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Medicare OPD<sup>01</sup>



FAX COVER SHEET

OFFICE OF LEGISLATIVE &  
INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 6

Date: 4/2/97

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REMARKS: Attached is some additional information on  
the OPD proposal.

I'm also sending a slightly revised  
version of the "rationale" document I sent you  
earlier. I revised the numbers in this document  
to be "5-yr." numbers to match the table.

**HEALTH CARE FINANCING ADMINISTRATION**  
200 Independence Ave., SW  
Room 341-H, Humphreys Building  
Washington, DC 20201

## MEDICARE HOSPITAL OUTPATIENT DEPARTMENT SERVICES

### Proposal

- o **Prospective Payment System** - Implement a prospective payment system (PPS) for outpatient department (OPD) services on January 1, 1999. The rates for the PPS in 1999 would be established so that total payments that hospitals receive would equal projected Medicare payments and coinsurance payments in 1999 (less the amount associated with eliminating the formula-driven overpayment and certain other policies set to expire at the end of 1998).
- o **Coinsurance Reduction** - Between 1999 and 2007, the beneficiary coinsurance rate would be gradually reduced from 46 percent to 20 percent.

Beneficiaries currently pay 20 percent of a hospital's charges for an OPD service, and average coinsurance rates in 1999 will be about 46 percent of total payments to hospitals (the Medicare payment plus coinsurance). Beneficiaries without Medigap insurance or other secondary coverage often face huge unexpected bills when they receive services in OPDs.

Without a legislative change, the coinsurance percentage in hospital OPDs will continue to grow and Medicare's share of total costs will shrink. This is because the Medicare payment for OPD services is calculated after a beneficiary's coinsurance payment has been subtracted from the allowable payment amount. Thus, as coinsurance increases each year, the amount that Medicare pays is reduced. The longer the delay in resolving the coinsurance problem, the worse it will become, and the more costly and difficult it will become to correct it.

### Cost Estimate (see attached table)

- o **Coinsurance Reduction** - This proposal would reduce coinsurance in each year so that by 2007, it would equal 20 percent. Between 1999 and 2002, the savings to the beneficiary would be \$6.8 billion. Between 1999 and 2007, the savings to the beneficiary would be \$59.2 billion.
- o **Impact on Hospitals** - Fixing the beneficiary coinsurance problem and implementing a PPS results in reduced hospital revenue. The amount of the reduction in revenue would be \$8.2 billion over a period of 5 years (1998-2002). Over a period of 10 years (1998-2007), the reduction in hospital revenue would be \$30.2 billion.
- o **Medicare Impact** - Under this proposal, there would be a savings to the Medicare program of \$1.6 billion over 5 years and a total cost to the program of \$38.9 billion over 10 years. [Note that this includes both the fee-for-service cost to Medicare, which is \$28.9 billion over 10 years and the impact of the proposal on managed care plans, which is \$10 billion over 10 years.]

OPD PROPOSAL - FY 1998 PRESIDENT'S BUDGET Sheet1

											TOTALS		
	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	5-Year	7-Year	10-Year
total	0	-1.75	-1.82	-2.07	-2.46	-3.71	-3.44	-4.12	-5.02	-5.84	-8.1	-15.25	-30.23
Coinsurance	0	-1.12	-1.25	-1.84	-2.58	-6.59	-8.45	-10.23	-12.42	-14.71	-6.79	-21.83	-59.19
Part B Payments	0	-0.63	-0.57	-0.23	0.12	2.88	5.01	6.11	7.4	8.87	-1.31	6.58	28.96
**In addition to the \$29 billion cost to Medicare over 10 years, there is a net budget cost of \$9.8 billion over 10 years equal to the impact of an OPD PPS on managed care.													
\\opd.dir\budget2.xls													

## MEDICARE HOSPITAL OUTPATIENT DEPARTMENT SERVICES

### Rationale for Implementing Outpatient Department Prospective Payment System and Reducing Coinsurance to 20 Percent

#### Proposal

- o **Prospective Payment System** - Implement a prospective payment system (PPS) for outpatient department (OPD) services on January 1, 1999. The rates for the PPS in 1999 would be established so that total payments that hospitals receive would equal projected Medicare payments and coinsurance payments in 1999 (less the amount associated with eliminating the formula-driven overpayment and certain other policies set to expire at the end of 1998).
- o **Coinsurance Reduction** - Between 1999 and 2007, the beneficiary coinsurance rate would be gradually reduced from 46 percent to 20 percent.

