Statement of

Alice M. Rivlin
Director
Congressional Budget Office

before the

Subcommittee on Health
Committee on Finance
United States Senate

May 16, 1983

Total Medicare outlays have been growing at an average annual rate of 17.7 percent since 1970, largely because of rapidly rising medical care costs, and Congressional Budget Office (CBO) projections suggest that high growth will continue. This projected growth in outlays threatens the solvency of the Hospital Insurance (HI) trust fund. Even with the recently enacted changes in hospital reimbursement, the HI trust fund is expected to be depleted by the end of 1989. By the end of 1995, the fund could have a cumulative deficit of more than $300 billion. The urgency of the HI financing problem has overshadowed the equally serious problem in the other part of Medicare--Supplementary Medical Insurance (SMI). Although SMI does not face insolvency in its trust fund, because transfers from general revenues are required by law, its increased outlays are adding significantly to the federal deficit. Despite these increased costs, however, there is also concern that the protection against catastrophic expenses offered by Medicare is inferior to that provided by most employment-based health insurance plans.

Although no single change is likely to be sufficient to solve Medicare's financing problems, one way of slowing the growth in outlays would be to make beneficiaries pay a greater share of the costs of Medicare-covered services.[1] Because such an approach might also worsen the financial position of the very ill, some or all of the savings could be used to fund improved catastrophic protection.

---

1. The issues and options discussed here are examined in more detail in Congressional Budget Office, Changing the Structure of Medicare Benefits: Issues and Options (March 1983).

My testimony today will cover three areas:

- o General considerations regarding cost-sharing in Medicare;
- o Issues and options for designing a specific proposal; and
- o The Administration's plan.

BACKGROUND

The term "cost-sharing" normally refers to the requirement that beneficiaries pay some of the costs incurred for their medical care.2 The two major forms of cost-sharing are a deductible amount, which the user must pay before Medicare coverage begins, and a payment of some portion of the cost of each service. This latter payment may be coinsurance (where the individual pays a percentage of the cost of the service) or a copayment (where the patient pays a set dollar amount per service). A broad definition of cost-sharing can also include insurance premiums.

Increased cost-sharing would lower Medicare outlays primarily by shifting costs to beneficiaries. In addition, because of their higher costs, beneficiaries would likely reduce their use of Medicare-covered services, thus increasing the federal savings slightly. In fact, cost-sharing has often been supported as a way to make patients more aware of the costs of their care, thereby encouraging prudent use of such care. When insurance fully covers costs, patients have no financial incentive to limit their consumption, for example, by questioning providers about the necessity of tests or procedures. Studies of cost-sharing--although largely confined to young,

---

2. The term "beneficiary" is used here to refer to all individuals enrolled in Medicare, regardless of whether they actually use reimbursed services in any year.

nondisabled users of health care--have generally shown that use does decline when patients are liable for some of the costs of their care, but the resulting impact on their health status is not known.

Current Levels of Cost-Sharing

Under both portions of Medicare, beneficiaries are now required to share some of the costs of covered services. Under HI, beneficiaries must pay a deductible amount--projected to be $352 in 1984--that is roughly equal to the average cost of being hospitalized one day. They are then not liable for any additional HI cost-sharing until they have been hospitalized more than 60 days.[3] Under SMI, the most important cost-sharing is the 20 percent of the cost of each covered service that beneficiaries must pay once a $75 deductible has been met.

If SMI premiums are considered part of cost-sharing, Medicare beneficiaries will pay, on average, just over $500 in cost-sharing in calendar year 1984, 80 percent of which will be for SMI deductible amounts, coinsurance, and premiums. In addition, they will be liable for health expenses not covered by Medicare, such as drugs, dental care, and physician bills in excess of Medicare's allowable charges. For an elderly beneficiary, such additional noninstitutional care is likely to cost about $550, on average, in 1984. Altogether, medical expenditures on noninstitutional care will consume 14 percent of the typical elderly family's income and range from 21

---

3. Calculation of the number of hospital days is based on a spell of illness--that is, beginning with the first day of hospitalization and ending when the beneficiary has not been a bed patient in a hospital or skilled nursing facility for 60 consecutive days.

