2 billion. About 70 percent of SMI enrollees would be affected.

Options That Vary More Directly With Use of Medical Services

A major argument in support of increased cost-sharing--especially coinsurance--is that it would lower the use of medical services by beneficiaries. A counter argument is that increased cost-sharing would impose the heaviest burden on those who already have the highest expenses. In addition, since many beneficiaries have private insurance that would likely pay much of the coinsurance, the reduction in use of medical services would be limited. The paper considers three basic options for changing coinsurance:

- o Increasing SMI coinsurance from 20 percent to 25 percent of allowed charges;
- o Adding hospital coinsurance of 10 percent of the deductible amount for each hospital day in the calendar year beginning with the second day of hospitalization (and eliminating the current coinsurance on days 61 through 150); and
- o Changing hospital coinsurance as in the second option, but limiting its application to days 2 through 30.

The effects of the first option would be relatively uniform among age and income groups. Although some beneficiaries with very high SMI use would be subject to disproportionately higher cost-sharing, the impact would

SUMMARY TABLE 1. FEDERAL SAVINGS FROM CHANGES IN MEDICARE'S BENEFIT STRUCTURE, AND THE COSTS FOR ELDERLY ENROLLEES, 1984

Option ^a	Fiscal Year Federal Savings (billions of dollars) ^b	Average Increased Calendar Year Costs per Capita (dollars)	
		All Elderly Enrollees	Elderly Enrollees with 1984 Cost-Sharing in Excess of \$1,000
SMI Premium Increase	1.4	68	68
HI Premium	2.5	120	120
SMI Deductible Increase	0.2	13	20
SMI Coinsurance of 25 Percent	0.6	40	212
Hospital Coinsurance of 10 Percent of Deductible	1.7	72	376
With \$1,000 limit	-1.9	-81	-841
With \$2,000 limit	0.3	15	-122
With \$3,000 limit	1.0	46	149
With \$4,000 limit	1.3	59	203
With \$2,000 limit for those with incomes below \$20,000; otherwise rising to \$4,000	0.6	29	1
With \$1,500 limit for those with incomes below \$20,000; otherwise rising to \$3,000	0.1	10	-226
Hospital Coinsurance of 10 Percent of Deductible for Days 2-30	1.2	52	212
Combination Option 1 ^c	2.6	120	280
Combination Option 2 ^d	2.3	112	589
Combination Option 3 ^e	1.8	74	379

SOURCE: Congressional Budget Office simulations from National Medical Care Expenditure Survey and Medicare History Sample.

- a. More detailed descriptions of these options are available in Chapter V.
- b. Savings for the options have been estimated independently and cannot, in general, be added together.
- c. Increase in SMI premium to 35 percent and shift in hospital coinsurance to days 2-30 at 10 percent of deductible amount.
- d. Change in hospital coinsurance to cover all days at 10 percent of deductible amount and increase in SMI coinsurance to 25 percent.
- e. Coinsurance of 10 percent on hospital stays, 5 percent on skilled nursing facilities, and coinsurance of 10 percent of the cost of each home health visit.

be spread across more than two-thirds of Medicare enrollees, increasing their annual liability by an average of \$40 if coinsurance of 25 percent were imposed.

The other two options--changes in hospital coinsurance--would have their greatest impact on beneficiaries in the highest cost-sharing brackets. For example, while the full 10 percent hospital coinsurance option would increase costs to all elderly enrollees by an average of \$72, the average increase for hospitalized enrollees would be \$351. Nearly half of federal savings would be achieved from the 5 percent of enrollees who have annual hospital stays in excess of 20 days, who would pay \$685 more on average. (A very few high users would gain from eliminating the relatively high coinsurance currently assessed after hospital day 60 of a spell of illness, as well as from eliminating the expenditures made after Medicare benefits are exhausted.)

OPTIONS TO INCREASE CATASTROPHIC PROTECTION

Increases in Medicare cost-sharing would be likely to increase the pressure to improve catastrophic protection for beneficiaries. For some, the burden of cost-sharing is already high: elderly enrollees in the top 11 percent of use of Medicare-covered services are expected to face average cost-sharing of \$1,675 in calendar year 1984. These beneficiaries would be most affected by an increase in coinsurance, for either hospital care or SMI.