#### Rationale

- o **Reforms to the Medicare outpatient department (OPD) payment system should be implemented as soon as possible.** There are serious flaws in the current payment system, necessitating a need for reform in three areas: (1) the calculation of beneficiary coinsurance; (2) payment reform through implementation of a prospective payment system; and (3) the correction of the current payment formula to eliminate the formula-driven overpayment.
- o **Prospective Payment System** - A prospective payment system offers significant advantages over the current system. It would provide financial incentives for hospitals to reduce costs, would simplify payment, and make payment more predictable. To the extent the current cost-based system is eliminated, greater control would be placed on outpatient expenditures.
- o **Coinsurance Reduction** - This proposal would reduce coinsurance in each year so that by 2007, it would equal 20 percent. Between 1999 and 2002, the savings to the beneficiary would be \$6.8 billion.

Coinsurance payments have grown as a proportion of total OPD payments. In 1999, beneficiary coinsurance in OPDs is estimated to equal about 46 percent of total payments to hospitals (the Medicare payment plus coinsurance). This percentage will continue to grow without a legislative change.

- Beneficiaries should not be paying coinsurance on the basis of hospital charges. Beneficiaries without Medigap insurance or other secondary coverage often face huge unexpected bills when they receive services in OPDs.
- The longer the delay in resolving the coinsurance problem, the worse it will become, and the more costly and difficult it will become to correct it.

o **How Coinsurance Reduction is Achieved**

The reduction in beneficiary coinsurance to 20 percent between 1999 and 2007 would be achieved through a variety of adjustments made to payments for OPD services. These adjustments are as follows:

- **Use of Savings from Eliminating the Formula-Driven Overpayment (FDO)**- In 1999, the initial coinsurance rate under the PPS would be established at a lower level than the current projection of coinsurance for that year. [83 percent of the savings associated with eliminating the formula-driven overpayment (FDO) would be applied to reducing coinsurance levels.]
- **Redistribution of Costs from Beneficiaries to Medicare** - Between 2000 and 2007, the proportion of the prospective rate paid by Medicare would be increased by a specified percentage amount each year and the proportion paid by beneficiaries would be reduced by the same amount as a direct offset. The specified percentage amounts would be approximately: 1.2 percentage points in 2000 - 2002; 14.9 percentage points in 2003; 1.5 percentage points in 2004; 1.7 percentage points in 2005 and 2006; and 1.8 percentage points in 2007.
- **Additional Reduction in Coinsurance** - Between 2004 and 2007, an additional small reduction in the coinsurance rate of .23 percentage points in each year would be made. This reduction would occur in such a way that the amount of Medicare payments would be unaffected and thus, would result in slightly reduced revenues to hospitals.

o **Formula-Driven Overpayment** - There is an anomaly in the payment formula for determining the amount that Medicare pays for surgical, radiology, and diagnostic procedures in OPDs. For these services, the amount of the Medicare payment is not reduced by the full amount of beneficiary coinsurance. As a result, Medicare's payment is higher than it should be. In addition, hospitals have an incentive to increase charges because this results in increasing beneficiary coinsurance without an offsetting reduction in the Medicare payment.

- Under this proposal, the PPS rates in 1999 would be established at a level to remove estimated savings that would result if the formula-driven overpayment were eliminated.

- This formula-driven overpayment (FDO) should not be allowed to continue. For other medical services paid by Medicare, the payment system is structured to encourage cost control and efficiency. The FDO, however, is blatantly contradictory in that hospitals have an incentive to increase their charges in order to receive more.
- o **Extension of Reductions** - There are two across-the-board reductions in hospital OPD services that are set to expire under current law in 1999: (1) a 10 percent reduction in outpatient capital that has been applied since FY 1992; and (2) a 5.8 percent reduction for hospital OPD services paid on a cost basis that has been authorized since 1991. Under this proposal, the initial payment amounts in 1999 for the PPS would be established assuming the extension of both of these reductions.
- o **Impact on Hospitals** - Fixing the beneficiary coinsurance problem and implementing a PPS results in reduced hospital revenue. This proposal, however, limits the amount of this reduction in revenue to \$8.1 billion over a period of 5 years (1998-2002).
- Over this same 6-year period of time, this reduction is roughly equivalent to the amount of revenue that hospitals would receive under current rules if the formula-driven overpayment (see above) were allowed to continue.