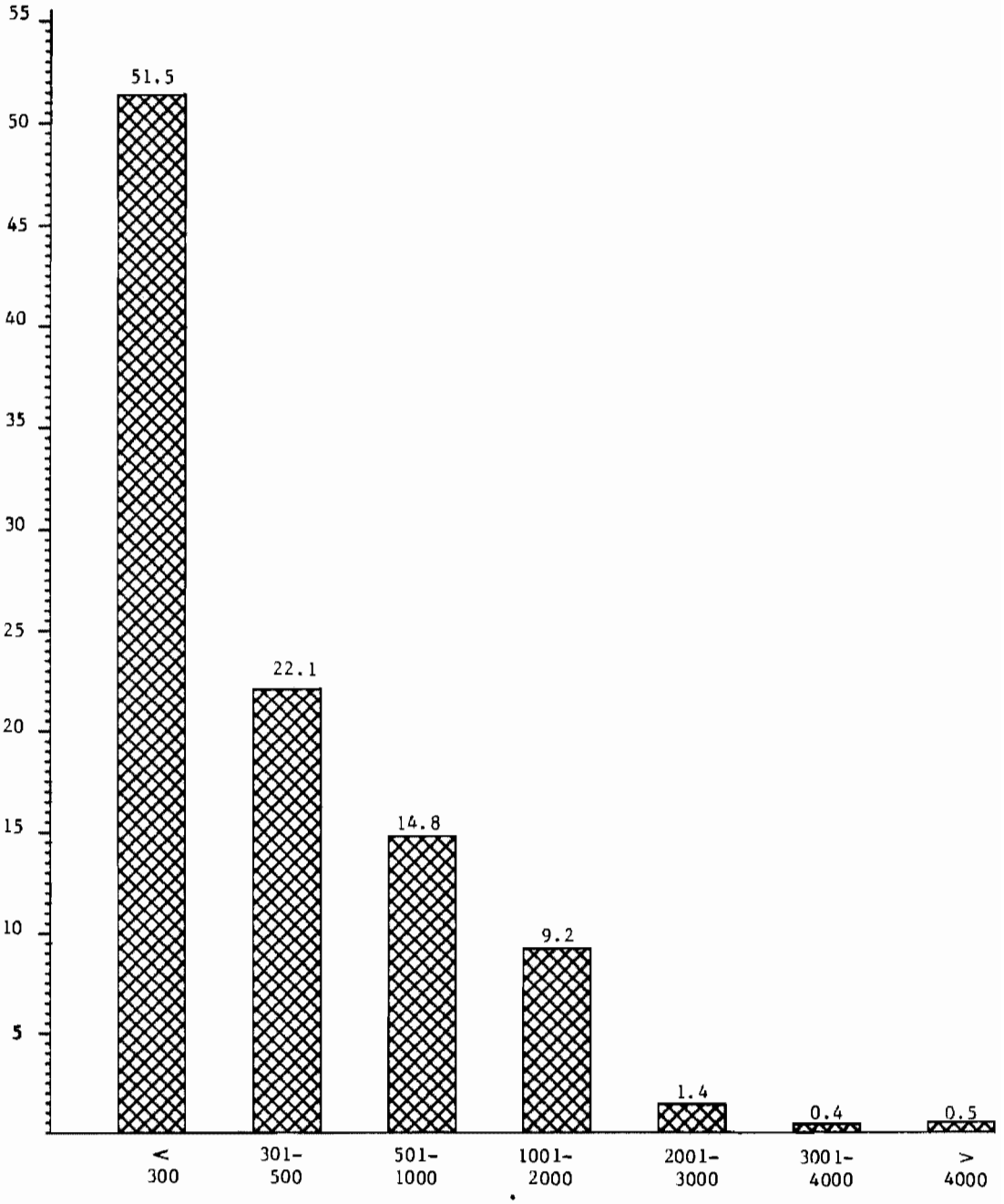
percent of income for those with incomes under $5,000 to 2 percent for those above $30,000. This range reflects both the fact that the elderly who are poor have greater actual health expenditures and the fact that these expenditures constitute a larger share of their incomes.

A few beneficiaries will experience much larger than average Medicare-related cost-sharing in 1984. As shown in Figure 1, while over half of all beneficiaries will pay less than $300, about 11 percent are expected to have Medicare-related cost-sharing in excess of $1,000. Less than 1 percent of beneficiaries will account for approximately 10 percent of all Medicare cost-sharing. In reality, however, the proportion of beneficiaries who must pay this high cost-sharing out-of-pocket will be much smaller, since many have private insurance to supplement Medicare.

The Role of Private Supplemental Insurance

Nearly two-thirds of the elderly and disabled currently have private supplemental insurance coverage--often referred to as "Medigap"--that pays a large share of the deductible and coinsurance costs of Medicare. Together, Medigap insurance and Medicaid (the major federal health care program for the poor) protect three-fourths of the elderly and disabled against liability for most cost-sharing for Medicare-covered services. Those without such protection tend to be individuals above the poverty line--who are not eligible for Medicaid--but with incomes low enough to make Medigap policies expensive for them.

