A COMPARISON OF HOUSE AND SENATE CATASTROPHIC BILLS

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EXECUTIVE SUMMARY

This paper compares the House and Senate versions of H.R. 2470, a bill to provide catastrophic and drug benefits under Medicare. It describes the two proposals, presents CBO's five-year cost estimates for them, and examines the impact of the catastrophic provisions on enrollees for calendar year 1989.

Both proposals would cap Medicare copayment costs, at least for services that are currently covered by Medicare. Both proposals would increase the average benefits paid by Medicare and total premiums (flat and progressive) paid by enrollees. Average values per enrollee for calendar year 1989 are shown below:

Provision	House Plan	Senate Plan
Copayment Cap	1,798[1/]	2,030
New Medicare Benefits:		
Catastrophic	163	120
Drug	56	0
New Medicare Premiums:		
Catastrophic	197	145
Drug	38	0

Over the five-year projection period, about 80 percent of new premium receipts under the House plan would be income-related, and 20 percent would be flat. Under the Senate plan, 55 percent of new receipts would be income-related and 45 percent would be flat. Enrollees could avoid the new premiums under the Senate plan by disenrolling from Part B of Medicare. The income-related portion of the new premium under the House plan would be paid by all those eligible for Part A of Medicare. Hence, it could not be avoided, although the new flat premiums could be avoided by disenrolling from Part B.

The automatic provisions for increasing premium rates in the House plan would be insufficient to keep pace with the costs of catastrophic benefits, requiring ad hoc premium increases to cover the shortfall, both over the five-year projection period and thereafter. The Senate plan would direct the Secretary to set premium rates to cover the full costs of new catastrophic and drug benefits each year, including the costs of a contingency margin.

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1. Composed of the SMI cap of $1,043, the hospital deductible of $580, and SNF coinsurance of $175. Copayment costs for the new drug and in-home care benefits would add to this total.

A COMPARISON OF HOUSE AND SENATE CATASTROPHIC BILLS

This paper provides comparative information about two bills currently under consideration in the Congress that would expand Medicare's coverage for catastrophic illnesses. The bills examined are the House version of H.R. 2470 (passed by the House on July 22); and the Senate version (passed by the Senate on October 27).

There are four sections below. The first section describes the provisions of current law and of the catastrophic bills. The second section contains CBO's cost estimates for the two proposals. The third section shows the impact of the Medicare catastrophic provisions on enrollees, while the fourth section shows the impact of the financing provisions.

The impact information in the third and fourth sections is presented for calendar year 1989, the first year that the catastrophic benefits would be fully effective. The impact of drug and Medicaid benefits provided in the bills are not shown in the tables in sections 3 and 4. 1/ Because the alternative proposals would affect different segments of the Medicare population, the numbers shown are averages or percentages for the entire Medicare population, whether they are enrolled in Part A, in Part B, or in both parts. In calendar year 1989, such enrollees will number just short of 33 million.

Unless otherwise indicated, benefit, copayment, and premium amounts are reported for all Medicare enrollees, including those who are dually eligible for Medicaid benefits. For the dually eligible group, though, copayment and premium costs are paid by Medicaid programs and new benefits under the proposals would accrue to Medicaid rather than to the enrollees. About 9 percent of Medicare enrollees are dually eligible. These dually eligible enrollees receive about 13 percent of current benefits, and would receive about 16 percent of new benefits under the proposals examined here.

DESCRIPTION OF CURRENT LAW AND CATASTROPHIC PROPOSALS

Medicare's current copayment structure is:

Under Part A Hospital Insurance (HI):

- First-day deductible of $520 (in 1987, indexed to hospital update factor) paid for the first hospital stay in each benefit period. 2/
- Hospital coverage limited to 90 days per benefit period, plus an additional 60 lifetime reserve days.

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1. The impact of the drug provisions are not shown because it is unlikely that a drug program could be implemented by 1989. The impact of the Medicaid provisions are not shown because there is no way to predict how some of the benefits would be distributed.

2. A benefit period—or spell of illness--begins with a hospital admission, and ends on the 61st day following discharge from the hospital or from a skilled nursing facility (SNF) entered subsequent to the hospital stay. Enrollees may have up to six benefit periods during a year.

- o Coinsurance of $130 a day paid for days 61-90 in each benefit period.
- o Coinsurance of $260 a day paid for each lifetime reserve day used.
- o Nursing home stays covered only for acute care subsequent to a hospital stay, limited to 100 days in each benefit period.
- o Coinsurance of $65 a day paid for nursing home days 21-100.
- o Small coinsurance requirements for certain home health and hospice benefits.

Under Part B (SMI):

- o Initial deductible of $75 a year.
- o 20 percent coinsurance on reasonable charges above the deductible amount.

Under current law, there is no limit on enrollees' potential liabilities for copayments on Medicare-covered services. In addition to copayments, enrollees are liable for all charges above Medicare's allowed amounts on unassigned physicians' claims. Further, there are a number of health-care services that are not covered by Medicare, such as prescription drugs (except for immunosuppressive drugs provided to heart and kidney transplant patients in the first year following their transplant operation), preventive care, and long-term nursing care.

The catastrophic proposals discussed here would each expand current-law Medicare benefits, but would retain the acute-care nature of Medicare coverage. Proposals that would provide long-term care benefits are beyond the scope of this memorandum. (See Table 1 for a summary description of the benefits provided under each proposal.)

House Plan

Benefits. The House proposal would eliminate the spell of illness concept and would reduce copayment requirements under the HI program effective January 1, 1988, while introducing a cap on copayments for the SMI program effective January 1, 1989. The SMI copayment cap would be set at $1,043 in 1989, indexed to the COLA (the cost-of-living adjustment made each year to Social Security payments) in subsequent years.

The HI deductible would be indexed to the hospital update factor as under current law. Enrollees would pay a deductible only for the first hospital stay each year, and there would be no hospital coinsurance payments required. Further, the current limit on covered hospital days would be eliminated.

