S. HRG. 98-204

# FISCAL YEAR 1984 BUDGET PROPOSALS RELATED TO MEDICARE AND MEDICAID COST-SHARING REQUIREMENTS

## HEARING

BEFORE THE

## SUBCOMMITTEE ON HEALTH

OF THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

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MAY 16, 1983

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# FISCAL YEAR 1984 BUDGET PROPOSALS RELATED TO MEDICARE AND MEDICAID COST-SHARING REQUIREMENTS

MONDAY, MAY 16, 1983

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
*Washington, D.C.*

The committee met, pursuant to notice, at 9:33 a.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger and Baucus.

[The press release announcing the hearing and the opening statement of Senator Dole follow:]

[Press Release No. 83-133]

FINANCE SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON FISCAL YEAR 1984 BUDGET PROPOSALS RELATED TO MEDICARE AND MEDICAID COST SHARING REQUIREMENTS

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Senate Committee on Finance subcommittee on health, announced today that the subcommittee has scheduled hearings on the Administration's budget proposals for fiscal year 1984 to revise beneficiary cost sharing requirements under the medicare and medicaid programs.

The hearing will begin at 9:30 a.m. on Monday, May 16, 1983, in Room SD-215 of the Dirksen Senate Office Building.

"The proposals offered by the Administration this year, in an effort to gain control over the rapid increase in health care spending, portend sweeping changes in the cost sharing levels required of medicare recipients," Durenberger stated in announcing the hearing. "We need to hear from various interested parties what the potential effects of these proposals might be." The subcommittee is especially interested in learning the impact of changes in cost sharing levels on such factors as program costs, access to care, utilization of services, and the financial status of beneficiaries.

OPENING STATEMENT OF SENATOR BOB DOLE

I am pleased to be able to join with the Chairman of the Health Subcommittee in welcoming all of our witnesses today. Cost sharing in health insurance is a very controversial topic, particularly when it comes to medicare and medicaid. However, the idea of using cost sharing to deter unnecessary utilization and hold down rapidly rising health care costs is hardly new.

There are those who strongly favor some form of cost sharing, believing that it is necessary to discourage overutilization. Alternatively, there are those who strongly oppose any form of deductibles and coinsurance, fearing that it may make care inaccessible to all but a few, and will hinder access to needed services, particularly by the poor and chronically ill.

Both those in favor of cost sharing and those opposed agree that cost sharing does result in reduced utilization of certain services. In fact, Dr. Newhouse who is with us today will, I hope, share the results of the work done by Rand in this area which demonstrates this quite clearly. The obvious question that comes to mind is whether individuals are able to make wise choices as to when they should seek care, and whether the decision is really theirs to make, given the role of the physician.

Also of importance to us is the question of the impact of cost sharing on the use of particular kinds of services. Can we perhaps construct cost sharing requirements that encourage the use of ambulatory services? Will this in turn reduce the use of hospital care?

IMPLICATIONS FOR MEDICARE

The larger question that needs to be answered is, "What are the implications of increased cost sharing on the medicare program?" Certainly we know less about how access and utilization of medicare services are affected by cost sharing than we do about cost sharing in general. Most of the existing research on the subject deals exclusively with individuals below the age of 65.

The medicare hospital insurance trust fund is in serious financial condition and the prognosis does not look good. The fund could be broke as early as 1988 unless something is done. I do not believe it will be any one thing that will correct the situation, but a combination of changes affecting providers, taxpayers, and beneficiaries. Certainly, cost sharing cannot do it all, but until we determine otherwise it should be considered as a part of the solution. What we learn today will go a long way toward helping us make that determination.

MEDICAID COST SHARING

The research done to date is applicable to medicaid beneficiaries in that more than three-quarters of them are less than 55 years old. We must remember, however, that the medicaid program serves a beneficiary population that is poor and cannot be expected to meet more than nominal cost sharing requirements. We recognized that fact last year, through the Tax Equity and Fiscal Responsibility Act, when we allowed the States to impose no more than nominal copayments on most beneficiaries and services. Whether the flexibility granted the States should be replaced with a mandate to impose cost sharing is a matter which must be carefully considered.

I welcome the witneses before us today and hope the information and views they present allow us to reach decisions that are fair and equitable.

Senator DURENBERGER. We will come to order.

The administration is proposing reforms in health care financing to contain rising health costs and to keep top quality health care affordable. The major element of that reform provides medicare coverage for catastrophic illness, coupled with greater cost sharing. In medicaid, the administration proposes mandated copayments.