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Attachment

### Revised Coinsurance Rates

The following chart compares coinsurance rates under current law with coinsurance rates that would be achieved under this proposal:

#### **Beneficiary Coinsurance Percentages**

<u>Year</u>	<u>Current Law</u>	<u>Proposal</u>
1998	46%	46%
1999	47%	46%*
2000	46%	44%
2001	47%	43%
2002	48%	42%
2003	49%	30%
2004	49%	25%
2005	50%	24%
2006	51%	22%
2007	52%	20%

\*In 1999, when the PPS is established, if all of the savings from eliminating the formula-driven overpayment had been used to reduce Medicare's payments and none were used to reduce coinsurance, the coinsurance rate would be 51 percent.

OPD options

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OPD

Under the President's Budget proposal, Medicare kept only 17% of the FDO savings. Medicare bought down coinsurance by 1.2 points per year in 2000-2003, 1.9 points in 2003, 1.5 points in 2004, 1.7 points per year in 2005 and 2006 and 1.8 points in 2007. Hospitals financed a .2 percentage point reduction per year in 2004 - 2007.

Under all new options, Medicare would keep 52% of the FDO savings.

Under, the 10 year option -- hospitals would buy down the coinsurance by 2.1 points per year in 2000 - 2002. Medicare would buy down the coinsurance by 4.5 points per year in 2003 - 2007.

Under the 15 and 20 year options, hospitals would pay for all of the buy-down (beyond the initial reduction resulting from Medicare sharing FDO savings): 2.1 points per year under the 15 year option and 1.5 points per year under 20 year option.

Sheet1

	Medicare		Hospitals		Beneficiaries		Coinsurance		
	5 year	10 year	5 year	10 year	5 year	10 year	1998	2002	2007
President's Budget	-1.5	31.7	8.9	34.5	-7.4	-66.1	48%	42%	20%
10 year Option	-6.5	10.4	13.1	54.6	-7.4	-62.4	48%	43%	20%
15 year Option	-6.5	-14.2	13.1	68.1	-7.4	-55.5	48%	43%	33%
20 year option	-6.5	-14.7	12	60.1	-8.4	-47.2	48%	45%	37%



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## MEDICAID SPENDING OPTIONS FOR MEDICARE HOME HEALTH

### ISSUE:

How could additional spending (not to exceed \$10 billion Federal) be used to relieve the financial impact on individuals, States, or both, that would result if Medicare home health is shifted from Part A to Part B, and if Part B premiums increase to reflect the cost of that shift?

### BACKGROUND:

Home health is now covered under Medicare Part A. If this benefit is shifted to Part B, then Part B five year costs would increase by \$80 billion. If Part B premiums were to remain at 25 percent of program spending, then \$20 billion of the \$80 billion increase would be collected from beneficiary payments of an additional \$8.90 per month in Part B premiums in 1988 (rising to \$10.60 by 2002). Medicaid would pay the increase for persons with income below 120 percent of poverty under the general mandate on States to cover Medicare cost-sharing for low-income persons.

### OVERVIEW OF OPTIONS:

- OPTION 1: Expand Medicaid eligibility for Part B premium assistance.** -- More people could be covered by raising the income eligibility threshold for mandatory coverage of premium assistance. The current Federal-State administrative and financing arrangements would continue.
- OPTION 2: Expand eligibility but just for home health share of premium.** -- Create a new eligibility category consisting of persons who could qualify for coverage of the full Part B premium except that they have income above 120 percent of poverty. The only benefit they would get would be the share of the premium attributable to home health. States would match.
- OPTION 3: Hold States harmless by enhancing FMAP for Medicare premiums.** -- Increase Federal matching rate for all State spending on Part B premiums by an amount sufficient to offset the cost to the State of the Medicare home health switch (average increase would be 6 percentage points).
- OPTION 4: Combination of SLMB eligibility expansions and provide State fiscal relief.** -- Increase SLMB eligibility limit on income. Raise Federal match rate for State spending on Part B premiums.
- OPTION 5: Federalize the QMB/SLMB-only part of the current State mandate.** -- All aspects of benefits, administrative and financial, for QMB/SLMBs not otherwise eligible for Medicaid would be assumed by the Federal government.