TABLE 1. DESCRIPTION OF MEDICARE BENEFITS AND FINANCING MECHANISMS UNDER CURRENT LAW AND CATASTROPHIC PROPOSALS, 1989

Provision	Current Law	House Proposal	Senate Proposal
HOSPITAL INSURANCE			
Coverage	Hospital inpatient care Short-term skilled nursing care Intermittent home health care Hospice care for terminally ill	Same as current law, with changes noted under limits to coverage	Same as current law, with changes noted under limits to coverage
Limits to coverage	Hospital stays covered up to 90 days per benefit period, plus up to 60 lifetime reserve days; benefit periods unlimited in number Lifetime limit of 190 days for inpatient psychiatric care SNF stays covered up to 100 days per benefit period, following hospital stay Lifetime limit of 210 days for hospice benefits	No limit on covered inpatient stays (except for psychiatric care) SNF limit changed from 100 days/spell to 150 days/year Prior hospitalization requirement eliminated for SNF stays Lifetime limit on hospice days eliminated Home health care permitted for up to 33 consecutive days	No limit on covered inpatient stays (except for psychiatric care) SNF limit changed from 100 days/spell to 130 days/year Prior hospitalization requirement eliminated for SNF stays Lifetime limit on hospice days eliminated Home health care permitted for up to 21 consecutive days for all enrollees, & up to 45 days for enrollees with prior hospital stay
Deductibles	First-day deductible ($580 in 1989) paid for first hospital stay in each benefit period Blood deductible of up to 3 units paid in each benefit period	First-day deductible ($580 in 1989) paid only for first stay/year Blood deductible changed to 3/year	First-day deductible ($580 in 1989) paid only for first stay/year if not limited by copayment cap Blood deductible changed to 3/year
Coinsurance	Coinsurance paid for hospital days 61-90 (1/4 deductible amount) and reserve days (1/2 deductible amount) Coinsurance paid for SNF days 21-100 (1/8 deductible amount) Coinsurance of 5 percent of charges for drugs and respite care provided by hospices	No coinsurance for hospital stays SNF coinsurance changed to 20% of reasonable costs for first 7 days each year	No coinsurance for hospital stays SNF coinsurance changed to 15% of reasonable costs for first 10 days each year
SUPPLEMENTARY MEDICAL INSURANCE			
Coverage	Physicians' services Outpatient departments Ambulatory surgicenters Laboratory services Home health care	Expanded to include outpatient prescription drugs and in-home personal care	Expanded to include outpatient prescription drugs (phased in from 1990 through 1993)
Limits to coverage	Most preventive care not covered Eyeglasses, hearing aids, and outpatient prescription drugs not covered except in certain cases (i.e. cataract patients, transplant patients in first year) Reimbursement limit of $250/year on outpatient psychiatric care	Reimbursement limit for psychiatric care increased to $1000/year In-home care limited to 80 hours/year	Same as current law
Deductibles	Annual deductible of $75	Separate $500 deductible for drugs (effective 1-1-89)	Separate $600 deductible for drugs (effective 1-1-90)
Coinsurance	Coinsurance of 20 percent of reasonable charges above the deductible amount (50 percent for outpatient psychiatric services)	Same as current law; 20 percent coinsurance applied to new drug and in-home care benefits as well	Same as current law; 20 percent coinsurance applied to new drug benefits as well
COPAYMENT CAP	None	Cap of $1040 (1989), SMI only Cap indexed to COLA	Cap of $1030 (1989), HI+SMI Cap indexed to charges per enrollee Cost of immunosuppressive drugs after 1st year and of certain preventive services count to cap
FINANCING MECHANISMS	Tax revenues and flat premiums	Progressive and flat premiums	Progressive and flat premiums

SOURCE: CONGRESSIONAL BUDGET OFFICE

Up to 150 days a year would be covered for SNF stays, and SNF coinsurance payments would be set at 20 percent of the approved cost per day for the first seven days each year, rather than at one-eighth the hospital deductible for days 21-100 in each benefit period as under current law. The current requirement for a 3-day prior hospital stay to receive Medicare coverage for a SNF stay would be eliminated.

In addition, the current 210-day lifetime limit on hospice benefits for terminally ill enrollees would be eliminated. Home health benefits would be expanded to permit up to 35 consecutive days of care. The blood deductible requirement would be changed to 3 units a year, instead of 3 units each benefit period. The current limit of $250 in Medicare reimbursements for outpatient mental health services would be increased to $1,000. The coinsurance rate for mental health benefits would remain at 50 percent, though, and the additional copayments that would result under this provision would not count toward the SMI copayment cap.

The House bill would provide coverage for two services not currently covered by Medicare—outpatient prescription drugs and in-home personal care for those too incapacitated to be left alone. Under the drug benefit, Medicare would reimburse 80 percent of reasonable costs above a deductible amount, which would be $500 in 1989 and indexed to a drug price index in subsequent years. Under the in-home care benefit, Medicare would reimburse 80 percent of costs for a total of up to 80 hours of care each year. None of the copayment costs for these two benefits would count toward the SMI copayment cap. The in-home care benefit would expire at the end of calendar year 1991.

Financing. Additional benefits would be financed through premium increases, in three parts—new outlay-based premiums, a new income-related premium, and ad hoc premium increases.

All of the outlay costs of the new in-home personal care benefit, and 75 percent of the outlay costs of the new drug benefit would be financed by new outlay-based premiums. 3/ In 1989, these additional premiums would amount to $2.70 monthly--$2.40 for the drug benefit and $0.30 for the in-home care benefit.

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3. Current SMI premiums are based on incurred costs, rather than outlay costs. The difference between incurred and outlay costs is due to lags in payment for services provided. When premiums are based on incurred costs, all expected costs for covered services used during a year are paid by that year's beneficiaries. When premiums are based on outlay costs, premiums paid by beneficiaries in the first year will typically not cover the costs of the services they received. Instead, part of the costs of services used by beneficiaries in one year will be paid from premiums paid by the next year's enrollees. Further, premiums set to cover only outlay costs provide no contingency margin for projection errors.

In addition, all taxpayers eligible for benefits under Part A of Medicare would pay a supplemental income-related or "progressive" premium through the income tax system, first effective for 1988. The income-related premium would not be eligible for the medical expense deduction provided in current law. Enrollees filing individual returns for 1988 would pay an amount equal to $10 for each $143 of adjusted gross income (AGI) in excess of $6,000, up to a maximum annual liability of $580. In subsequent years, the basic premium rate and the ceiling on liability would be indexed to growth in the subsidy value of Medicare benefits (excluding the drug and in-home care benefits). 4/ Beginning in 1989, the basic premium rate would also be increased by an amount sufficient to pay 25 percent of the outlay costs of the drug benefit. In addition to annual adjustments to the premium rate, the AGI parameters of $143 and $6,000 would be indexed to the Consumer Price Index. As a result, for 1989 Part A enrollees would pay an estimated $12.70 for each $149 of AGI above $6,258, up to a maximum of $737.

Growth in income-related catastrophic premium receipts would not keep pace with growth in catastrophic benefits under the House bill because premium rates would be indexed to the rate of growth in the value of total Medicare benefits per enrollee, which would grow less rapidly than the value of new benefits (12 percent growth for total benefits compared to 16 percent growth for new benefits). As a result, the House bill would result in net budget costs of $410 million by 1992, were it not for the ad hoc premium increases specified in the bill ($1.00 a month in 1991 and $1.30 in 1992). These ad hoc increases would become part of the base that was indexed to the COLA for 1993 and all subsequent years.

Eligibility. The new HI benefits under this proposal would be provided to all those eligible for Part A benefits. The new SMI benefits, including the copayment cap, would apply only to those enrolled under Part B of Medicare. Unlike the Senate proposal, there would be no need to administer a two-track HI system, or to retain administrative information on benefit periods and hospital coinsurance or reserve days.

Senate Plan

Benefits. The Senate proposal would cap copayments under HI and SMI combined, while reducing copayment requirements under the HI program by limiting payment of the HI deductible to the first stay each year and eliminating hospital coinsurance requirements and the limit on covered hospital days. The copayment cap would be set at $1,850 a year in 1988, and indexed

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4. The subsidy value of Medicare benefits is defined as 50 percent of the per-enrollee value of HI benefits, plus the excess of per-enrollee SMI benefits over (flat) premium amounts.

thereafter to increases in charges per enrollee (for catastrophic, but not drug benefits). For 1988 the cap would apply only to copayments incurred during the last six months of the year. Thereafter, the cap would apply to copayments incurred during the entire calendar year.