FIGURE 1. DISTRIBUTION OF BENEFICIARIES BY PROJECTED MEDICARE-RELATED COST SHARING, 1984



SOURCE: Congressional Budget Office simulations from the Medicare History Sample.

The availability of Medigap policies complicates considerably the cost-sharing issue. On the one hand, because covered beneficiaries generally do not have to pay any deductibles or coinsurance out-of-pocket, they are not sensitive to the cost of their care, so increased cost-sharing would have little effect on their use of services. On the other hand, Medigap policies ensure that covered beneficiaries would not face extraordinary increases in out-of-pocket costs if more cost-sharing was enacted; instead, they would pay only the increase in premiums that would result from the rise in the average costs of insuring against the greater cost-sharing. The one-fourth of beneficiaries who are not protected by Medigap policies or Medicaid would face very large increases in out-of-pocket costs, however, if they required substantial amounts of medical services.

ISSUES AND OPTIONS

Changes in cost-sharing might be introduced to achieve a variety of objectives, such as obtaining large amounts of federal savings, providing incentives for more efficient use of health care services, and financing improved catastrophic coverage. Each might call for different types or amounts of cost-sharing, however.

To highlight some of the tradeoffs involved in meeting any of these goals, I shall focus on three issues:

- How should the burden of increased cost-sharing be distributed?
- Should catastrophic coverage be improved?
- Should the amount of cost-sharing vary with income?

How Should the Burden of Increased Cost-Sharing Be Distributed?

One of the most important issues in designing any cost-sharing proposal is how to distribute the burden across beneficiaries. Broad-based options would spread the costs among the largest number, ensuring that no one beneficiary would face a major financial loss. In contrast, more narrowly targeted cost-sharing tied to the use of Medicare-covered services would concentrate the added costs on a smaller group, but might lower their use of medical services.

The broadest-based cost-sharing changes 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. (These and other options are displayed in Attachment A.) For example, an increase in SMI premiums to cover 35 percent of the per capita program costs for aged enrollees--rather than the current 25 percent share--would raise the monthly cost to enrollees by about $6 and yield total federal savings in fiscal year 1984 of $1.4 billion. Establishing an HI premium of $10 per month would provide additional savings of $2.5 billion in fiscal year 1984. Neither would generate indirect savings, since the premiums would not be tied to the use of health care services.

In contrast, options linked directly to the use of hospital services would not spread costs widely, since in any one year only about one-fourth of enrollees are hospitalized. The heaviest burdens would thus be imposed on those who already have the highest medical expenses. Although such options would lower the use of medical services by some beneficiaries, those

with private supplemental insurance coverage would largely be insulated from the new incentives. An example of such cost-sharing would be to require beneficiaries to pay coinsurance of 10 percent of the HI deductible amount--about $35 in 1984--for each hospital day after the first. Such a change would raise costs by about $2,100 for someone with a hospital stay of 60 days in 1984 and no supplemental policy. Those with private insurance would pay higher premiums--probably about $70 more in 1984--reflecting the average increase in insurers' costs that would be passed on to beneficiaries. These increased costs for beneficiaries and an estimated reduction in the use of services would generate federal savings of about $1.7 billion in 1984.

Should Catastrophic Coverage Be Improved?

More cost-sharing in Medicare would probably increase the pressure to improve catastrophic protection for beneficiaries. For some, the burden of cost-sharing is already high: the 11 percent of elderly beneficiaries with the highest use of Medicare-covered services are expected to face average cost-sharing of $1,675 in calendar year 1984, in addition to expenses for noncovered services. These beneficiaries would be most affected by a rise in coinsurance, for either hospital care or SMI. Combining improved catastrophic protection--through a limit on cost-sharing, for example--with greater hospital coinsurance would result in a more equal distribution of the burden, but at the expense of considerably lower federal savings.

Although it would be relatively easy to limit the amount of Medicare-related costs required of any beneficiary in a year (or perhaps over several

years), the form of such a cap would be important. A limit could be placed on hospital coinsurance by eliminating the current coinsurance that begins with the 61st day of hospitalization and extending coverage to those who now lose it once their lifetime reserve days have been exhausted.[4] If the cap was financed by a mandatory monthly premium, each beneficiary would pay about $4 per month in 1984. Alternatively, a cap could be placed on combined cost-sharing under HI and SMI, since those with long hospital stays are also likely to have extensive physician and laboratory bills. A $2,000 annual cap on combined HI and SMI cost-sharing, together with hospital coinsurance set at 10 percent of the deductible amount per hospital day, would achieve federal savings of about $0.3 billion in 1984--compared to $1.7 billion with no cap. This option would provide greater protection for those with high medical expenses, but would significantly increase costs for other hospitalized beneficiaries, especially compared with the first option of financing catastrophic coverage through a premium.