**DESCRIPTION AND DISCUSSION OF OPTIONS:****OPTION 1: Expand Medicaid eligibility for Part B premium assistance.**

Option: The income eligibility level in the Federal mandate that States pay the Part B premium for specified low-income Medicare beneficiaries (SLMBs) could be raised from the current level of 120 percent of poverty.

Impact Spending \$10 billion Federal would mean --

- income threshold would increase to 190 percent of poverty,
- four million additional people would become SLMBs.

Spending \$5 billion Federal would mean --

- income threshold of 160 percent of poverty,
- 2 million additional SLMBs.

Discussion: Relieves near-poor Medicare beneficiaries of having to pay the entire premium amount. Amount of relief exceeds the premium increase attributable to the home health shift.

This is good public policy on general grounds, but does not target the new spending on the effects of Medicare home health switch.

Creates a new unfunded mandate on States. This eligibility expansion mandate would be in addition to what States will perceive to be the unfunded mandate to pay higher Part B premiums for low-income Medicare beneficiaries whom they already cover.

**OPTION 2: Expand eligibility but just for home health share of premium.**

Option: Create a new eligibility category SLMB-HHs for persons with income above the current SLMB level of 120 percent of poverty. The only benefit they would get would be the share of the premium attributable to home health. States would match.

Impact Spending \$10 billion over five years would provide relief to about 2/3 of all Medicare beneficiaries. Spending only \$5 billion would cover about 1/3.

Discussion: Large processing burden on State Medicaid agencies and Federal government for benefit of relatively small value to its intended beneficiaries. Processing costs to government and individuals could well

exceed the value of the benefit. Money cost (e.g., obtaining and copying documents, transportation, postage) and hassle factor could discourage beneficiaries from applying.

Unfunded mandate on States for both the new coverage and for substantial administrative investments related to increased casework and computer modifications/expansions. In addition, substantial modifications would be needed in Federal-State administrative arrangements (known as the "Buy-In" program), which would involve some increase in Federal administrative costs.

No enduring rationale (other than short-term political) for covering home health share of premium for SLMB-HH's but not premium share or increases related to other Part B services that are equally valuable to beneficiaries.

### **OPTION 3: Hold States harmless by enhancing FMAP for Medicare premiums. --**

Option: Increase Federal matching rate for all State spending on Part B premiums by an amount sufficient to offset the cost to the State of the Medicare home health switch for currently covered groups. On average, the increase would be 6 percentage points.

Impact: Cost of \$1.4 billion over five years in shift of State share to the Federal government.

Discussion: Eliminates the argument that the including Medicare home health in the Part B premium imposes an unfunded mandate on States.

Avoids technical/administrative quagmire of treating home health differently from the rest of Part B.

While the average increase would be 6 percentage points, increases for each State would vary depending on its basic match rate. The percentage increase would be smallest for States with a higher basic Federal rate and largest for States at 50-50 match. This is because under the current matching arrangements, a 50-50 match State would pay \$1 of every \$2 of premium increases due to the home health shift, while a 75-25 State would pay only \$1 of \$4 increase, and would experience half the effect of the shift as compared to a 50-50 State.

Variable percentage increases by State could be conceptually hard explain and defend as necessary for equity among States. Such variations may in

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fact be seen as inequitable, especially to high base match States who may argue that their small increases make them "losers" relative to the 50-50 States. But effectively contradicting such arguments could prove difficult.

Establishing different but "fair" matching percentages for each States would be technically messy.

Does nothing to directly to relieve the impact of the premium increase on persons marginally above the SLMB income level.

#### **Option 4: Expand SLMB eligibility and provide State fiscal relief.**

Option: Increase SLMB eligibility limit on income. Raise Federal match rate for Part B premiums.

Impact: Spending \$10 billion could result in:

- raise in SLMB income threshold to 160 percent of poverty,
- two million more SLMBs,
- average match rate for premiums of 74 percent.

Spending \$5 billion:

- SLMB threshold at 135 percent of poverty.
- 0.8 million new SLMBs,
- 69 percent FMAP on premiums (average).

Discussion: Allows different goals to be pursued at once.