I believe there is much to be said for cost sharing whether through deductibles or co-insurance or premiums as a mechanism for discouraging the inappropriate utilization of services. We all know that the insensitivity to the cost of our health care leads to overuse of medical services. For example, between 1971 and 1980 the average number of home health visits, which require no cost sharing, increased by over 350 percent per beneficiary.

The idea of cost sharing is to deter unnecessary utilization and dampen spiraling health care costs and is by no means a resolved issue. There are those like myself who favor the idea as well as those who oppose it. Both groups seem to agree that cost sharing does deter the use of services, but disagree as to whether it is necessary or inappropriate services that beneficiaries are deterred from using.

Medicare and medicaid beneficiaries should be made sensitive to the high cost of care. But I would agree price sensitivity through cost sharing only makes sense when the beneficiary's decision to

seek care is truly his or hers to make, and it does not cause needless delay in seeking needed care. I believe cost sharing can be useful and is appropriate in many instances.

We need to hear from the various interested parties here before us this morning as to whether the administration's proposals are appropriate. The hearing today also offers us an opportunity to learn in general about the impact of cost sharing on such factors as program costs, access to care, utilization of services, and the financial status of beneficiaries.

I look forward to hearing this morning from all of our witnesses, the first of whom is Dr. Robert Rubin, Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, Washington, D.C.

Robert, welcome.

Dr. RUBIN. Thank you.

Senator DURENBERGER. Max, do you have any opening comments?

Senator BAUCUS. I think that we all agree that reform is needed in the health care delivery system. All of us know that the costs of health care are growing. We all know the budget projections for medicare for the next decade. In light of this I hope that, in subsequent hearings we look beyond cost sharing as a means to save medicare money; we need to look for ways to handle the root causes of medicare deficits and health care inflation. Copayments and deductibles may be a part of the solution, I expect. But I also expect that there are other more fundamental reforms that are needed. I hope those reforms are not lost sight of.

Senator DURENBERGER. Thank you.

Dr. Rubin, you may proceed. Your full statement will be made a part of the record.

## STATEMENT OF DR. ROBERT RUBIN, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Dr. RUBIN. Thank you. With your permission I would like to summarize it briefly.

Senator DURENBERGER. You have our permission.

Dr. RUBIN. Mr. Chairman, Senator Baucus, the proposed reforms that we are going to discuss today would continue the administration's efforts to stem health care inflation while assuring financial stability of the programs that the poor and the elderly rely upon to meet their basic health care needs.

I believe to properly evaluate the administration's medicare and medicaid proposals, one must consider the large investment the Federal Government is now making in these programs.

During the current fiscal year medicare will spend an average of $1,940 per beneficiary, and $6,190 per user of both medicare hospital and outpatient services. Medicare's spending per beneficiary has increased at an average annual rate of roughly 15 percent since 1975.

Medicaid costs have also grown rapidly. Since 1975, Federal medicaid spending per beneficiary has grown at an average annual rate of 13 percent.

As you know, the large increases we are experiencing in medicare spending will make it difficult to maintain the solvency of the program. Notwithstanding the recently enacted legislation establishing a system of prospectively determined rates for hospital care, the Health Care Financing Administration (HCFA) projects that medicare's hospital insurance trust fund will be depleted in 1990, using intermediate economic assumptions.

Although the fiscal problems in the HI trust fund receive more attention, the supplementary medical insurance portion of medicare, usually known as part B, is subject to the same health care inflation. In fact payments for physician services, which are covered under part B, are the most rapidly growing portion of medicare. Without new legislation, payments to physicians are projected to increase 22 percent in 1983, and 17 percent in 1984.

It is, of course, widely recognized that soaring health care costs are a serious problem, not only for medicare and medicaid but also for private health plans. The question is if we all recognize the problem, why do costs continue to skyrocket?

Costs continue to risk because they are too often hidden from the view of both the patient and the provider. Costs continue to rise because third party payers, including private health plans as well as the Federal Government, have failed to act as prudent buyers of health services on behalf of their enrollees. Too often, the practice has been to pay virtually whatever the provider billed.

If we are going to reduce health care inflation, we must correct the backward incentives that result from current health care policy. Federal health policy is obviously a good place to start because Federal tax and health programs have done much to hide health care costs and to remove incentives for efficiency.

The administration's health incentive reform package addresses the features of the health care financing system that promote inefficiency and inflation; cost based reimbursement, poorly structured cost sharing, and open ended tax preferences for health insurance.