The costs of immunosuppressive drugs for transplant patients would count toward the copayment cap every year, but (as under current law) would not be covered beyond the first year following the transplant operation. In addition, the costs of certain preventive services would be counted toward the copayment cap. These would include annual mammograms, pap smears, blood and stool tests, among others.

Beginning in 1990, a drug benefit would be gradually phased in, with coverage of 80 percent of the reasonable costs of all prescription drugs above a deductible expected by 1993. The deductible would be $600 in 1990, indexed to growth in drug charges per enrollee.

The spell of illness concept would be eliminated, but enrollees who paid a hospital deductible in December of one year would not have to pay another deductible if readmitted to the hospital in January of the next year. Up to 150 days a year would be covered for SNF stays, and SNF coinsurance payments would be set at 15 percent of the approved cost per day for the first ten days each year. Home health benefits would be provided for up to 21 consecutive days for all enrollees, and up to 45 days for enrollees discharged from the hospital within the previous 30 days. The 210-day lifetime limit on hospice benefits would be eliminated, and the blood deductible would be changed to 3 units a year.

Financing. New benefits would be financed by a two-part additional premium for SMI enrollees, similar to the mechanism already described for the House bill. All SMI enrollees would pay a new catastrophic flat premium of $4.00 a month in 1988. This premium would be separate from the current SMI premium, and would reflect increases in the per-enrollee value of catastrophic benefits (excluding drugs). In 1990, an additional flat premium of $0.90 a month would be added to cover a portion of the costs of the new drug benefit.

In addition, SMI enrollees with income tax liability of $150 or more would pay a supplemental income-related premium designed to cover the remaining costs of the new benefits. This premium would be eligible for the medical expense deduction. The income-related premium rate would be $13.08 for each $150 of tax liability in 1988, up to a maximum liability of $800 per enrollee. The premium rate would reflect growth in benefits per enrollee, so that it would increase to $14.76 for 1989. The maximum liability would also increase, to $850. Although the income-related premium would be a deductible expense, and despite the ceiling on liability, receipts would keep pace with costs because the Secretary would be directed to adjust rates as necessary to accomplish that goal.

Eligibility. The new benefits under the Senate bill would apply only to those enrolled under Part B of Medicare. This plan would retain the current HI benefit structure for HI-only enrollees. Hence, a two-track HI program would exist. In addition, information on spells of illness, hospital coinsurance and reserve days, and SNF coinsurance days under current law would have to be retained in order to compute catastrophic premium increases.

ESTIMATES OF COPAYMENT PARAMETERS AND PREMIUMS

The values that would determine copayment rates under current law and under each of the proposals are shown in Table 2. Under current law and both proposals, the hospital deductible would be indexed to the hospital update factor. It would grow from $520 in 1987, to $540 in 1988, and to $700 by 1992. These values and projected reasonable costs per SNF day are shown only once, for current law.

TABLE 2. PROJECTED COPAYMENT PARAMETERS UNDER CURRENT LAW AND CATASTROPHIC PROPOSALS, 1988-92 (Calendar year amounts, in dollars)

Proposal	1988	1989	1990	1991	1992
Current Law					
Hospital Deductible	540	580	620	660	700
Reasonable Cost Per SNF Day	118	126	134	141	149
SNF Coinsurance Per Day	67.50	72.50	77.50	82.50	87.50
Copayment Cap	na	na	na	na	na
House Plan					
SNF Coinsurance Per Day	23.50	25.00	27.00	28.00	30.00
Copayment Cap a/	na	1,043	1,089	1,136	1,185
Drug Deductible	na	500	528	556	586
Senate Plan					
SNF Coinsurance Per Day	18.00	19.00	20.00	21.00	22.00
Copayment Cap b/	1,850	2,030	2,235	2,446	2,675
Drug Deductible	na	na	600	644	689

SOURCE: Congressional Budget Office.

a. Cap would apply only to SMI copayments.

b. Cap would apply only for the last half of 1988.

Under current law, coinsurance rates per SNF day are set at one-eighth the hospital deductible amount. Hence, the daily coinsurance rate would be $67.50 in 1988 under current law. Under the House and Senate proposals, SNF coinsurance rates would be keyed to reasonable costs per day. The coinsurance rate under the House plan would be 20 percent, resulting in daily coinsurance payments of $23.50 in 1988. Under the Senate plan, the coinsurance rate would be 15 percent, with daily coinsurance payments equal to $18.00 in 1988.

Under the House plan, the copayment cap would be indexed to the COLA. Under the Senate plan, the copayment cap would be indexed instead to the rate of growth in catastrophic charges per enrollee, with the result that the cap would grow more rapidly and the proportion of enrollees affected by the cap would be constant, rather than growing. By 1992, the copayment cap under the Senate plan would be $2,675. Unlike the Senate plan, where the cap would apply to copayments under either part of Medicare, the cap under the House plan would apply only to SMI copayments and would reach $1,185 by 1992.

The premiums that would be paid by Medicare enrollees under current law and the catastrophic proposals are shown in Table 3. Under current law, the flat SMI premium would be $24.80 monthly in 1988, growing to $29.70 monthly by 1992. This is paid only by Part B enrollees. There is no income-related premium under current law.

Under the House plan, SMI enrollees would pay additional outlay-based flat premiums of $2.70 a month beginning in 1989, to fund all of the in-home care benefit and 75 percent of the outpatient drug benefit. This premium would increase to $4.10 a month in 1990. In 1991, SMI enrollees would pay an ad hoc premium increase of $1.00 a month, in addition to the outlay-based premium of $4.60, for a total premium increase above current law of $5.60. In addition, HI enrollees with taxable income would be subject to an income-related premium. The maximum liability for any enrollee under the income-related premium would be set at $580 for 1988, with the maximum increased in subsequent years based on the rate of growth in the subsidy value of all Medicare benefits, including that portion of costs for the drug benefit not financed by a flat premium.

Like the House plan, the Senate plan would be financed by a combination of additional flat premiums and an income-related premium. The additional flat premium would be $4.00 a month in 1988, and the maximum income-related premium would be $800 a year. By 1992, the additional flat premium would be an estimated $9.40 a month ($5.90 for catastrophic benefits and $3.50 for the drug benefit), and the maximum income-related premium would be $1,000 a year.

TABLE 3. PREMIUMS PER ENROLLEE UNDER CURRENT LAW AND CATASTROPHIC PROPOSALS (Calendar year amounts, in dollars per enrollee)

Proposal	1988	1989	1990	1991	1992
Current Law					
Flat Premiums					
Monthly	24.80	25.80	27.20	28.50	29.70
House Plan					
New Flat Premiums					
Catastrophic	0.0	0.30	0.50	1.60	1.40
Drug	0.0	2.40[a/]	3.60[a/]	4.00	4.30
Total	0.0	2.70	4.10	5.60	5.70
Progressive Premiums					
Maximum annual liability	580.00	737.00	842.00	934.00	1,017.00
Senate Plan					
New Flat Premiums					
Catastrophic	4.00	4.50	4.90	5.30	5.90
Drug	0.00	0.00	0.90	2.00	3.50
Total	4.00	4.50	5.80	7.30	9.40
Progressive Premiums					
Maximum annual liability	800.00	850.00	900.00	950.00	1,000.00

SOURCE: Congressional Budget Office.

a. These are higher than the premiums specified in the bill because of a reestimate made subsequent to passage by the House.