Proposal could be modified to emphasize one goal over the other.

Same problems as under Option 3, in establishing, explaining, and defending different percentage increases based on each State's basic matching rate.

#### **Option 5: Federalize the QMB/SLMB-only part of the current State mandate.**

Option: Retain the current law mandate that States pay Medicare cost-sharing but limit it to "regular" dual eligibles (for example, SSI recipients or medically needy).

All aspects of benefits, administrative and financial, for QMB/SLMBs not otherwise eligible for Medicaid would be assumed by the Federal

government.

The proposal could also be expanded to relieve States of the judicially imposed mandate to pay providers based on higher, Medicare-related rates, rather than on the State's Medicaid rates.

Impact: Five year Federal cost in the \$15-20 billion range, including both benefit and administrative spending.

States would continue to cover about three-fourths of the current QMB/SLMB/dual population. One fourth would be shifted to the Federal government.

In addition, Federalization would increase participation in the program by roughly 25 percent among those currently eligible but not enrolled.

Discussion: **States:** NGA recommendations to Congress typically include such a proposal. It would represent an acceptable return to the status quo before the QMB/SLMB mandates when States most Medicare cost-sharing for these groups was covered by States. Though such coverage was at State option, actual coverage was close to the maximum level allowed.

**Administrative implications:** A new Federal administrative apparatus would have to be established, with attendant resource demands.

- **Determining QMB/SLMB eligibility.** The only way this function could be an add-on, not a start-from-scratch endeavor, would be to build it on to the knowledge base and structure which SSA uses to administer the means-tested SSI program.

- **Paying cost-sharing bills.** HCFA and its contractors would modify reimbursement procedures on claims submitted for services to QMBs to pay deductibles and coinsurance.

**Impact on beneficiaries** would vary by type of beneficiary:

- No impact on the majority of beneficiaries who are fully **dually eligible**, who would continue to be served by their States.

- Persons eligible solely for Medicare cost-sharing as **QMB/SLMB-only's**:

- > Some short-term disruptions until new administrative

arrangements start running smoothly.

- > In the long-term, an SSA District Office-based structure could be more beneficiary-friendly. More who are entitled would apply and be served.

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## ADDITIONAL MEDICAID SPENDING OPTIONS MEDICARE COST-SHARING RELATED TO HOME HEALTH UNDER PART B

### ADDITIONAL OPTIONS:

- From discussion of options 1-5 at 3/18 meeting of principals,
- Relayed by e-mail from Bvladeck,
- Developed by Lcarpenter,
- Cost and people estimates under development by Jklemm.

### **OPTION 6: Increase Federal administrative match for outreach and/or program match for new State spending on Medicare premiums related to enrollment increases.**

Option: *Administrative match* for QMB/SLMB outreach activities would be set at 75 percent, compared to the usual administrative match rate of 50 percent. The increase would be contingent on Federal approval of an outreach plan approved by the Secretary. The increase would discontinue after two years unless actual QMB/SLMB enrollment increased.

*Program match* would increase by one percentage point(s) for every percentage point increase over the prior year in numbers of persons for whom a State paid Part B premiums. The increase would remain in effect unless and until enrollment dropped by 1 percentage point or more.

### Impact:

% New Enrollees over base	# New Enrollees by '02 (mill)	5-yr Fed Cost (\$bill)	State Cost (\$bill)	FY02 avg FMAP
0%	0	3.3	-3.2	83%
1	0.3	5.4	-3.3	88
2	0.6	7.5	-3.4	93
5	1.7	14.5	-3.9	108

Notes: Baseline is the Presidents 98 proposed law budget with the home health add-on to the B premium.

Table shows the impact if enrollment grows by more than baseline rates (5 percent per year) by the indicated amounts.

Average FMAP could eventually exceed 100% because of cumulative effect of FMAP increments.

Discussion: Avoids problem of unfunded Federal mandate.

Not clear how States would respond. Enhanced match is not a reliable tool for encouraging States to adopt new behaviors.

Most of the new Federal costs are related to estimated average growth in enrollments of 5 percent per year that are projected to occur even in the absence of any new State outreach or other efforts to increase enrollment. Enhancing Federal match for these enrollment increases would serve no purpose. While it would be hypothetically desirable to provide enhanced match for only those enrollment increases due to a State's outreach efforts, it would not be feasible to measure this increase separately from those that would have occurred automatically.