For purposes of today's hearing, it is also important to observe that the administration's package recognizes the need to provide appropriate economic incentives for consumers. It's not enough to regulate health care providers while telling consumers that "more health care is better and money is no object."

The administration's proposals call on all segments of society—physicians, hospitals, beneficiaries of public programs, workers and their employers, and private insurers—to share the responsibility for slowing health care inflation, while assuring that no one is asked to make a contribution beyond his or her means. That is the only fair approach, and the only approach that will work.

I would like to focus my oral comments on one specific proposal—the proposal to restructure the coverage provided under medicare's hospital insurance program—as an example of the thinking that went into our program.

Under current law, a medicare beneficiary who is hospitalized pays the first day deductible, and then pays nothing out of pocket from the 2d to the 60th hospital day. From that point on, the beneficiary faces ever higher out of pocket payments. After 90 hospital days in a spell of illness, medicare's hospital coverage ends, except

that each beneficiary is entitled to 60 nonrenewable lifetime reserve days.

The administration's proposal would change part A cost sharing to create incentives for efficiency, and it would better protect the medicare patient needing long hospitalization. Under the proposal, medicare would cover all hospital days; not just 90 days per spell of illness. In addition, the heavy patient cost sharing now required on hospital days after the 60th would be eliminated. The administration believes that this cost sharing imposes a burden on the seriously ill and has, at best, a marginal effect in utilization patterns.

To finance this expanded coverage, beneficiaries would pay added coinsurance at the beginning of the hospital spell of illness. But instead of $88 or $175 per day now charged the most seriously ill beneficiaries, these beneficiaries would now pay $18 or $28 a day.

The administration's proposal would provide significant benefits for the most seriously ill medicare beneficiaries. Under our proposal, a medicare beneficiary experiencing a single spell of illness in 1984 with 150 consecutive hospital days would pay $1,530 in out-of-pocket costs for his hospital care. Under current law, the same spell of illness would cost the beneficiary $13,475 in out-of-pocket costs, if that beneficiary were fortunate enough not to have used any of his nonrenewable lifetime reserve days.

In conclusion, any long-term solution to the financial problems of medicare and medicaid must be broad based, and include reforms to increase cost consciousness in both consumers and providers. Although some critics of patient cost sharing argue that more and better regulation of hospital rates will solve our problems, that position is clearly more politically expedient than financially realistic. A sound program for slowing the rise in health care costs must involve everyone.

The administration welcomes the Finance Committee's willingness to discuss the complicated and sensitive issue of patient cost sharing. Many would prefer not to face the issue now, but I believe we cannot afford the luxury of waiting. We need to constrain the growth of health care spending now.

I would be happy to answer any questions you have.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. Rubin follows:]

STATEMENT OF ROBERT J. RUBIN, M.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the subcommittee: I am pleased to have this opportunity to discuss the Administration's proposals for health incentives reform and, specifically, its proposals to modify beneficiary cost sharing in the Medicare and Medicaid programs. These proposed reforms would continue our efforts to stem health care inflation, while assuring the financial stability of the programs that the poor and the elderly rely upon to meet their basic health care needs.

The Administration's legislative package addresses the underlying causes of excessive increases in health costs: the perverse incentives operating in the market for health services. The package is directed at cost-based reimbursement, poorly structured cost-sharing, and open-ended tax preferences for health insurance, the features the health care financing system that have promoted inefficiency and inflation in the health care system.

The Administration's proposals would restore incentives for efficiency, thus encouraging all participants in the health care market to look for more efficient financing and service delivery arrangements. Furthermore, the Administration's proposals are fair; they call on all segments of society -- physicians,

hospitals, beneficiaries of public programs, workers and their employers, and private insurers -- to share the responsibility for bringing down health care costs, while assuring that no one is asked to make a contribution beyond his or her means.

PUTTING THE ADMINISTRATON'S PROGRAM IN CONTEXT

To properly evaluate the Administration's Medicare and Medicaid proposals, one must consider the large investment the Federal government is now making in these programs.

During the current fiscal year, Medicare will spend an average of $1,940 per beneficiary, and $6,190 per user of both Parts A and B services. Medicare spending per program beneficiary has increased at an average annual rate of 15 percent since 1975.

Medicaid costs have also grown rapidly. Since 1975, Federal Medicaid spending per beneficiary has grown at an average annual rate of 13 percent, with projected spending for this fiscal year reaching $820 per beneficiary.