ESTIMATES OF COSTS AND RECEIPTS

CBO's five-year projections for the two proposals are shown in Tables 4 through 7. Table 4 presents cost estimates for the House version of H.R. 2470, while Table 5 shows results for the Senate version. Results are shown separately for Medicare catastrophic benefits, Medicare drug benefits, and Medicaid benefits. A comparison of the individual Medicare benefits provided under the two bills is given in Table 6, together with five-year cost estimates. Table 7 compares Medicare administrative costs under the two bills.

In Tables 4 and 5, results are shown as though both the House and the Senate bills would establish separate trust funds or accounts for the catastrophic and drug benefits provided. In fact, though, only the Senate bill would set up new trust funds for the new Medicare benefits. Under the House bill, new HI benefits would instead be paid out of the current HI trust fund, with the costs of those new benefits "paid" for by removing home health costs from the HI trust fund to the SMI trust fund. The costs of home health benefits, new SMI benefits, and drug benefits would be paid out of the current SMI trust fund, with additional receipts going to the SMI trust fund from the new flat premiums that would be imposed under the bill and from general revenue transfers.

It is useful, nevertheless, to examine both bills as though separate catastrophic and drug accounts would be established, in order to determine whether the funding for new benefits would be sufficient to provide an adequate margin for contingencies, such as projection errors.

The two measures of trust fund or account status shown are:

- Reserve margin. This is the ratio of net assets (assets less upaid expenses) at the end of the calendar year, over expected costs for the coming year. In the Senate bill, a reserve margin goal of 5 percent was specified for the catastrophic trust fund. A reserve margin of less than 0 would mean that assets at the end of the year were insufficient to cover outstanding liabilities.

- Cash margin. This is the ratio of assets at the end of the calendar year, over outlays for the same year. A cash margin goal of 15 percent was specified in the Senate bill for the drug trust fund. A negative cash margin would mean that the trust fund would be depleted—that is, in default.

The trust fund or account values shown in Tables 4 and 5 assume that start-up costs for the drug benefit would be paid out of the catastrophic account, rather than the drug account. Further, they assume that all administrative costs except mandated studies and the Bipartisan Commission would be paid out of the new accounts.

Catastrophic Benefits

Under the House bill, Medicare catastrophic benefit costs would total $26.2 billion for fiscal years 1988 through 1992. Administrative costs would total another $0.3 billion. Flat and progressive premium receipts over the period would exceed costs by $2.1 billion. This excess would not, however, be sufficient to provide a prudent contingency margin.

TABLE 4. SUMMARY FOR H.R. 2470 AS PASSED BY THE HOUSE (JULY 22, 1987)

	1988	1989	1990	1991	1992
Medicare Catastrophic Benefit Fiscal Years (In millions of dollars)					
Benefits	1,050	4,025	5,950	7,105	8,095
Administrative Costs	66	64	54	54	54
Flat Premiums	10	-105	-210	-575	-635
Progressive Premiums	-1,420	-5,070	-6,070	-6,825	-7,675
NET OUTLAYS	-295	-1,086	-276	-241	-161
End-of-Year Account Status Calendar Years (in percents)					
Reserve margin a/	-7.6	-11.6	-12.8	-12.6	-13.9
Cash margin b/	-6.8	4.1	2.4	3.2	1.7
Medicare Drug Benefit Fiscal Years (In millions of dollars)					
Benefits	0	765	1,495	1,840	2,060
Administrative Cost	90	182	228	243	258
Flat Premiums	0	-685	-1,290	-1,560	-1,735
Progressive Premiums	0	-100	-380	-550	-590
NET OUTLAYS	90	162	53	-27	-7
End-of-Year Account Status Calendar Years (in percents)					
Reserve margin a/	0.0	-41.5	-47.1	-45.6	na
Cash margin b/	0.0	-15.9	-15.4	-13.3	-13.4
Medicaid Benefits Fiscal Years (In millions of dollars)					
Offsets From:					
Catastrophic benefit	-85	-325	-480	-555	-635
Drug benefit	0	-30	-60	-75	-85
Medicaid Buyin Costs From:					
Catastrophic benefit	70	360	425	490	535
Drug benefit	0	25	45	65	90
Spousal Impoverishment	55	175	185	195	210
NET OUTLAYS	40	205	115	120	115
TOTAL NET OUTLAYS	-165	-720	-108	-148	-53

SOURCE: Congressional Budget Office and Joint Committee on Taxation.

a. Net assets/next year's costs.

b. Assets/current year's outlays.

TABLE 5. SUMMARY FOR H.R. 2470 AS PASSED BY THE SENATE (OCTOBER 27, 1987)

	1988	1989	1990	1991	1992
Medicare Catastrophic Benefit Fiscal Years (In millions of dollars)					
Benefits	1,355	3,245	4,270	4,850	5,430
Administrative Costs	72	27	27	27	27
Flat Premiums	-1,140	-1,685	-1,885	-2,085	-2,350
Progressive Premiums	-685	-2,375	-2,685	-2,985	-3,340
NET OUTLAYS	-398	-789	-274	-194	-234
End-of-Year Trust Fund Status Calendar Years (in percents)					
Reserve margin a/	-1.1	-0.1	2.2	3.5	5.1
Cash margin b/	18.6	18.7	20.1	21.6	23.4
Medicare Drug Benefit Fiscal Years (In millions of dollars)					
Benefits	0	0	45	735	1,420
Administrative Cost	7	45	105	105	105
Flat Premiums	0	0	-260	-705	-1,280
Progressive Premiums	0	0	-160	-670	-1,125
NET OUTLAYS	7	45	-270	-535	-880
End-of-Year Trust Fund Status Calendar Years (in percents)					
Reserve margin a/	0.0	0.0	18.0	9.1	na
Cash margin b/	0.0	0.0	192.8	76.9	106.1
Medicaid Benefits Fiscal Years (In millions of dollars)					
Offsets From:					
Catastrophic benefit	-55	-185	-260	-295	-330
Drug benefit	0	0	0	-40	-80
Medicaid Buyin Costs From:					
Catastrophic benefit	5	130	250	245	50
Drug benefit	0	0	0	40	80
Spousal Impoverishment	245	280	210	225	255
NET OUTLAYS	195	225	200	175	-25
TOTAL NET OUTLAYS	-196	-519	-344	-554	-1,139

SOURCE: Congressional Budget Office and Joint Committee on Taxation.

a. Net assets/next year's costs.

b. Assets/current year's outlays.

The Medicare actuaries believe that receipts each year should be at least sufficient to cover liabilities for the year, with perhaps some extra to allow for projection errors. In other words, the reserve margin should be greater than or equal to 0 each year. Under the House bill, the reserve margin for the catastrophic portion of new benefits would be negative throughout the projection period.