**OPTION 7: Raise the percent of poverty eligibility level for premium assistance for SLMBs by (10%), (20%), (30%)**

Option: Retain current SLMB mandates but at higher income levels. No change to the current QMB eligibility rules. In addition, enhanced match could be provided for spending on premiums for persons enrolled because of this expansion.

Impact:

Elig Level	New Benes.	Fed w/o HH add-on	State w/o HH add-on	Fed w/ HH add-on	State w/ HH add-on
130%	0.5 mill	\$1.1 bill	\$0.8 bill	\$1.3 bill	\$1.0 bill
140	1.0	2.2	1.6	2.6	1.9
150	1.6	3.5	2.5	4.1	2.9

Notes: State costs are for expansion eligibles only and do not include cost of new home health add-on for current beneficiaries.

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Estimates are for option 7 as a stand-alone. Costs of combining options 6 and 7 are more than the sum of the two because of interactive effect. Numbers for interaction under development.

Discussion: Option 7 is basically the same as Option 1 on the first options paper, except that Option 1 started with the cost "estimate" of \$5 or \$10 billion and backed the people impact out of that (i.e., what the new SLMB income threshold would be and how many new SLMBs there would be). This option starts with various percents of poverty to arrive at related people and cost impacts.

Like Option 1, this would be an unfunded mandate on States, both for new eligibles and for Part B premium cost of Medicare home health switch.

The effect of the unfunded mandate could be ameliorated if enhanced match rates were provided just for the expansion group. However identifying them as distinct from the non-expansion group would be problematic.

Provides relief to new SLMBs for all premium costs, not just the costs related to the home health switch. (Roughly, annual increases in premium amounts related to home health switch would be \$107. If the SLMB income eligibility level for a single individual were raised to 130 percent of poverty, income levels in dollar terms would rise from the current level of \$9468 at 120 percent by \$789 per year to \$10,257.)

**Option 8: Raise the Federal match rate for spending on Medicare premiums by (10), (20) percent.**

Option: Raise FMAP on Medicare premiums in conjunction with expanding eligibility for premium assistance.

Impact:

Elig Level	+10 Fed Impact (\$bill)	+10 State Impact	+20 Fed Impact (\$bill)	+20 State Impact
130%	3.8	-1.5	6.3	-4.0
140	5.3	-0.8	8.0	-3.5
150	7.0	0.0	10.0	-3.0

**OPTION 9: Raise the percent of poverty eligibility level for both QMBs and SLMBs by (10%), (20%), (30%). No change to FMAP.**

**Option:** Raise the eligibility floor for all mandatory Medicaid coverage of Medicare cost-sharing. For example, if the increase were 10 percent, then income eligibility level for QMBs (for whom Medicaid pays Medicare premiums, deductibles, coinsurance) for an individual in 97 would rise from \$7890 to \$8679. The income level for SLMBs (whose assistance consists only of the premium payment) would by rise from 120 percent of poverty (\$9,468) to 130 percent (\$10,257).

**Impact:**

Elig Level Increase	New Benes.	Fed w/o HH add-on	State w/o HH add-on	Fed w/ HH add-on	State w/ HH add-on
10%	0.5 mill	\$4.2 bill	\$3.0 bill	\$4.4 bill	\$3.1 bill
20	1.0	8.4	6.0	8.8	6.3
30	1.6	12.7	9.1	13.3	9.5

**Notes:** This option expands the number of beneficiaries by the same amount as in option 7. However costs are significantly higher because of the conversion of a segment of current SLMBs to QMB status. The additional benefits for the conversion groups of part A premiums plus coverage of deductibles and coinsurance significantly. (Part A adds about 40% to premium costs, and the cost of deductibles and coinsurance components of cost-sharing is roughly twice the cost of premiums.)

**Discussion:** Unfunded Federal mandate.

Same impact on new SLMBS as under option 7, above. New people would qualify, and they would receive assistance in excess of the amount of the Part B premium increase due to the home health switch.

Persons now covered as SLMBS and who would convert to QMB status (e.g., they become QMBs because their income of 100-110% of poverty falls within the new, higher thresholds), would continue to be protected against premium increases, but in addition they would benefit from coverage of Medicare deductibles and coinsurance for all Medicare benefits, including any that might result from the switch of Medicare home

health from Part A to Part B.