As you know, the large increases in Medicare spending will make it difficult to maintain the solvency of the program. The Health Care Financing Administration (HCFA) has reviewed the finances of Medicare's Hospital Insurance (HI) Trust Fund, taking into

account the effect of the recently enacted prospective payment system and other provisions of the Social Security Amendments of 1983 that affect the HI program. HCFA's projections indicate that the HI Trust Fund will be depleted in 1990 under intermediate economic assumptions, or in 1988 under more pessimistic assumptions. If Congress were to enact the Administration's entire Medicare package, insolvency could be delayed one year -- until 1991 -- under intermediate economic assumptions.

Using intermediate economic assumptions, the HCFA actuaries project that under the new Social Security Amendments, the HI Trust Fund deficit in 1992 will reach $64 billion. If we assume that the Administration's FY 1984 Medicare legislative package were enacted, the projected deficit in the HI trust fund would be $28 billion in 1992.

To put the problem another way, over the next 25 years, the average cost of the HI program is estimated to be 4.31 percent of payroll. During the same 25-year period, the average current law tax rate (counting both the employer and employee shares) is 2.87 percent. Thus, to assure the solvency of the HI Trust Fund, HI payroll taxes will have to be increased by 50 percent over the next 25 years. Alternatively, program outlays must be reduced 33 percent.

Although the financial problems of the HI Trust Fund receive the most attention, the Supplementary Medical Insurance portion of Medicare (also known as Medicare Part B) is subject to the same health care inflation. In fact, payments for physician services, which are covered under Part B, are the most rapidly growing portion of Medicare. Without new legislation, payments to physicians are projected to increase 22 percent in 1983 and 17 percent in 1984.

THE NEED TO CHANGE INCENTIVES

It is, of course, widely recognized that the sustained increase in health care costs is a serious problem, not only for Medicare and Medicaid but also for private health plans. If we all recognize the crucial need to be cost-conscious in the health care marketplace, why do costs continue to skyrocket? The answer boils down to basic economics and human nature.

Costs continue to rise because they are too often hidden from the view of both patient and provider. Costs continue to rise because third-party payers, including private health plans as well as Medicare and Medicaid, have failed to act as prudent buyers of health services on behalf of their enrollees. Too often, the pattern has been to pay virtually whatever costs are billed.

Hidden costs, unquestioning reimbursement, and the resulting absence of price competition among providers have worked to sustain the high inflation rate in health care. Basically it's a question of incentives -- the incentives for cost-effectiveness in health care. Today, the incentives are frequently absent, or even perverse. When neither patients nor providers feel any pressure to purchase and provide health care thoughtfully and prudently, the system is doomed to uncontrollable inflation.

Many Americans feel that they are protected against rising health care costs because they have comprehensive insurance. In fact, rising costs have spurred many private health plans to add coverage to "protect" their enrollees against rising costs. What has been ignored is that adding more of the same kind of insurance does not reduce health care costs; it only hides them.

The entire nation is paying for the high cost of health care, but we often pay in hidden ways: in higher employer-paid insurance premiums that reduce the financial resources available for increased wages and new jobs, in higher prices for goods and services to cover high-benefit health plans which are favored by our tax policy, and in higher taxes to support Medicare and Medicaid. Ultimately, the nation could face the highest hidden cost of all: rationing of care because we cannot afford what is available.

Hidden costs make it especially hard to control health care inflation. By hiding costs, the health care financing system severs the connection between the health care buyer or provider and the costs they incur. This, in turn, reduces, or even eliminates, the incentives for efficiency that operate in other markets.

If we are ever to get control of health care inflation, we must correct the system's "backward" incentives. Federal health policy is a good place to start, because Federal tax and health programs have done much to hide health care costs and remove incentives for efficiency.

The package of reforms proposed by the Administration for FY 1984 will control inflation and encourage competition in the health care marketplace by creating positive economic incentives for providers and patients to control costs. Unlike proposals that merely attempt to "cap" the rise in health care costs through regulation of health care providers, the Administration's package recognizes the need to provide complementary incentives for consumers. The Administration's proposals call on all participants in the market for health services -- physicians, hospitals, insurers, consumers, employers and government -- to work together and share the responsibility for controlling costs.

Working together, the Administration and Congress have taken an important first step by scrapping Medicare's retrospective, cost-based reimbursement system for hospitals in favor of a system using prospectively-determined payment rates. In the remainder of my statement, I will focus on the other Medicare and Medicaid proposals in the Administration's package.