To avoid default, receipts must be sufficient to cover claims for payment throughout the year. That is, the cash margin must be greater than 0, or payment of claims would have to be suspended if there were no borrowing authority. It would be more prudent to maintain a cash margin of at least 15 percent, to allow for projection errors. Under the House bill, the cash margin for catastrophic benefits in 1988 would be negative, indicating that claims could be paid during the last month of the year only by further depleting the SMI reserves for current law benefits (which are already low due to underestimates of 1987 costs).

Costs under the Senate bill would be lower than under the House version of H.R. 2470, equal to $19.2 billion for benefits over the 5 years, with an additional $0.2 billion for administrative costs. Progressive and flat premium receipts would exceed costs by $1.9 billion. The Senate bill provides for a separate trust fund for catastrophic benefits, and requires that funding be sufficient to provide a reserve margin of 5 percent by the end of calendar year 1992. The cash margin would be positive throughout the projection period.

Drug Benefits

Drug benefits under the House bill are supposed to begin in January 1989, although there is some doubt that a drug program could be implemented that quickly. If it were, estimated benefit costs through fiscal year 1992 would total $6.2 billion, with another $1.0 billion in administrative costs. Flat premium receipts would cover nearly 75 percent of these costs, but progressive premium receipts earmarked for the drug benefit would be insufficient to cover all remaining costs. Total receipts would fall short of costs over the 5-year period by $271 million. If the drug benefit were financed by a separate trust fund (as in the Senate bill) the trust fund would either have to delay payments or borrow in order to pay claims during the last two months of each year. This is indicated by the negative cash margin shown in Table 4 for all years.

The drug benefit under the Senate bill would not begin until 1990, and in that year benefits would be limited to chemotherapeutic, antiinfective, and immunosuppressive drugs administered by infusion in the home. For 1991 and 1992, cardiovascular and diuretic prescription drugs would be added. In 1993, all prescription drugs would be covered, subject to cost limits specified in the bill. Estimated benefit costs through fiscal year 1992 would total $2.2 billion, with another $0.4 billion in administrative costs.

TABLE 6. MEDICARE BENEFITS UNDER HOUSE AND SENATE VERSIONS OF H.R. 2470 (Fiscal years, in millions of dollars)

	1988	1989	1990	1991	1992
Items Common to Both Bills					
All Items Effective January 1, 1988					
No Limit on Hospital Days	180	300	345	380	420
No Hospital Coinsurance	295	485	560	615	680
Maximum of 1 HI Deductible a Year	395	530	550	595	655
No Limit on Hospice days	*	1	1	1	1
Limit Blood Deductible to 3 Units a Year	5	8	10	10	11
TOTAL	875	1,324	1,466	1,601	1,767
Additional Items in House Bill					
First Item Effective January 1, 1988; Rest Effective January 1, 1989					
SNF Coinsurance Changed to 20% of Costs for First 7 Days a Year	170	275	315	350	385
Eliminate 3-day Prior Hospitalization for SNF	0	40	55	65	75
Home Health Up to 35 Consecutive Days	0	155	240	275	315
Up to 80 Hours of In-home Care Through 1991 a/	0	80	170	240	94
Increase Mental Health Limit to $1,000 a/	0	85	185	255	335
Cap on SMI Copayments of $1,043 (1989) Indexed to COLA	0	2,065	3,515	4,310	5,125
Catastrophic benefits	175	2,701	4,484	5,504	6,328
Drug benefits ($500 deductible) a/	0	765	1,495	1,840	2,060
TOTAL	175	3,466	5,979	7,344	8,388
Additional Items in Senate Bill All Effective January 1, 1988, Except for Cap (1-1-88), Screens (1-1-89), and Drugs (1-1-90)					
SNF Coinsurance Changed to 15% of First 10 Days a Year	175	285	325	360	395
Eliminate 3-day Prior Hospitalization for SNF	35	50	55	65	75
Home Health up to 21 Consecutive Days	4	5	5	5	5
With prior inpatient stay, to 45 days	115	175	205	235	270
Year-end Protection on HI Deductible	0	9	10	11	12
Cap on HI+SMI Copayments of $1,850 (1988) Indexed to Charges Per Enrollee b/	151	1,397	2,204	2,573	2,906
Catastrophic benefits	480	1,921	2,804	3,249	3,663
Drug benefits ($600 deductible) a/	0	0	45	735	1,420
TOTAL	480	1,921	2,849	3,984	5,083

SOURCE: Congressional Budget Office and Joint Committee on Taxation.

a. Copayments do not count toward copayment cap.

b. Charges for certain preventive services and for immunosuppressive drugs count toward copayment cap.

TABLE 7. MEDICARE ADMINISTRATIVE COSTS UNDER HOUSE AND SENATE VERSIONS OF H.R. 2470 (Fiscal years, in millions of dollars)

	1988	1989	1990	1991	1992
Items Common to Both Bills					
Notice to Enrollees of Benefits a/	4.0	4.0	4.0	4.0	4.0
Bipartisan Commission	1.5	0.0	0.0	0.0	0.0
TOTAL	5.5	4.0	4.0	4.0	4.0
Additional Items in House Bill					
Administration of Copayment Cap a/	30.0	30.0	20.0	20.0	20.0
Administration of Drug Benefit b/	90.0	180.0	225.0	240.0	255.0
Drug Payment Review Commission b/	0.0	1.5	3.0	3.0	3.0
Participating Directories a/	25.0	25.0	25.0	25.0	25.0
Long-term Care Study	5.0	5.0	5.0	5.0	5.0
Catastrophic administrative costs	60.0	60.0	50.0	50.0	50.0
Drug administrative costs	90.0	181.5	228.0	243.0	258.0
TOTAL	150.0	241.5	278.0	293.0	308.0
Additional Items in Senate Bill					
Administration of Copayment Cap a/	60.0	20.0	20.0	20.0	20.0
Administration of Drug Benefit b/	5.0	45.0	105.0	105.0	105.0
Survey of Drug Costs	1.0	0.0	0.0	0.0	0.0
IoM Study of Drug Coverage	1.0	0.0	0.0	0.0	0.0
Counseling for Beneficiaries a/	2.5	2.5	2.5	2.5	2.5
Case Management Demonstration a/	2.0	0.0	0.0	0.0	0.0
Long-term Care Study	2.0	0.0	0.0	0.0	0.0
Catastrophic administrative costs	66.5	22.5	22.5	22.5	22.5
Drug administrative costs	7.0	45.0	105.0	105.0	105.0
TOTAL	73.5	67.5	127.5	127.5	127.5

SOURCE: Congressional Budget Office.

a. Paid from catastrophic trust fund.

b. Paid from drug trust fund.

The Senate bill provides for a separate trust fund for the drug benefit. Estimated premium receipts would exceed costs over the 5-year period by $1.6 billion, if premiums were set at the ceilings specified in the bill. Although these rates would achieve far more than the 15 percent cash margin required in the bill if CBO's projections for drug costs are accurate, it seems likely that the Secretary would set the premiums at the ceiling. This is because the bill directs the Secretary to increase premiums up to the ceiling each year if appropriate to facilitate transition to accounting based on incurred costs and to maintain adequate reserves. Given the Administration's current estimates of drug costs, even premiums at the ceiling would not achieve a cash margin of 15 percent. Further, for a new benefit with uncertain costs, a cash margin considerably higher than 15 percent might be prudent.