**Option 10 (Stark/Vladeck): Federalize all spending for Medicare cost-sharing.**

Option: This is Option 5, but for all beneficiaries, including dual eligibles, QMB onlys, and SLMB onlys.

Impact: Applying the assumptions of Option 5 to the entire cost-sharing population (about 4 times as big as the "onlys") gives a cost of about \$68 billion before the home health premium add-on. Including the HH add-on adds about \$3 billion.

[Note: This is considerably bigger than the numbers originally quoted earlier because of induction assumption (25% increase in enrollees,) administrative costs, and payment rate adjustment, which were not included in the original number.]



File  
Sarah Chris  
~~Part~~ Medicare

FAX COVER SHEET

Part B



Surcharge

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Number of Pages: 4

Date: 4/4/97

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REMARKS: I understand that you talked to Peter Hickman about the difference between the HCFA + CBO cost estimate for the Part B surcharge proposal.

FYI - attached is some information we sent to CBO a few days ago. This attempts to explain who the Part A only beneficiaries are, why they haven't enrolled in Part B + why they probably won't even if the surcharge goes down.

Give me a call if you have any questions.

HEALTH CARE FINANCING ADMINISTRATION

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## **PART A ONLY BENEFICIARIES**

On July 1, 1996, there were 1,870,709 Part A only Medicare beneficiaries. Of this number, 1.4 million were aged, and .47 million were disabled. (See attached table for break-out by age.) Of the total number of Part A only beneficiaries, there is a quantifiable group of at least 1.35 million for whom a change in the Part B premium surcharge would not be likely to affect their decision about Part B enrollment (see attachment). These individuals are described below and include: individuals enrolled in group health plans for whom Medicare is the secondary payer, residents of foreign countries, residents of Puerto Rico, low-income beneficiaries, and a group of individuals who are still carried on the enrollment files but who are deceased.

In addition to the above quantifiable groups, there are groups of individuals of an unknown number for whom a change in the surcharge would also not be likely to affect their enrollment decision. These individuals are described below and include the following: individuals with comprehensive retiree coverage, individuals receiving care at military treatment facilities, veterans who receive care solely from VA facilities, and individuals between age 65 and 70 for whom the difference in premium payments under the current and revised surcharge is not large.

### **Reasons for Not Enrolling in Part A**

- o **Medicare Secondary Payer** - Approximately 200,000 individuals who are Part A only are individuals who are subject to the Medicare secondary payer provisions. When these individuals enroll in Part B, they will not be subject to a surcharge.
- o **Residents of Foreign Countries** - Approximately 250,000 Part A only individuals live in foreign countries where they are not able to use Medicare. Reducing the surcharge would not cause them to enroll in Part B.
- o **Puerto Rico** - Approximately 150,000 Part A only beneficiaries reside in Puerto Rico. (Puerto Rico is not subject to the Part B automatic enrollment provisions. The reason for this exclusion was because many residents are eligible for comprehensive care under Medicaid.)
- o **Low-Income Beneficiaries** - Based on the Current Beneficiary Survey (CBS), approximately 44 percent of Part A only beneficiaries have income that is less than \$15,000. It is likely that many did not enroll in Part B initially at the standard premium amount because of their low income.

The financial ability of Part A only beneficiaries to purchase health insurance can also be seen by comparing the extent to which Part A only individuals and other Medicare beneficiaries have private health insurance. Based on the CBS, whereas 19 percent of Part A only beneficiaries rely solely on Medicare for health insurance, only 10 percent of other beneficiaries rely solely on Medicare. In addition, less than 5 percent of the Part A only population purchased individual supplemental policies while 33 percent of the rest of the Medicare population did so.

- o **Retiree Coverage** - An unknown number of individuals have comprehensive retiree coverage and do not enroll in Medicare. [Note that based on the CBS, 57 percent of Part A only beneficiaries have employer-sponsored health coverage whereas 31 percent of other Medicare beneficiaries have employer-sponsored health coverage.]

Conversely, it is also possible that some individuals with retiree coverage currently enroll in Part B at age 65 in order to avoid the surcharge in the future. A lower surcharge level may encourage them to wait and pick up Part B at a later date if their retiree benefits change.