Placing Limits on Cost-Sharing

It would be easy to limit the amount of Medicare-related costs required of any beneficiary in a year (or perhaps over several years).⁹ Combining a limit on cost-sharing with increased hospital coinsurance would result in a more equal distribution of the burden, but at the expense of a considerable loss in federal savings. Further, above a certain point it might also remove incentives for high users to restrain their use.¹⁰

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9. An alternative approach would be to defer some cost-sharing until the deaths of the beneficiaries and their dependents.
 10. The most likely response to such a change in incentives would be for patients to remain in a hospital rather than moving to a facility such as a nursing home when such care would be appropriate.

The options discussed here use four limits on the combined beneficiary liability from HI and SMI cost-sharing in conjunction with 10 percent hospital coinsurance on all days after the first. The amount of federal savings achieved would be highly sensitive to the value of the limit. For example, a \$1,000 annual limit would result in a net rise in federal Medicare outlays, since many beneficiaries now have liabilities in excess of \$1,000 without an increase in hospital coinsurance. Even a \$3,000 annual limit would result in federal savings 70 percent lower than without a limit on cost-sharing. Overall, the lower the limit, the smaller the increase in average enrollee liability and the greater the proportion of enrollees affected by the limit. At the \$1,000 limit, 16 percent of enrollees would benefit, while at \$4,000 only 1 percent would benefit.

Varying Cost-Sharing Changes with Income Level

Cost-sharing could also be varied according to the incomes of enrollees. This could be done by assessing higher cost-sharing on those with higher incomes, or by varying the limit on cost-sharing to provide greater protection for those with low incomes. Varying the limit would allow greater protection for those least able to afford cost-sharing than would a uniform increase in cost-sharing generating the same reduction in federal outlays.

Many would oppose converting a social insurance program into a means-tested one, however. In addition, such options would involve a number of practical problems. For one thing, income may not be the best indicator of ability to pay, since the elderly often have other assets such as their homes. Moreover, families of different size and composition may have varying demands on their resources. If a means test is modified to meet these difficulties, it then becomes more complex to measure and monitor. These are not insurmountable obstacles to means-testing, though, since the same problems arise in other programs that are currently means-tested.

The paper examines two options that would tie cost-sharing to the family income of the enrollee. In the first, cost-sharing would be limited to \$2,000 for those with 1983 family incomes less than \$20,000—a group that includes about 68 percent of the beneficiaries. The limit would be increased gradually, ultimately reaching a maximum of \$4,000. Total federal savings would be \$1 billion in fiscal year 1984, with enrollees paying \$29 more, on average. In the second, the caps would be \$1,500 and \$3,000 and the same income cutoff would be used. Savings to the federal government would be \$0.1 billion, while elderly enrollees would, in calendar year 1984, pay \$10 in additional cost-sharing, on average.

CHAPTER I. INTRODUCTION

Medicare serves as the major source of insurance for acute medical care services for the elderly and, since July 1973, for disabled persons receiving Social Security. In fiscal year 1982, nearly 29 million persons were enrolled in Medicare Hospital Insurance, 90 percent of whom were 65 or older.

Medicare is organized in two parts--Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). HI covers mainly short-stay hospitalization and is available without charge to eligible enrollees. SMI coverage is voluntary for persons 65 and over and for eligible disabled persons, all of whom must pay a monthly premium to participate. SMI covers physician and other outpatient services.

Beneficiaries are required--under both portions of Medicare--to share some of the costs of covered services.¹ Hospitalized beneficiaries must pay a deductible amount in each benefit period, but are not liable for any additional costs until they have been hospitalized more than 60 days. Skilled nursing home care through HI also requires some cost-sharing on the part of beneficiaries. Under SMI, the most important cost-sharing is the 20 percent of each covered service (except home health care) that must be paid by the beneficiary once a relatively small deductible has been met.

Pressures to change the benefit structure of Medicare arise from two competing sources. First, in a period of budget stringency, the size and growth of the Medicare program have made it a target for potential cutbacks. Moreover, the HI trust fund faces a financial crisis later in this decade, so either outlays must be reduced, revenues must be increased, or a combination of the two must be enacted. On the other hand, a second source of concern is the absence of protection against catastrophic medical expenditures under Medicare. The amount that beneficiaries are required to contribute for long hospital stays--for both HI and SMI services--can be very large. This situation has led to calls for expanded rather than reduced benefits for the eligible population.

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1. This coverage is discussed in more detail in Chapter II. As used in this paper, the term "enrollee" refers to all persons covered by Medicare, while "beneficiary" will be used to describe those actually receiving covered services. "Cost-sharing" refers to the requirement that beneficiaries pay some of the costs incurred for providing services.