MEMORANDUM November 13, 1998

FROM: Sally T. Burner
Office of the Actuary
Health Care Financing Administration

SUBJECT: Estimated "First Full Year" Expenditure Impact of Illustrative Proposals To Revise Medicare's Cost Sharing Requirements

This memorandum provides the estimated financial impact of 12 illustrative proposals to revise the cost-sharing provisions applicable to beneficiaries receiving Medicare covered services through fee-for-service reimbursement.[1] Under the subject proposals, Medicare's Part A and Part B benefit packages would be combined and the existing deductibles, coinsurance requirements, and coverage limitations would be replaced with a new cost-sharing structure incorporating the following elements:

- Annual deductible: Beneficiaries would be responsible for the full cost of covered health services up to this amount each year, with the exception of certain services that would be reimbursed 100 percent by Medicare (primarily preventive services such as immunizations and health screening tests).

- Coinsurance percentage: Beneficiaries would generally pay a specified percentage of covered costs above the deductible, subject to a maximum out-of-pocket limit described below. The primary exceptions would be (i) inpatient hospital care (zero coinsurance), (ii) skilled nursing care (same coinsurance requirements as under present law), home health care ($5.00 per visit copayment), (iv) outpatient mental health care (same as present law), and (v) the preventive services described above (zero coinsurance).

- Maximum out-of-pocket limit: Total cost-sharing payments by beneficiaries would be limited to a specified maximum amount each year. Once an individual's out-of-pocket costs reached this maximum, Medicare would cover 100 percent of the cost of any additional covered services.

Covered services (e.g., inpatient and outpatient hospital care, physician services, skilled nursing and home health care, lab tests, etc.) would remain the same as under present law. The existing limits on inpatient hospital days would be eliminated, as would the "benefit period" basis for Part A coinsurance under present law. Also, the gradual transition for outpatient hospital

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[1] Beneficiaries enrolled in Medicare+Choice plans would continue to be subject to the individual plans' cost-sharing requirements. For purposes of the cost estimates shown in this memorandum, we assumed that capitation payments on behalf of plan enrollees would continue to be set as under present law. If such payments were revised to reflect the higher average cost to Medicare for fee-for-service beneficiaries under the revised cost-sharing provisions, then the estimated costs shown in this memorandum would be roughly 40 percent higher.

SNF current law b/c we thought it would be high.

coinsurance under the Balanced Budget Act (designed to correct the current excessive beneficiary costs) would be immediately replaced with the fixed coinsurance percentage described above.

The attached table summarizes the estimated changes in Medicare expenditures and beneficiary out-of-pocket costs in calendar year 2000 that would result from the illustrative proposals. Out-of-pocket costs shown do not include the Part B premium or other supplementary health insurance premiums. Estimates are shown on a "first full year" basis, i.e., as if the modified cost-sharing structure were fully in effect throughout the year.[2] As shown in the table, Medicare expenditures under each of these proposals are estimated to increase—by as much as about $18 billion in the first full year for proposals with a low deductible and coinsurance percentage, to as little as $2 billion for proposals with higher cost-sharing requirements. Relative to total incurred Medicare benefit expenditures under present law (estimated to be $175 billion in calendar year 2000 for fee-for-service beneficiaries), these increases represent 10 and 1 percent, respectively.

Under each proposal, estimated beneficiary coinsurance costs would decrease by roughly the same amount that Medicare expenditures increase. Utilization of covered services (and therefore total cost) is estimated to vary relatively little under these proposals. Individual beneficiaries facing an increase in out-of-pocket costs would tend to decrease their utilization of services somewhat. This effect would be dampened substantially, however, by the continuing availability of private supplementary health insurance and Medicaid coverage for the great majority of beneficiaries. Moreover, as indicated in the attached table, the average beneficiary would incur *lower* out-of-pocket costs under these proposals. For beneficiaries without supplementary coverage, these lower cost-sharing amounts are estimated to increase utilization of services, thereby contributing to higher overall costs.[3]

Charts 1 and 2, attached, illustrate the nature of these proposals' impact on beneficiary out-of-pocket costs. Chart 1 compares the distribution of out-of-pocket costs under present law with those that would result under a proposal with a $200 annual deductible, 20-percent coinsurance rate, and annual maximum of $3,750. As indicated, an estimated 43 percent of fee-for-service beneficiaries would incur lower out-of-pocket costs, averaging $1,378. About 42 percent would face higher costs, with an average increase of $95.