- o **Department of Defense** - An unknown group of individuals who receive care at DOD military treatment facilities (MTFs) have not enrolled in Part B because they are able to receive comprehensive care through the MTF.
- o **VA** - There are approximately 4 million category A veterans who are Medicare beneficiaries. (Category A veterans are individuals who have service-connected disabilities or who have low-incomes.) Although there is no data available, there is some subset of category A veterans who obtain medical care solely from VA facilities.
- o **Individuals on Medicare Rolls as Part A Only Beneficiaries but who are Deceased** - In 1991, the HCFA Office of the Actuary estimated that approximately 400,000 of the individuals carried on the Medicare enrollment file as Part A only beneficiaries were deceased. These beneficiaries are primarily individuals who were not getting Social Security cash benefits (and thus SSA did not receive notification of death) but whose Part B was terminated when they died for nonpayment of premiums. We believe there has been some effort to correct these records but that the number still remains high, perhaps between 200,000 and 300,000.

Note that one indication of this problem is the number of Part A only individuals on the Medicare enrollment file who are age 95 and over. This number (104,826) is almost 4 times as high as the number of beneficiaries between the age of 90 and 94. (See attached age chart.)

### **Age of Part A Only Beneficiaries**

- o Of the total 1.87 million Part A only Medicare beneficiaries, 36 percent (or 670,000) are between the ages of 65 and 69. (54 percent are between the ages of 65 and 74.)
- o For individuals between ages 65 and 69, the difference between what an individual's annual premium payments would be under the current surcharge and what the annual premium payments would be under the revised surcharge are not large. For example, assuming the Part B premium is \$43.80 (the premium for 1997), if an individual enrolled at age 70, the difference between the current surcharge (50%) and the revised surcharge (16%) would result in annual savings for that individual of \$179. It is unlikely that this level of premium savings would affect an individual's decision to enroll in the program.

## PART A ONLY BENEFICIARIES

**Total Part A Only Beneficiaries - 1,870,709**

**Individuals for whom a lower Part B premium surcharge would not be likely to cause them to enroll in Part B:**

### (1) Quantifiable Groups

Medicare Secondary Payer beneficiaries -	200,000
Residents of Foreign Countries -	250,000
Residents of Puerto Rico -	150,000
Deceased -	200,000
Low-Income Beneficiaries*-	<u>550,000</u>
<b>TOTAL - -</b>	<b>1,350,000</b>

### (2) Other Groups:

Individuals with retiree coverage

Individuals receiving care at Military Treatment Facilities

Veterans who receive care solely from VA facilities

Individuals between ages 65 and 69 for whom the difference in premium payments under the current and revised surcharge is not large. (670,000 individuals)

\* According to the Current Beneficiary Survey, approximately 44% of Part A only beneficiaries have income less than \$15,000. Since the CBS does not include residents of foreign countries or the deceased, the 44 percent is applied to total Part A only beneficiaries after these groups have been removed. Residents of Puerto Rico are also removed so as not to double count. 550,000 low-income beneficiaries represents 44 percent of 1,270,000.

<b>PART A ONLY BENEFICIARIES</b>	
<b>(July 1, 1996)</b>	
	<b>AGED</b>
<b>65-69</b>	<b>670,419</b>
<b>70-74</b>	<b>331,301</b>
<b>75-79</b>	<b>145,659</b>
<b>80-84</b>	<b>78,258</b>
<b>85-89</b>	<b>45,759</b>
<b>90-94</b>	<b>27,785</b>
<b>95-Over</b>	<b>104,826</b>
<b>Unknown</b>	<b>1,279</b>
<b>TOTAL</b>	<b>1,405,284</b>
	<b>DISABLED</b>
<b>Under 20</b>	<b>545</b>
<b>20-24</b>	<b>6,791</b>
<b>25-29</b>	<b>15,427</b>
<b>30-34</b>	<b>29,366</b>
<b>35-39</b>	<b>46,052</b>
<b>40-44</b>	<b>59,817</b>
<b>45-49</b>	<b>75,798</b>
<b>50-54</b>	<b>70,547</b>
<b>55-59</b>	<b>75,486</b>
<b>60-64</b>	<b>85,796</b>
<b>TOTAL</b>	<b>485,425</b>
<b>TOTAL AGED</b>	
<b>AND DISABLED</b>	<b>1,870,709</b>