## Restructured Medicare Cost Sharing and Hospital Catastrophic Coverage

One important element in the Administration's plan to correct system incentives is the proposal to restructure Medicare cost-sharing. This proposal would promote cost-conscious decisions while providing beneficiaries with better protection against catastrophic hospital expenses.

Under current law, a Medicare beneficiary who is hospitalized pays a first day deductible (about $350 in CY 1984) and then pays nothing out of pocket until the 61st hospital day in a spell of illness. On hospital days 61-90, a beneficiary must pay coinsurance equal to 25 percent of the deductible for each day (about $88 per day in CY 1984). After 90 hospital days in a spell of illness, Medicare's hospital coverage ends, except that

each beneficiary is entitled to 60 nonrenewable lifetime reserve days. For each lifetime reserve day, a beneficiary must pay coinsurance equal to 50 percent of the deductible (about $175 per day in CY 1984).

Under current law, a beneficiary must pay the first day deductible at the beginning of each hospital spell of illness, and there is no limit on the number of deductibles a beneficiary must pay in a calendar year. Similarly, there is no limit on the number of days a beneficiary can be charged for or on the beneficiary's total out-of-pocket cost for hospital care.

Under current law, Medicare beneficiaries must also pay coinsurance on the days they spend in skilled nursing facilities (SNFs). On SNF days 21-100, a beneficiary must pay 12.5 percent of the deductible each day (about $44 per day in CY 1984).

The Administration's proposal would change Part A cost-sharing to create incentives for savings where those incentives can work and to better protect the Medicare patient needing long hospitalization. Under the proposal, Medicare would cover all hospital days, not just 90 days per spell of illness. In addition, the heavy patient cost sharing now required on hospital days after the 60th would be eliminated. The Administration believes that the current cost sharing requirements impose a burden on the seriously ill and have, at best, a marginal effect on utilization patterns.

To finance this expanded coverage, beneficiaries would pay the first day deductible provided for under current law and then pay 8 percent of that amount -- about $28 per day in 1984 -- for days 2 through 15 of hospital care in a spell of illness. For days 16 and after in a spell of illness, this amount would be reduced to 5 percent of the deductible -- or about $18 per day. After the beneficiary has paid for 60 days of cost-sharing in a calendar year, Medicare would pay for unlimited hospital days without additional patient cost-sharing. In addition, no beneficiary would be required to pay the $350 deductible more than twice per year.

The Administration's proposal would also reduce the skilled nursing facility coinsurance for days 21-100 from 12.5 percent to 5 percent of the deductible.

Under the Administration's proposal, a Medicare beneficiary experiencing a single spell of illness in 1984 with 150 hospital days would pay $1530 in out-of-pocket costs for hospital care. Under current law, the same spell of illness would cost the beneficiary $13,475 in out-of-pocket costs (assuming the beneficiary had not previously used any lifetime reserve days). Similarly, the maximum out-of-pocket cost for covered SNF services would be reduced from $3500 per spell of illness to $1400.

Under the Administration's proposal, a Medicare beneficiary with a hospital stay of 11 days (the average length of stay) would pay $280 more out of pocket than under current law. One should remember, however, that Medicaid may pay the patient cost sharing for about 4 million Medicare beneficiaries with low incomes. It is also important to remember that the modest increase in patient cost sharing would provide a needed incentive for patients and their physicians to consider whether "one more hospital day" is truly necessary and to use outpatient care wherever feasible. These incentives will complement the similar incentives that the prospective payment legislation has established for hospitals.

The net budget effect of the proposed restructuring of Medicare's hospital benefit would be to reduce Medicare outlays by $710 million in FY 1984 and by about $6.8 billion over the next five years. In order to pay the cost sharing for low income beneficiaries, Federal outlays for Medicaid would increase by about $47 million in FY 1984 and by about $435 million over the next five years.

Increase Medicare Part B Premium in Stages

The Administration is also proposing increases in the Part B premium. The intent of this proposal is to move closer to the original balance between premium and general revenue financing of Part B.

When Medicare was established, premiums covered half of the estimated costs of Part B, with the remainder financed from general revenues. Under the Social Security Amendments of 1972, however, the annual premium increase was limited to the same percentage as the annual increase in Social Security cash benefits. As a result, the original balance between premium financing and general revenue financing eroded, until in 1981 premiums covered less than one-quarter of Part B costs. The Tax Equity and Fiscal Responsibility Act of 1982 suspended the limitation on annual premium increases and set a new premium level at 25 percent of projected costs (for the aged) for premium years beginning in July 1983 and July 1984. In subsequent years, premium increases would again be linked to increases in Social Security benefits.