Similarly, chart 2 compares the out-of-pocket cost distribution under present law versus the proposal with a $1,000 deductible, 25-percent coinsurance rate, and $5,000 annual maximum. In this instance, we estimate that 17 percent of beneficiaries would have lower out-of-pocket costs, by an average of $2,086, and 69 percent would have higher costs, with an average increase of $398.

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[2] In practice, the financial impact of a major revision in cost-sharing would build up over several years as a result of billing and payment lags.

[3] About 12.5 percent of fee-for-service beneficiaries do not have supplementary coverage. At this time we have not attempted to model the changes in such coverage that might result from either (i) changes in Medicare's cost-sharing requirements, or (ii) associated changes in the cost of supplementary coverage. Similarly, we have not estimated the enrollment shifts that might occur between fee-for-service and Medicare+Choice as a result of these proposals.

As these proposals are in an early stage of design and consideration, no specifications have yet been provided concerning the financing of the combined Part A and Part B benefit package. Accordingly, this memorandum presents only the estimated impacts on Medicare benefit expenditures and beneficiary out-of-pocket costs and does not reflect potential changes in trust fund income from payroll taxes, general revenues, beneficiary premiums, or other sources.

The estimates in this memorandum are based on the intermediate set of assumptions from the 1998 Trustees Reports and on data from the Medicare Current Beneficiary Survey (1995 Cost and Use File). As with any other major revision to the Medicare program, the financial implications are necessarily uncertain. Our estimates represent a reasonable indication of the likely financial impact but actual future changes in program expenditures and beneficiary payments could differ significantly.