Medicaid Benefits

Under both bills, Medicaid outlays would be affected in three ways:

- The new Medicare benefits would reduce Medicaid costs for those enrollees eligible for both Medicare and Medicaid, as costs currently paid by Medicaid would be picked up by Medicare.

- State Medicaid programs would be required to pay the Medicare premium and copayment costs for some or all Medicare enrollees with incomes below the poverty line, even though they are not otherwise eligible for Medicaid benefits. Under the House bill, all poor Medicare enrollees would receive this benefit. Under the Senate bill, an estimated 40 percent of the poor Medicare enrollees (not already covered by Medicaid) would receive this benefit.

- State Medicaid programs would be required to increase the assets and income that at-home spouses of institutionalized Medicaid beneficiaries could retain for their own use, so that the community spouse would not be reduced to poverty.

The net effect on Medicaid outlays would be $595 million from fiscal year 1988 through 1992 for the House bill, while Medicaid costs would total an estimated $770 million under the Senate bill.

IMPACT ON ENROLLEES FROM MEDICARE CATASTROPHIC BENEFIT PROVISIONS, 1989

Under current law, CBO estimates that the average benefit per Medicare enrollee will be $3,113 in calendar year 1989. The average Medicare copayment will be $524. In addition, Medicare enrollees will pay $265, on average, for outpatient prescription drugs. Drug costs are not included in the results shown in this and the following sections.

Under the House proposal, benefits per enrollee would increase by 5 percent relative to current law, while they would increase by 4 percent under the Senate proposal. The benefit increases represent, in large part, a transfer of copayment costs from enrollees to Medicare. 5/ Average enrollee copayment costs would be 75 percent of current law amounts under the House proposal, and 80 percent of current law under the Senate proposal. The proportion of enrollees who would be affected by the copayment caps (that is, who would have some portion of their copayment liabilities assumed by Medicare) would be 8.1 percent under the House proposal and 4.6 percent under the Senate proposal. Nearly 12 percent of enrollees would receive some benefit from the catastrophic provisions of the House bill, while nearly 9 percent would benefit under the Senate bill (Table 8).

TABLE 8. MEDICARE CATASTROPHIC BENEFITS AND COPAYMENTS PER ENROLLEE UNDER CURRENT LAW AND CATASTROPHIC PROPOSALS, 1989

	Current Law	House Plan	Senate Plan
Average Benefit ($)	3,113	3,276	3,233
Relative to current law	1.00	1.05	1.04
Change in Average Benefit ($)	0	163	120
Average Copayment ($)	524	391	419
Relative to current law	1.00	0.75	0.80
Percent of Enrollees Affected by Copayment Cap a/	0.0	8.1	4.6
Percent of Enrollees Receiving Higher Medicare Benefits	0.0	11.9	8.6

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

a. Under the House plan, the copayment cap would apply only to SMI copayments. The Senate cap would apply to HI and SMI copayments together.

5. In addition to the copayment costs assumed by Medicare, benefits would increase due to enrollees' increased used of services following reduction or elimination of cost sharing.

Both proposals would succeed in eliminating very high copayment costs for enrollees. Under current law, the distribution of copayment costs is very uneven, with 30 percent of enrollees incurring little or no costs, while about 0.5 percent of enrollees with long or multiple hospital stays will incur copayment costs of about $8,000, on average, in 1989. Under both catastrophic proposals, the very high copayment costs of those enrollees at the high end of the distribution would be capped (Table 9).

TABLE 9. MEDICARE COPAYMENTS BY USE OF SERVICES, 1989 (In dollars per enrollee)

Enrollee Group	Percent of Enrollees in Group	Current Law	House Plan	Senate Plan
By Use of Services a/				
No reimbursable services	29.1	23	23	23
No stays, other services	49.0	293	247	271
One stay, no coinsurance	14.6	1,250	1,112	1,154
2+ stays, no coinsurance	6.9	2,211	1,375	1,500
1+ stays, coinsurance days	0.5	8,164	1,499	1,750
All Enrollees	100.0	524	391	419

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

a. The use groups are defined in terms of current law.

About 3.5 percent of enrollees will incur copayment costs in excess of $2,500 in 1989, under current law. Under the House plan, no enrollees would face Medicare copayment costs above $2,000. Under the Senate plan, no SMI enrollees would incur copayment costs above $2,500, but a very small number of HI-only enrollees (who would not be affected under the Senate bill) would incur copayment costs of $3,000 or more (Table 10).

TABLE 10. PERCENT DISTRIBUTION OF ENROLLEES BY COPAYMENT LIABILITY, 1989

Copayment Class (In dollars per enrollee)	Current Law	House Plan	Senate Plan
$0	3.2	3.2	3.3
$1-100	39.2	39.2	39.2
$101-200	22.3	22.2	22.2
$201-500	7.7	7.5	7.5
$501-1,000	10.9	11.5	11.5
$1,001-1,500	7.3	9.5	8.3
$1,501-2,000	3.9	6.9	5.6
$2,001-2,500	2.0	0.0	2.5
$2,501-3,000	1.2	0.0	0.0
$3,001 or more	2.3	0.0	*
Total	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

* Less than .05 percent.

Although copayments would fall, on average, under both proposals, individual enrollees could face either a rise, a fall, or no change in their copayment costs. Under the House proposal, 1 percent of enrollees would face an increase in copayment costs in 1989 that would vary from a few dollars to more than $1,000; 10 percent of enrollees would see their copayment costs fall by amounts ranging from a few dollars to more than $3,000; and 89 percent of enrollees would experience no change in copayment costs (Table 11).

Those enrollees who would experience an increase in copayment costs would do so for one of two reasons. First, some enrollees would pay a hospital deductible that they would not pay under current law because of the elimination of the spell of illness concept (Table 12). Another reason that

TABLE 11. PERCENT DISTRIBUTION OF ENROLLEES BY CHANGE IN COPAYMENT LIABILITIES, 1989

	House Plan	Senate Plan
Average Change in Copayment Liability	-133	-105
Percent of Enrollees for Which Copayments Would Decrease By:		
$1-250	1.7	0.8
$251-500	1.3	0.6
$501-1,000	3.5	2.9
$1,001-2,000	1.9	1.3
$2,001-3,000	0.6	0.4
$3,001 or more	1.0	0.9
Total	10.0	6.9
Percent of Enrollees for Which Copayments Would Increase By:		
$1-250	0.4	0.4
$251-500	0.1	*
$501-1,000	0.6	0.7
$1,001-2,000	0.0	0.0
$2,001-3,000	0.0	0.0
$3,001 or more	0.0	0.0
Total	1.0	1.1

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

* Less than .05 percent.

copayments would increase for some enrollees is that enrollees with short SNF stays might pay SNF coinsurance that they would not pay under current law, because of the shift in coinsurance requirements from the last days to the first days of SNF stays. This would amount to less than $200 per enrollee, though, and fewer than 1 percent of enrollees would be affected.

Another, still small, impact from changes in the provisions applicable to SNFs relates to the number of SNF days covered under the proposals. (Enrollee costs for SNF days not covered by Medicare are not included in copayment costs.) Under the House and the Senate proposals, about 7,880 enrollees would experience an increase in the number of SNF days covered by Medicare, while about 120 enrollees would see a fall in covered days.