Should the Amount of Cost-Sharing Vary with Income?

If Medicare cost-sharing were increased, varying benefits with income would enable higher savings to be achieved while protecting those with modest incomes. This approach would, however, change the nature of Medicare--converting a social insurance program into a means-tested one. Although many would oppose such a change, proponents point out that the

---

4. Medicare allows a lifetime reserve of 60 days of hospital coverage that may be used when a beneficiary is hospitalized for more than 90 days during any spell of illness.

aged and disabled now receive far more in benefits than the actuarial value of their contributions into the system.

For very low-income beneficiaries--usually those receiving Supplemental Security Income--additional medical benefits that cover Medicare cost-sharing are now available through Medicaid. The approximately 15 percent of Medicare beneficiaries receiving Medicaid generally have incomes below the poverty line, however. Means-tested Medicare benefits, on the other hand, are often suggested as a way to protect the elderly and disabled with moderate-incomes--in the $8,000 to $20,000 range, for example--from greatly increased cost-sharing.

Means-testing could be implemented in a variety of ways. For example, hospital coinsurance could be enacted for the early days of a hospital stay, but at a higher rate for those with higher incomes. Alternatively, catastrophic limits could be varied with income, guaranteeing low-income beneficiaries a smaller maximum out-of-pocket liability.

Means-testing would involve a number of practical problems, however. First, income might not be the best indicator of ability to pay, since the elderly often have assets such as their homes. Moreover, families of different size and composition might have varying demands on their resources. Another problem in defining income is its timeliness. Ideally, variations in the amount of required cost-sharing should be based on current income, but it is likely to be more feasible to use the previous year's tax forms.

If a means test were designed to meet these difficulties, it would be complex to administer, particularly since even the current Medicare cost-sharing structure is cumbersome. This problem could be mitigated somewhat by limiting the number of cases to which the means test would have to be applied. For example, more stringent cost-sharing could be automatically assessed except when the beneficiary applied for a reduction. In addition, if the means test were implemented through differential catastrophic limits, only the small number of beneficiaries with both high medical expenses and low incomes would be subjected to the means test.

Perhaps the simplest approach to means-testing would be to vary the SMI premium, or any new HI premium, according to the beneficiary's income. Since a premium increase would not have to be that great to achieve a considerable amount of federal savings, a simple--and therefore not always equitable--definition of income for the means test would not severely penalize any beneficiary. Moreover, the premium could either be based on the previous year's income or be adjusted retroactively through the income tax structure, if a beneficiary's income turned out to be higher or lower than originally anticipated.

THE ADMINISTRATION'S PLAN

The Administration has proposed several changes that would directly affect beneficiaries (see Attachment B for a more detailed description). Under the Administration's plan, the SMI premium would rise gradually over time to a maximum of 35 percent of average SMI benefits, reducing the general revenue transfers required for SMI by about $10.0 billion over the

1984-1988 period. The SMI deductible would be increased each year by the rate of increase in the Medicare economic index--rather than remaining fixed at $75 per year as under current law. This provision would generate five-year savings of about $0.9 billion. Increased hospital coinsurance combined with a catastrophic cap on liability for hospital bills would save Medicare about $12.1 billion over five years.

The higher SMI premiums would affect virtually all beneficiaries and the increase in the SMI deductible would affect about 70 percent of them in any one year. In contrast, the coinsurance proposal would effectively lower coinsurance for those who have very long hospital stays--less than 1 percent of all beneficiaries--but would increase it for those with hospital stays under 60 days--about 25 percent of beneficiaries.

Finally, the Administration has proposed a freeze on physician reimbursement under SMI--a change that might be considered an implicit increase in cost-sharing. Since beneficiaries can be billed for physician charges over the Medicare payment, the elderly and disabled would likely pay more for such services. This provision would generate Medicare savings of about $6.1 billion between 1984 and 1988.