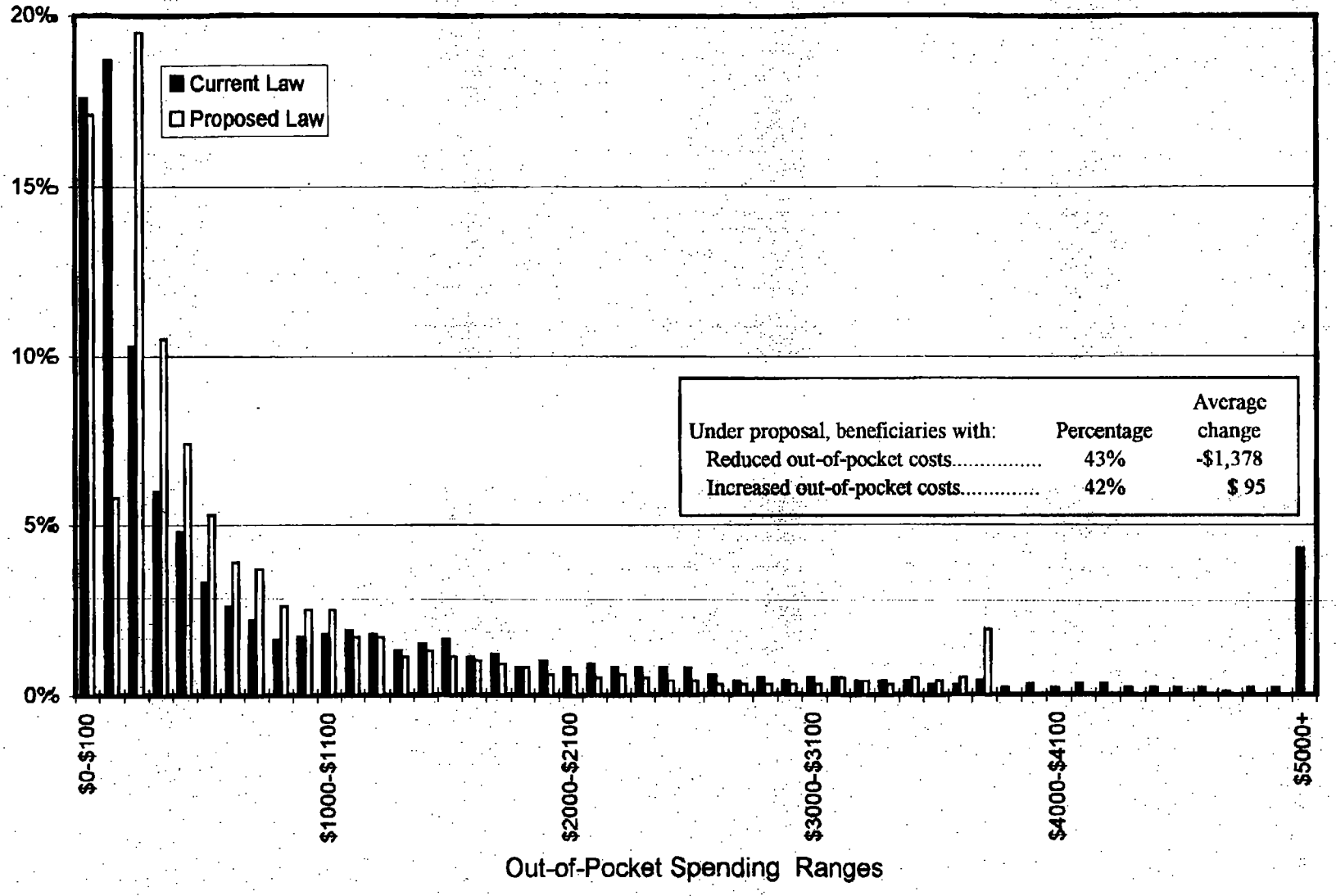
Sally T. Burner

Sally T. Burner, A.S.A.
Special Assistant to the Chief Actuary

Attachments (3)

Chart 1

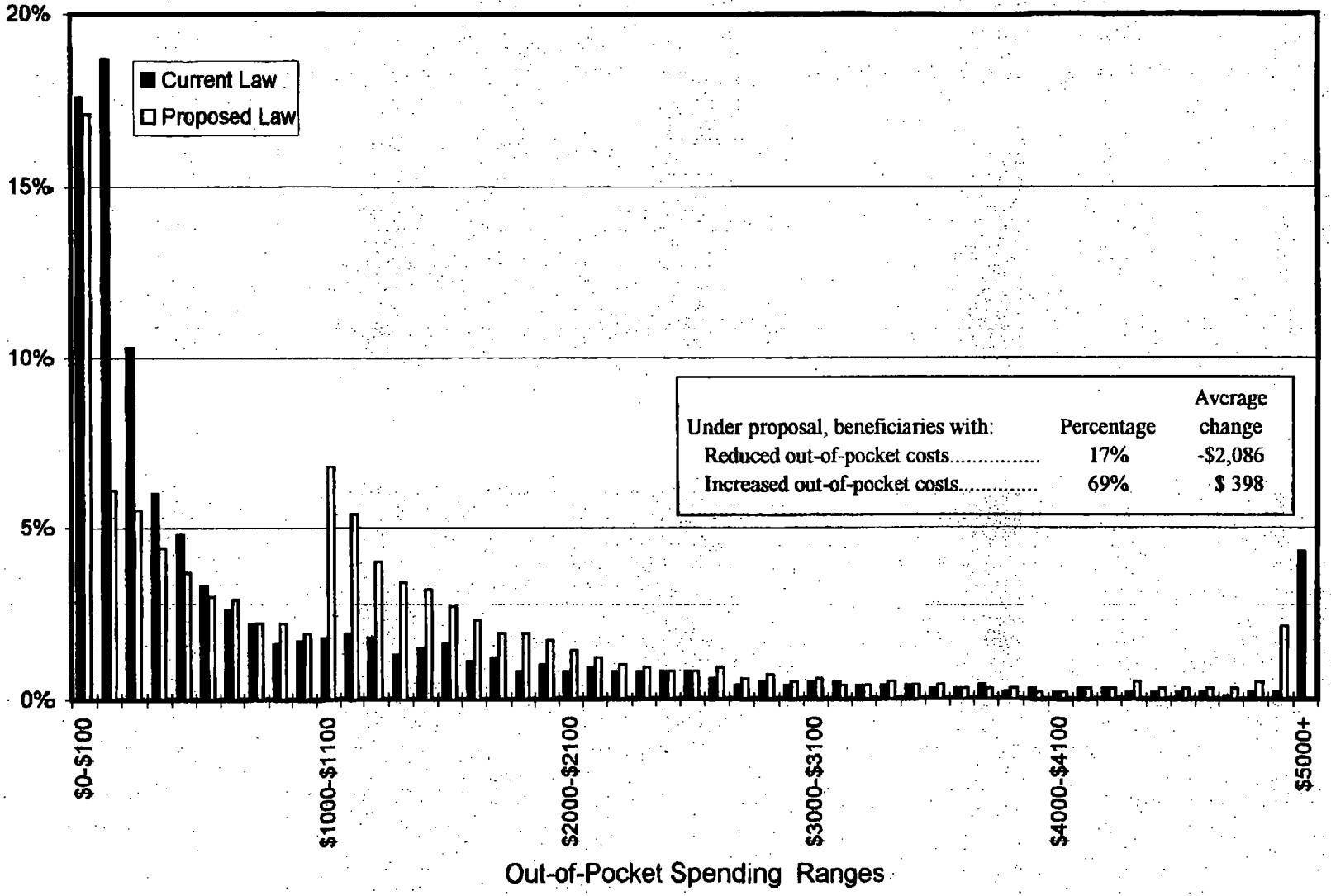
Percent Distribution of Beneficiaries by "Out-of-Pocket" Spending: Current Law vs. $200-20%-$3,750 Proposal