TABLE 12. PERCENT DISTRIBUTION OF ENROLLEES BY HI DEDUCTIBLES INCURRED, 1989

	Current Law	House Plan	Senate Plan
Percent of Enrollees Who Would Incur HI Deductibles Equal to:			
0	79.0	78.1	78.1
1	17.7	21.9	21.9
2	2.9	0.0	*
3 or more	0.4	0.0	0.0
Percent of Enrollees for Which Deductibles Incurred Would:			
Decrease	0.0	3.3	3.3
Not change	100.0	95.7	95.7
Increase	0.0	1.0	1.0
Total	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

* Less than .05 percent.

The benefit increases that would occur under both plans would be larger for lower income enrollees. Under the House plan, the average increase in benefits would be $163, varying from $183 for enrollees with family incomes below $5,000 to $145 for those with incomes above $50,000. The average increase in benefits under the Senate plan would be $120 in 1989, but it would be $157 for poor enrollees and only $106 for nonpoor enrollees (Table 13).

TABLE 13. AVERAGE CATASTROPHIC BENEFITS BY INCOME AND POVERTY STATUS, 1989 (In dollars per enrollee)

	Average Benefit	Change in Average Benefit	
	Current Law	House Plan	Senate Plan
By Family Income			
Under $5,000	3,222	183	136
$5,000-10,000	3,462	191	146
$10,000-15,000	3,372	177	132
$15,000-20,000	3,197	160	117
$20,000-30,000	2,903	154	113
$30,000-$50,000	2,808	148	108
$50,000 or more	3,017	145	103
By Poverty Status			
Poor	3,354	202	157
Near poor a/	3,621	192	145
Nonpoor	2,922	148	106
All Enrollees	3,113	163	120

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

Changes in copayment liabilities under the proposals are the mirror image of changes in benefits. Copayment reductions are larger for lower income groups (Table 14).

TABLE 14. AVERAGE COPAYMENT LIABILITIES BY INCOME AND POVERTY STATUS, 1989 (In dollars per enrollee)

	Average Liability	Change in Average Liability	
	Current Law	House Plan	Senate Plan
By Family Income			
Under $5,000	556	-154	-121
$5,000-10,000	580	-160	-130
$10,000-15,000	562	-147	-117
$15,000-20,000	529	-128	-100
$20,000-30,000	491	-123	-97
$30,000-50,000	483	-118	-93
$50,000 or more	505	-115	-88
By Poverty Status			
Poor	573	-169	-139
Near poor a/	594	-159	-129
Nonpoor	495	-118	-91
All Enrollees	524	-133	-105

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

A disproportionate share of benefits--both current and new--would accrue to disabled enrollees, especially those with chronic renal disease. Disabled enrollees comprise about 10 percent of all Medicare enrollees, but would receive from 20 percent to 23 percent of new benefits under the proposals. Enrollees with renal disease, both aged and disabled, make up about 0.4 percent of enrollment, but would receive at least 14 percent of new benefits (Table 15).

TABLE 15. PERCENT OF CATASTROPHIC BENEFITS RECEIVED BY TYPE OF ENROLLEE, 1989

	Percent of Enrollees in Group	Percent of Current Benefits	Percent of New Benefits Received	
		Current Law	House Plan	Senate Plan
By Disability				
Aged Enrollees				
Without renal disease	90.2	86.4	75.3	71.4
With renal disease	0.1	1.6	5.1	6.4
Disabled Enrollees				
Without renal disease	9.4	9.4	10.3	10.2
With renal disease	0.3	2.6	9.4	12.3
By Age				
Less than 65	10.1	12.4	20.1	22.8
65-69	28.0	20.2	19.1	18.0
70-74	23.4	22.1	20.5	19.7
75-79	17.4	19.1	17.7	17.0
80-84	11.4	13.8	12.3	11.9
85 or more	9.7	12.2	10.5	10.7
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

About 12 percent of all Medicare enrollees are poor, but these enrollees would receive about 16 percent of new benefits under the proposals. Those with incomes more than 1.5 times the poverty line comprise about 70 percent of all enrollees; this group would receive about 60 percent of new benefits under both of the catastrophic proposals (Table 16).

TABLE 16. PERCENT OF CATASTROPHIC BENEFITS RECEIVED BY INCOME AND POVERTY STATUS, 1989

	Percent of Enrollees in Class	Percent of Current Benefits	Percent of New Benefits Received	
		Current Law	House Plan	Senate Plan
By Family Income				
Under $5,000	5.5	5.7	6.2	6.3
$5,000-10,000	14.4	16.0	16.9	17.5
$10,000-15,000	15.3	16.5	16.6	16.8
$15,000-20,000	15.5	15.9	15.2	15.1
$20,000-30,000	17.9	16.6	16.9	16.8
$30,000-50,000	19.8	17.9	18.0	17.8
$50,000 or more	11.7	11.3	10.4	10.0
By Poverty Status				
Poor	12.8	13.8	15.8	16.7
Near poor a/	19.4	22.5	22.8	23.4
Nonpoor	67.9	63.7	61.6	60.0
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All HI and/or SMI enrollees are included.

NOTE: Drug and Medicaid benefits are not shown.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

IMPACT ON ENROLLEES FROM FINANCING PROVISIONS 6/

The proposals differ in the extent to which they would rely on flat versus income-related premiums. Because of this, as well as the different structure of income-related premium rates under the House and Senate plans, the distributional effects are different. The flat and income-related premiums that would be paid by individuals under the proposals (without drug premiums) are shown by income in Figure 1. 7/

Both the House and the Senate plans would rely on a mix of flat and income-related premiums, but the Senate plan would rely more heavily on flat premiums than would the House plan. Over the period from 1988 to 1992, about 45 percent of projected additional premium receipts would come from flat premiums in the Senate plan, while only 20 percent of receipts would be from flat premiums under the House plan.

Under the House plan, income-related premiums for individuals in 1989 (exclusive of drug premiums) would be about 8 percent of all AGI above $6,258, with the maximum liability capped at $700. Hence, under this plan, the income-related premium would represent a fixed addition to income tax rates, at least up to the ceiling liability. This ceiling would be reached at about $15,000 of AGI for individuals. The average income-related premium paid by enrollees in 1989 would be about $193, and enrollees would pay an additional $3.60 a year in new flat premiums (for the in-home care benefit). Hence, the total amount paid in Medicare premiums (including the current law premium) in 1989 would be about $507, on average (Table 17).