The Administration's proposal would increase the Part B premium in stages. In CY 1984, the Part B premium would be set so that premiums cover 25 percent of projected program costs for aged beneficiaries. Beginning January 1, 1985, the share of projected program costs covered by premiums would be increased by 2.5 percentage points each year until in CY 1988 premiums would cover 35 percent of program costs. In all subsequent years, the premium for each calendar year would be set so that premium income equals 35 percent of estimated costs.

The Administration's proposal also includes a "hold harmless" provision. Beneficiaries who have their Part B premium deducted from their Social Security checks (about 90 percent of the beneficiaries) would not have the dollar amount of those checks reduced below the previous year's level due to the proposed premium increase.

The Administration's proposal would increase premium income by $9.2 billion over the next five years. During the same period, Federal Medicaid outlays would increase by about $516 million because Medicaid pays the Part B premium for low income beneficiaries.

Index Part B Deductible to the Medicare Economic Index

A third Administration proposal is to index the Part B deductible to increase with annual changes in the Medicare economic index. This provision would help maintain the constant dollar value of the deductible, thus preserving its utility as a deterrent to unnecessary utilization.

When Medicare was established, the Part B deductible was set at $50. The deductible has only been increased twice since then: to $60 in 1973 and to $75 in 1982. As a result, the initial

beneficiary liability for medical services has been decreasing in real terms. If the Part B deductible had been indexed to the CPI since 1965, it would now be about $153.

Current law does not provide for future increases in the Part B deductible despite a projected 102 percent increase in Part B outlays between FY 1983 and FY 1988.

This proposal would result in Medicare savings of $50 million in FY 1984 and savings of $1.1 billion over the next five years. Since Medicaid may pay the deductible for low-income beneficiaries, Federal outlays for Medicaid would increase by about $84 million over the next five years.

Medicaid Cost Sharing Requirement

The Administration believes that nominal copayments should be required for both inpatient and outpatient services financed by Medicaid. The Administration has therefore proposed a $1 copayment for the categorically needy and a $1.50 copayment for the medically needy for each visit for physician, clinic, and hospital outpatient services. Inpatient services would be subject to $1 and $2 per day copayments for the categorically needy and medically needy, respectively.

States would be required to exempt from these copayments services for long term care inpatients and services for categorically needy individuals enrolled in HMOs. States would be given the option to exempt from these copayments services to pregnant women, emergency services, and services to medically needy individuals enrolled in HMOs, but Federal matching payments would not be available for amounts equal to the copayments the State could have charged for services to pregnant women and emergency services.

The proposed copayments are needed because Medicaid's first-dollar insurance coverage leaves the beneficiary with no financial incentive to be cost conscious in seeking services. Demand for medical care is responsive to price, and services that are free are likely to be overutilized. If patients are made to share in some of the costs, they and their physicians will reduce unnecessary or marginal utilization.

The level of the copayments is low enough not to be unduly burdensome. According to the National Medical Care Expenditure Survey (1977), the average Medicaid recipient visits a physician or outpatient clinic 5 times per year and uses 2 days of hospital care.

We anticipate that this proposal will result in Federal Medicaid program savings of $249 million in FY 1984 and savings of $1.4 billion over the next five years.

Conclusion

Any long term solution to the financial problems of Medicare and Medicaid must be broad-based and include reforms to increase patient cost-consciousness as well as provider cost consciousness. Although some critics of cost sharing argue that more and better regulation of hospital rates will solve our problems, that position is more politically expedient than financially realistic. A sound program for slowing the rise in health care costs must involve everyone.

The Administration appreciates the Finance Committee's willingness to discuss the complicated and sensitive issue of patient cost sharing. Many would prefer not to face the issue now, but the nation cannot afford that luxury. The need to constrain the growth of health care spending is too urgent.

Working together, we have established an admirable record in beginning to change the incentives in the health care system. We want to continue this effort so that quality health care will continue to be available to all Americans.

I welcome your questions.

Senator DURENBERGER. I have more question than we have time for this morning. But my concern in this area, obviously, breaks down into several areas. In your oral testimony you covered one of them, which is the need to provide catastrophic coverage for the elderly. We also have the issue of copayments or coinsurance and their impact on utilization. We also have the issue of the role that physcians play in some of these decisions, and the use of cost sharing in medicare part B. I am also concerned about what a lifetime of being without major cost sharing does to people's sensitivity to cost sharing once they become eligible for medicare. If they are coming off of a system in which they pay very little for their sick care, and in many cases very little or nothing for their health insurance, I can appreciate the resistance to the medicare cost sharing we've talking about today.