Under proposal, beneficiaries with:	Percentage	Average change
Reduced out-of-pocket costs.....	43%	-$1,378
Increased out-of-pocket costs.....	42%	$ 95

Chart 2

Percent Distribution of Beneficiaries by "Out-of-Pocket" Spending: Current Law vs. $1,000-25%-$5,000 Proposal



Estimated increase (+) or decrease (-) in total covered benefit costs, Medicare expenditures, and beneficiary out-of-pocket costs under illustrative proposals to revise Medicare cost-sharing

Cost-sharing parameters			Estimated change (in billions) in:		
Deductible	Coinsurance percentage	Maximum out-of-pocket limit	Total covered benefit costs	Medicare expenditures	Beneficiary out-of-pocket costs
$200	20%	$3,750	$0.9	$17.7	-$16.8
$200	25%	$3,750	$0.7	$15.6	-$14.9
$250	20%	$3,750	$0.8	$16.7	-$15.9
$250	25%	$3,750	$0.7	$14.7	-$14.1
$1,000	20%	$3,750	(*)	$5.2	-$5.2
$1,000	25%	$3,750	-$0.1	$3.8	-$3.9
$200	20%	$5,000	$0.8	$16.5	-$15.7
$200	25%	$5,000	$0.7	$14.3	-$13.6
$250	20%	$5,000	$0.8	$15.6	-$14.8
$250	25%	$5,000	$0.6	$13.3	-$12.8
$1,000	20%	$5,000	$0.0	$3.7	-$3.8
$1,000	25%	$5,000	-$0.2	$2.0	-$2.2

* Increase in costs of less than $50 million.

Notes: 1. See accompanying memorandum for summary of proposals and limitations of estimates.
2. Estimates are based on the intermediate set of assumptions from the 1998 Trustees Reports and on data from the Medicare Current Beneficiary Survey, 1995 Cost and Use File.

Office of the Actuary
Health Care Financing Admin.
November 13, 1998

20% over (40 years?) $5 billion = OPD on Inpt = lose a lot of $

* NOT just MCR utilization - MCD, ESI, Medigap.

W/O cap on out of pocket limits, would medigap cause same impact?

Who is hitting the Deductible Cap when there's No Hosp Coins

*SNF
*OPD some law
OPD

$500 $5000 DOP, 20% SNF 100 days

only place to "save" is deductible bc that's where immediate $ are.