CONCLUSION

Efforts to slow the growth of Medicare outlays are likely to continue to focus attention on cost-sharing proposals. Such changes would raise the costs of care for the elderly and disabled, many of whom have limited resources and already devote a large share of those resources to the purchase of medical services. Spreading costs across many beneficiaries--

through premium increases or means-tested cost-sharing changes, for example--could limit the burdens on those least able to afford care. If the goal is to improve the efficiency of medical care use, changes in coinsurance--perhaps with improved catastrophic protection--might be emphasized.

ATTACHMENT A. FEDERAL SAVINGS FROM CHANGES IN MEDICARE COST-SHARING AND THE COSTS FOR ELDERLY ENROLLEES

Option	Average Increased 1984 Calendar Year Costs per Capita (dollars)		Fiscal Year Federal Savings (billions of dollars)a	
	All Elderly Enrolleesb	Elderly Enrollees with 1984 Cost-Sharing in Excess of $1,000	1984	Total 1984-88
SMI Premium Increase to 35 Percent of Costs	68	68	1.4	14.8
Increase only for those with incomes above $20,000	22	22	0.4	4.8
HI Premium of $10 per Month in 1984	120	120	2.5	20.3
SMI Deductible Increase to $100 in 1984	13	20	0.2	4.1
SMI Coinsurance of 25 Percent	40	212	0.6	7.7
Hospital Coinsurance of 10 Percent of Deductible	72	376	1.7	16.2
With $1,000 limit	-81	-841	-1.9	-18.8
With $2,000 limit	15	-122	0.3	2.6
With $3,000 limit	46	149	1.0	9.9
With $4,000 limit	59	203	1.3	13.0
With $2,000 limit for those with incomes below $20,000; otherwise rising to $4,000	29	1	0.6	5.5
With $1,500 limit for those with incomes below $20,000; otherwise rising to $3,000	10	-226	0.1	1.1
Hospital Coinsurance of 10 Percent of Deductible for Days 2-30	52	212	1.2	11.9

SOURCE: Congressional Budget Office, Changing the Structure of Medicare Benefits: Issues and Options (March 1983).

a. Savings for the options have been estimated independently and cannot, in general, be added together.

b. The numbers in this column are mainly of interest to illustrate the likely increases in Medigap premiums associated with each option.

ATTACHMENT B

THE ADMINISTRATION'S PLAN FOR MEDICARE

Hospital Coinsurance and Catastrophic Cap

This proposal would eliminate the current coinsurance on days 61 and above and extend coverage to those hospital days not now reimbursed because a beneficiary has exhausted his or her lifetime reserve. In addition, the deductible would not be assessed more than twice in one year. (Currently, the deductible is owed for the first hospital day in each spell of illness.)

To finance these changes--and to provide net federal savings as well--coinsurance would be added to the early days of hospitalization for each spell of illness. For the first 15 days of a spell of illness (not counting any day to which the deductible is applied), the coinsurance rate would be 8 percent of the deductible--about $28 per day in 1984. After that, the rate would fall to 5 percent--just under $18 per day. No beneficiary would pay more than 60 days of coinsurance in any year, but the mix of 8 percent and 5 percent rates would depend on the number of spells of illness.

Skilled Nursing Facility Coinsurance

As part of the changes in HI coinsurance, the coinsurance for skilled nursing facility care would be reduced from 12.5 percent of the HI deductible amount to 5 percent--about $18 per day in 1984.

SMI Deductible Amount

The SMI deductible amount would be increased each year beginning on January 1, 1984. The Administration's proposal would tie this increase to the Medicare economic index (MEI). The MEI is now used to limit the rate of increase in physician services and is calculated to reflect the rise in the costs of providing such services. As a consequence of this change, the deductible would rise about $4 in 1984 to $79.

SMI Premiums

This proposal would raise the share of costs financed by premiums by 2.5 percentage points per year beginning January 1, 1985, until it covers 35 percent of costs beginning in January 1988. In 1988 the projected monthly premium would be about $32 under this proposal. Currently, premiums finance 25 percent of the costs of care for elderly beneficiaries. Without changes in current law, that proportion would begin to decline after 1985 and the monthly premium would be about $18.

Physician Payment Freeze

This proposal would freeze amounts paid to physicians under Medicare's "allowed charge" system at the current rate for the period July 1983 to July 1984. After the year is up, the prevailing rate would again be tied to the MEI, but with no "catch-up" allowed.

Other Proposals

The Administration's proposals that are described here are those most relevant to cost-sharing and represent only a portion of the full Administration plan for Medicare. Other proposals include a delay in the start of initial eligibility for Medicare until the first full month in which beneficiaries are age 65, a voluntary voucher that beneficiaries could use to purchase insurance in the private market and other more technical changes.