So there's a wide range of issues that we would like to address during the course of the hearing today. But let me start with the so-called catastrophic proposal of the administration, and just ask you if there really aren't two issues here. It would appear to me that you have combined the issue of catastrophic with the issue of copays. Use the latter to help finance the former.

If you were to be able, Dr. Rubin, to start, from scratch and provide catastrophic coverage for people over 65, is this the ideal way to go? Might we not consider catastrophic as a totally separate issue? Perhaps the Government could sell them a separate policy to cover catastrophic expenses. Might there not be a better way to approach this whole issue of catastrophic than the one you are proposing?

Dr. RUBIN. I think we would all agree that the system as constituted in 1965 had a few flaws in it. One of them, I think, was the way in which cost sharing was set up to, in essence, provide for confiscatory cost sharing of 25 and 50 percent of the first day deductible on hospital days after the 60th. In 1984 this would be $88 for hospital days 61 through 90 and $175 after the 90th day. Clearly this is not desirable from a health policy standpoint, although it has some effect on reducing outlays.

I think that it's clear that all of us who have dealt with medicare beneficiaries either as patients or as family members realize that it's this fear of catastrophic illness that is the pervasive concern of the medicare beneficiary. I think that this fear is something we need to remove.

What is the best way to do it? I think that the administration's medicare restructuring proposal certainly is one attempt that is financially responsible, and it really gets to the root cause of the problem. The proposal will eliminate the current limit on covered hospital days, and will prevent medicare coverage from running out altogether when somebody is significantly ill.

Obviously, this catastrophic coverage has a cost associated with it that we need to finance. And I think doing it on front end cost sharing, which we know has an effect on utilization is a reasonable way to proceed.

Now are 8 percent and 5 percent the right numbers to use in cost sharing? I don't know. Those are the numbers that we are putting forward. Certainly it would not be totally beyond the realm of belief if the Congress changed those numbers somewhat. But I

think that the administration's proposal is a good place to begin the discussion, which is what I believe we are doing this morning.

Senator DURENBERGER. So there might be other ways to approach catastrophic than to use copays to finance it?

Dr. RUBIN. I think we need to do it in some way that does not add to the already significant fiscal burden that the medicare trust fund is experiencing.

Senator DURENBERGER. All right. But you wouldn't mind if we explored some other alternatives that didn't add to the significant burden that medicare——

Dr. RUBIN. I would be surprised if you didn't.

Senator DURENBERGER. Oh, all right. Thank you.

Wouldn't it make more sense to construct a catastrophic benefit not just around hospitalization, but around the entire medicare package? It seems to me catastrophic should provide protection against part A and part B. Is that a better approach to catastrophic?

Dr. RUBIN. Our belief was that we were beginning on a path that really has not been well explored, and that the major financial burden for the beneficiary in terms of catastrophic illness was hospitalization. Given the precarious state of the medicare hospital insurance trust fund, we needed to look at utilization decisions affecting hospitalization, so adding catastrophic hospitalization coverage and changing the coinsurance feature was a reasonable place to begin.

I think that to provide catastrophic coverage for all services in one fell swoop may make it very difficult to predict the effect. And, indeed, tha approach may run into the problem of not being fiscally responsible. Certainly there are other ways of looking at it, but I think that we chose a cautious approach that removed the fear that most of the beneficiaries have—that is, catastrophic hospital stays.

Senator DURENBERGER. There's a fair amount of talk around this place about means-testing medicare as a partial solution to the problem. And, obviously, one of the areas in which some forms of means testing could be applied is in the area of catastrophic where the catastrophic cap could be a percentage of income.

Is it inappropriate for us to consider catastrophic in terms of a percentage of income for persons who are 65 and older?

Dr. RUBIN. I don't think it is inappropriate for you to do whatever you like.

Senator DURENBERGER. But from a health policy standpoint are you demonstrating a trust in us by that response?

Dr. RUBIN. I think there are some economists that you might hear from later today that might find that reasonable. I think there are probably other people you will hear from today that think that is in violation of the contract that the Government made with the elderly back in 1965. I think the administration's position on means testing medicare was made clear last October when the President said he wasn't in favor of it. And then Secretary Schweiker agreed with him. I don't believe there has been movement from that position.

Senator DURENBERGER. On the other side of the proposal is the whole issue of cost sharing. Could you describe briefly for us your

views on the utilization impact of the administration's cost sharing proposal? Do you view cost sharing as having some, little, or no impact on utilization of services?