10% copayment → $ + other variables
(inc homeh.)

15% sounds high.

Zero deductible
5000 out of pocket 8000 couple
OPA continues
10% copayment

November 21, 1998

NOTE TO: Gary Claxton, Barbara Cooper, Jeanne Lambrew, Mark Miller, Jennifer Ryan, Sharman Stephens, Bonnie Washington

SUBJECT: Sensitivity of Medicare Cost-Sharing Proposals to Variations in Deductible, Coinsurance Percentage, or Maximum Out-of-Pocket Limit

The attached charts may help illustrate the nature of the various cost-sharing proposal alternatives and the relative sensitivity of program costs to changes in the deductible, coinsurance rate, or maximum out-of-pocket limit. For simplicity, the charts are based on a theoretical specification where *all* covered services would be subject to the given deductible, coinsurance, and maximum parameters. In practice, of course, the cost-sharing requirements differ substantially by type of service (see Sally's memorandum of November 13) and actual Medicare reimbursement under these proposals would typically be higher than the simplified levels shown here.

The gray bars on the charts show the distribution of Medicare fee-for-service beneficiaries by level of total allowed costs (left-side scale).[1] We estimate, for example, that in calendar year 2000 about 27 percent of beneficiaries will incur total costs of less than $500, while 14 percent will have costs in the range of $500 to $999. The distribution continues to fall off as total costs increase, reflecting the well-known pattern that a relatively small proportion of beneficiaries incur a high proportion of total program costs.

The charts are designed primarily to illustrate the impact of changing the three key parameters on Medicare reimbursement (right-side scale). The baseline for the comparison is the $200-20%-$3,750 proposal:

Chart 1 Increasing the deductible from $200 to $1,000 reduces an individual's (simplified) Medicare reimbursement by a maximum of $640. For beneficiaries incurring total costs below $200 or above about $18,000, the Medicare reimbursement is the same under either proposal. The great majority of beneficiaries, however, would have higher cost-sharing payments with a $1,000 deductible and, consequently, the deductible has a major impact on estimated program costs. As indicated in Sally's November 13 memorandum, increasing the deductible to $1,000 lowers the first-full-year cost by $12.5 billion, compared to the baseline $200-20%-$3,750 proposal.

[1] "Total allowed costs" are the total charges, fees, and/or costs recognized by Medicare for covered services. The beneficiary is responsible for payment of a portion of these amounts under the cost-sharing provisions and the Medicare program reimburses the remainder. Costs for noncovered services, e.g., most prescription drugs or skilled nursing care in excess of 100 days, are not included.

Chart 2 Increasing the coinsurance rate from 20 percent to 25 percent also reduces Medicare reimbursement, by a gradually increasing amount as total costs rise. The maximum theoretical difference is $710. Again, Medicare reimbursement is the same under both proposals for beneficiaries incurring total costs below $200 or above about $18,000. The financial impact of this change is relatively small, since most beneficiaries incur costs at the lower end of the distribution, where the reimbursement levels are very similar. In the November 13 estimates, a 25-percent coinsurance rate lowered the cost of the baseline proposal by only $2.1 billion.

Chart 3 Increasing the maximum out-of-pocket limit from $3,750 to $5,000 results in a fairly significant difference in Medicare reimbursement levels (as much as $1,250, naturally) but only for the relatively few beneficiaries with total costs above about $18,000. In contrast to the prior two illustrations, the differential in program costs associated with the higher out-of-pocket limit affects all beneficiaries above this level (i.e., the differential does not eventually return to zero). The higher out-of-pocket limit, relative to the baseline proposal, reduces estimated costs by only $1.2 billion.

We hope these charts help explain the nature of the proposals to revise Medicare's cost-sharing requirements. Please let us know if you have any questions about them or if we can provide additional information.