Under the Senate plan, the income-related premium in 1989 would be about 10 percent of tax liability, up to a ceiling of $850. This would add about 1.5 percent to the tax rate for income in the 15 percent tax bracket,

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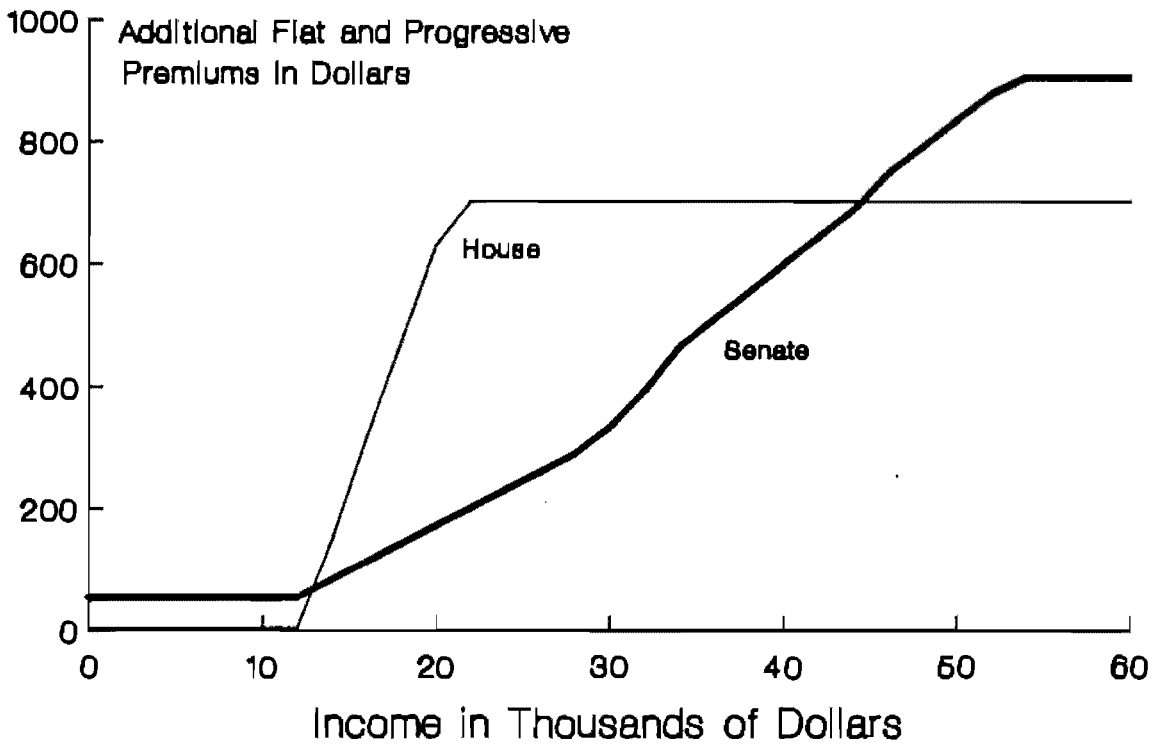
6. Results discussed in this section are based on simulations from the March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. The institutionalized population is not included in this survey. Consequently, the sample population differs from the sample population used for the results shown in preceding sections of this paper, because the Medicare claims data do include information about institutionalized enrollees. Results differ from those by the Joint Committee on Taxation because these are based on family income while the JCT results are based on tax unit income; and because these are based on a less inclusive definition of income.

7. The estimates shown in the figure assume that individuals would either claim itemized deductions equal to one-sixth of their AGI or claim the standard deduction (including the extra deduction for the elderly), whichever was larger. They also assume that the individual would receive $6,000 in Social Security income.

Figure 1. Additional Premiums Under House and Senate Plans by Income, 1989



SOURCE: Congressional Budget Office.

NOTE: For single enrollees. Assumes that individuals receive $6,000 in Social Security benefits and would either claim itemized deductions equal to one-sixth of AGI or claim the standard deduction, whichever was larger. Premiums for the drug benefit are not shown.

TABLE 17. ANNUAL PREMIUM AMOUNTS PAID BY MEDICARE ENROLLEES UNDER CATASTROPHIC PROPOSALS, 1989 (In dollars per enrollee)

Component	House Plan	Senate Plan
Current Law SMI Premiums	310	310
New Premiums		
Flat	4	54
Average progressive		
For all enrollees	193	91
For enrollees with liability	457	222
Percent with liability	42	41
Average New Premiums	197	145
Average Total Premiums	507	455

SOURCE: Congressional Budget Office simulations using the March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. All noninstitutionalized HI and/or SMI enrollees are included.

NOTE: Drug premiums are not shown.

and about 2.8 percent for income in the 28 percent tax bracket. Thus, compared to the House plan, the Senate income-related premium would be a smaller and slightly progressive addition to income tax rates, at least up to the ceiling. The ceiling under the Senate plan would be reached at about $50,000 of AGI for individuals. The average income-related premium paid by enrollees in 1989 would be about $91 with an additional $54 paid in new flat premiums. Under the Senate bill, the total amount paid in Medicare premiums (including the current law premium) in 1989 would be about $455, on average.

Those with income less than $10,000 would pay only the flat premium amounts (if that) and none of the progressive premium amounts. Many low-income enrollees would see their Medicare premium costs eliminated because of the expansion of Medicaid benefits provided for in both catastrophic bills. For example, although Table 18 shows that poor enrollees

would be liable for flat premiums equal to $310 (current law) plus additional costs of $4 (under the House bill) or $54 (under the Senate bill), in fact Medicare premium costs would be paid by Medicaid for all poor enrollees under the House bill, and for about 40 percent of poor enrollees under the Senate bill.

TABLE 18. AVERAGE FLAT AND PROGRESSIVE PREMIUMS PAID BY INCOME AND POVERTY STATUS, 1989 (In dollars per enrollee)

	Average Premium	Change in Average Premium	
	Current Law	House Plan	Senate Plan
By Family Income			
Under $5,000	310	4	54
$5,000-10,000	310	4	54
$10,000-15,000	310	25	56
$15,000-20,000	310	98	68
$20,000-30,000	310	194	100
$30,000-50,000	310	422	199
$50,000 or more	310	547	489
By Poverty Status			
Poor	310	4	54
Near poor	310	5	54
Nonpoor	310	266	178
All Enrollees	310	197	145

SOURCE: Congressional Budget Office simulations using March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. All noninstitutionalized HI and/or SMI enrollees are included.

NOTE: Drug premiums are not shown.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

Under both proposals, lower income groups would pay a disproportionately small share of the costs relative to the benefits they would receive. But this effect is more pronounced for the House than for the Senate proposal. Under the House plan, the poor would pay 0.2 percent of the costs, and would receive 15.8 percent of the new benefits. Under the Senate plan, the poor would pay 4.4 percent of costs, and would receive 16.7 percent of the new benefits (Table 19).

TABLE 19. PERCENT OF FLAT AND PROGRESSIVE PREMIUMS PAID BY INCOME AND POVERTY STATUS, 1989

	Percent of Enrollees in Class	Percent of Current Premiums	Percent of New Premiums Paid	
		Current Law	House Plan	Senate Plan
By Family Income				
Under $5,000	5.3	5.3	0.1	2.0
$5,000-10,000	18.7	18.7	0.4	7.0
$10,000-15,000	14.8	14.8	1.9	5.7
$15,000-20,000	12.5	12.5	6.2	5.8
$20,000-30,000	17.9	17.9	17.6	12.4
$30,000-50,000	18.4	18.4	39.3	25.2
$50,000 or more	12.4	12.4	34.4	41.8
By Poverty Status				
Poor	11.8	11.8	0.2	4.4
Near poor a/	14.7	14.7	0.4	5.5
Nonpoor	73.5	73.5	99.2	90.2
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using the March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. All noninstitutionalized HI and/or SMI enrollees are included.

NOTE: Drug premiums are not shown.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.