Rick Foster

Sally Burner /for

Attachments (3)

Chart 1—Distribution of total allowed costs for fee-for-service Medicare beneficiaries and illustrative level of Medicare reimbursement under two proposals to modify cost-sharing

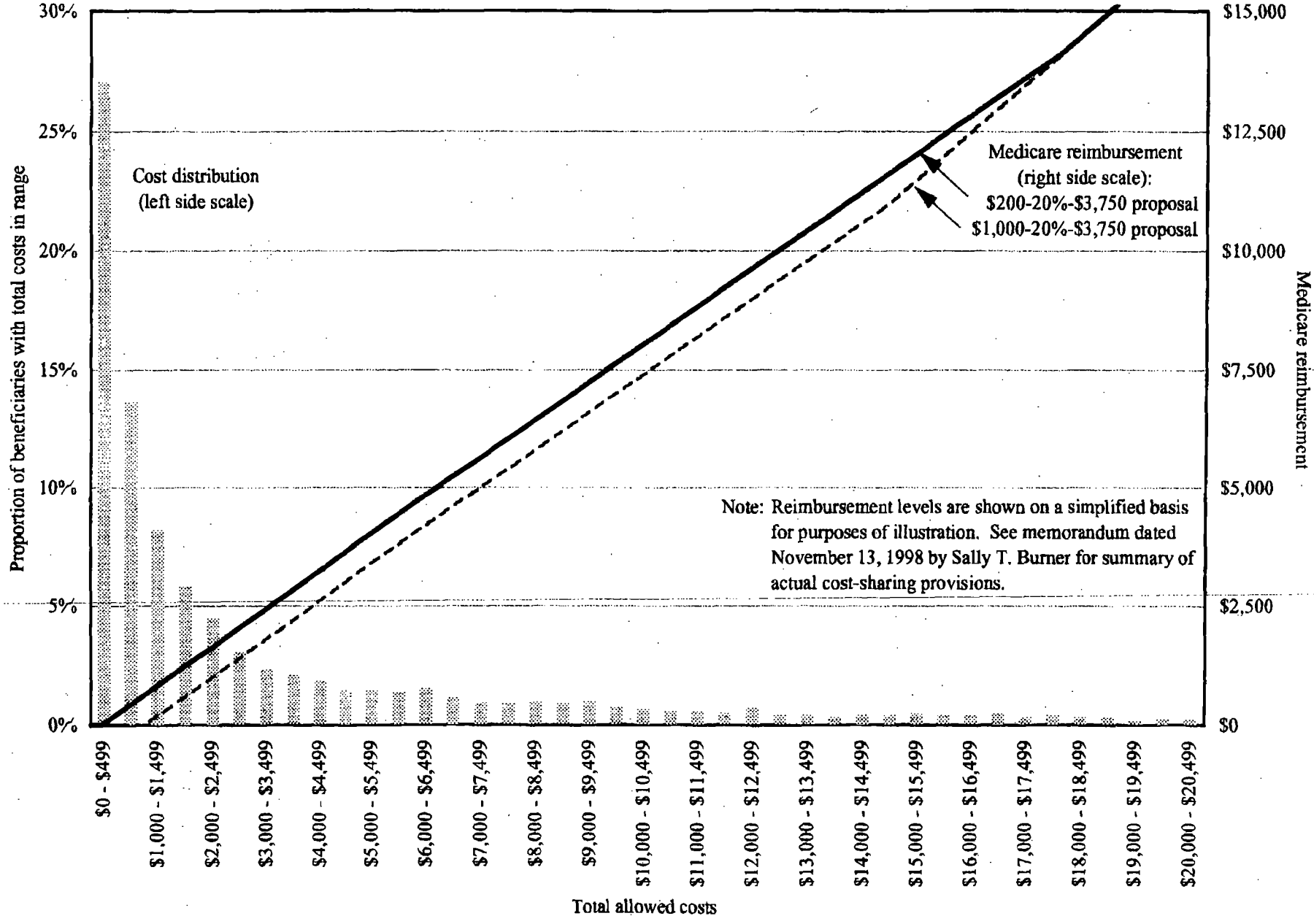


Chart 2—Distribution of total allowed costs for fee-for-service Medicare beneficiaries and illustrative level of Medicare reimbursement under two proposals to modify cost-sharing

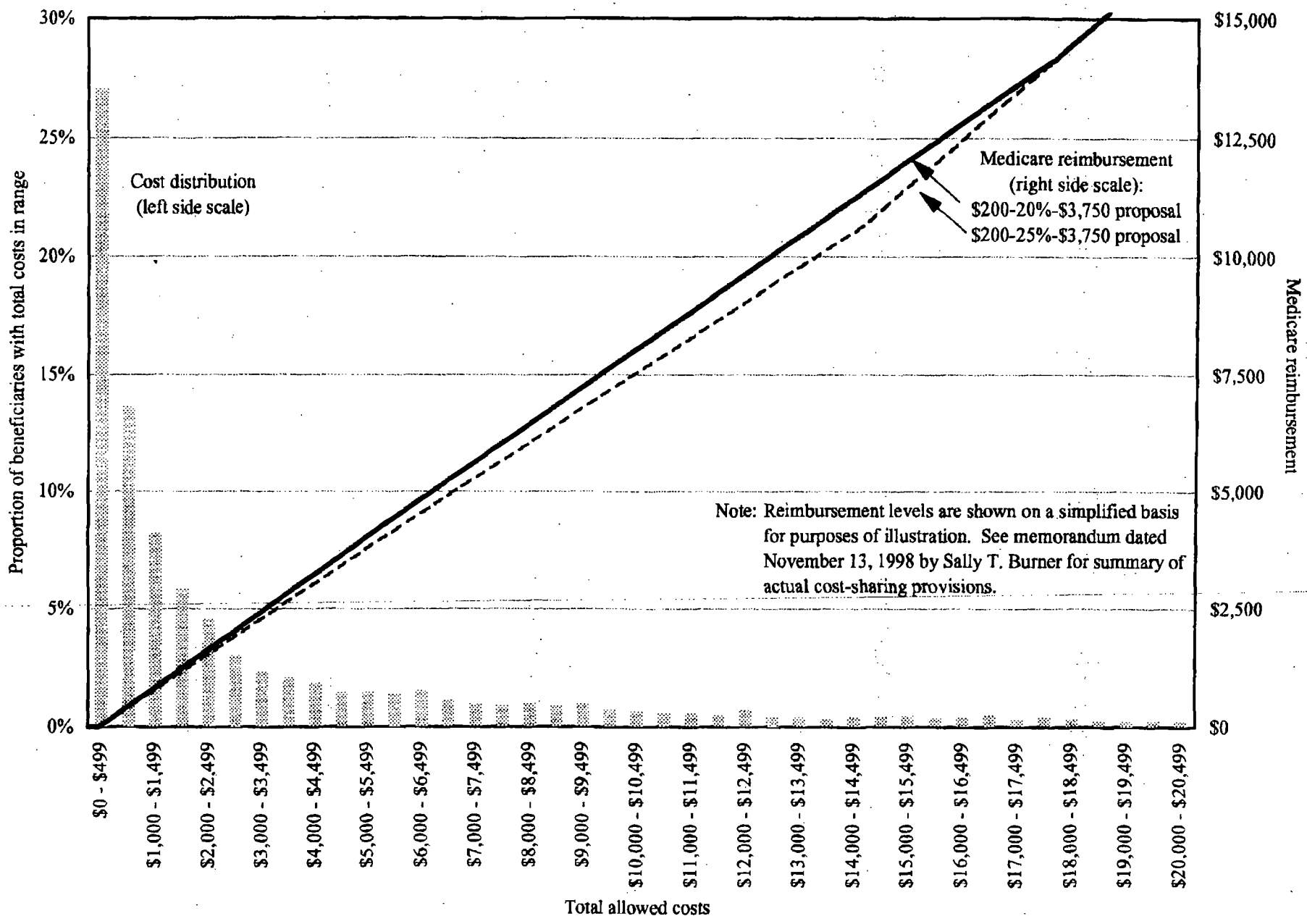


Chart 3—Distribution of total allowed costs for fee-for-service Medicare beneficiaries and illustrative level of Medicare reimbursement under two proposals to modify cost-sharing