Dr. RUBIN. As you know, the Congress passed a prospective payment provision bill that will go into effect on October 1 of this year. The goal in that is to create an incentive for hospitals to decrease length of stay.

The administration's cost sharing provision is complementary to that in that it now puts an incentive on the patient to decrease length of stay. And I think that both of those working together will clearly have an effect on utilization. Is there any data to suggest that? Surprisingly little, although one notes that Blue Cross and Blue Shield reported over the weekend that for their under 65 population, length of stay in a hospital has diminished over the last fiscal year. Why is that?

Well, we know from a survey done by the Hay Associates that a large number of employers have begun to change their policies away from comprehensive first dollar insurance coverage to a more actuarially sound policy requiring copayments and deductibles. One can only guess whether that was the reason for the effect or whether there were other reasons.

We do know that, at the margin, there is some discretion on the part of consumers—and certainly on the part of physicians—to allow them to perhaps go home a little bit earlier than they might if they were indifferent to the financial consequences of their decision. And so, therefore, we believe that this will have an effect on utilization. How much? We don't know. And in point of fact, we did not base any budget estimates on it having such an effect. But we are hopeful that it will have a significant effect over time.

Senator DURENBERGER. Well, I have two questions about that. One, where is the benefit to the subscriber or the medicare beneficiary in a DRG system? Once we move from a cost based reimbursement system to a prospective episodic system, where are the rewards to the individual in copayment of the nature we have been talking about?

Dr. RUBIN. I think the phrase that we use here in Washington is cost avoidance. And I think that we are talking having beneficiaries richer by $28 or $18 per day for every discretionary day that they are no longer in the hospital. So there is a powerful incentive there. Currently, there is no incentive.

Senator DURENBERGER. The other side of the issue is the fact that two thirds of the medicare eligible persons find some way to cover their out-of-pocket expenses with what is called "medigap" insurance. If that percentage is approximately correct, and if the traditional medigap policy covers a fair amount of copayments, then what kind of utilization impact do we expect to be able to get? Aren't we just buying ourselves increased medigap premiums with the administration's proposal?

Dr. RUBIN. Well, you made two very big "if's." The data available, from a 1977 survey, suggests that 60 percent or 65 percent of medicare beneficiaries have medigap insurance and another 15 percent are on medicaid. But we must look at what we mean by medigap very carefully. That data is really from a period prior to the implementation of Senator Baucus' medigap amendment so that

the term "medigap" really covers a multitude of sins. Some of these policies offer rather shallow coverage. Some of them are very good and conform with the requirements in the statute.

But I think that what we need to do and what we don't have precise information on are the number of so-called medigap policies that really do address the issue that you just suggested. HCFA is just beginning to take a look at this. We may find that a lot of these policies really will not remove the incentive of cost sharing to the extent that some people might have thought. So the issue of the depth of coverage in medigap is an important one.

The other issue is that we are trying to change the incentives in the system. If in point of fact individuals choose to spend their own out-of-pocket, after-tax, dollars to do a variety of things, I don't think the Government ought to be interfering with that. And I think that is the point of one of our other proposals that will be before this committee; namely, the limit on tax-free health insurance.

Senator DURENBERGER. All right. Max.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Rubin answered some of the questions I had in mind. Let me just flush a few of them out a little bit here. Isn't it reasonable to assume that if copays increase that medigap policies will begin to cover these additional gaps in coverage? It seems to me that insurance companies would cover, through medigap policies, these copays. Does that sound reasonable to you?

Dr. RUBIN. I would think that if insurance companies are fairly good at marketing and they saw they had a market out there that they surely would adapt to that market. Yes.

Senator BAUCUS. And what would be the effect of private insurance coverage be? If 75 percent of medicare beneficiaries are already covered by medicaid and medigap policies, only a quarter of all beneficiaries would have to make the copayments you advocate? What would be the net effect of this situation on utilization or overutilization?

Dr. RUBIN. Again, it would depend upon the depth of coverage of the individual policies. It would depend on the extent of the catastrophic insurance that these companies would be willing to underwrite. And it would depend, I would imagine, on the cost of the policies as medicare expenditures increased. I think that all of those things are difficult to predict. If one assumes that the 25 percent of people who did not have supplemental insurance are uniformly distributed as to their illness—that is, they are no more or less ill than the 75 percent that do—then that would still represent 6 or 7 percent of the hospital bill in this country.

Senator BAUCUS. There is another problem that I see. It seems to me that since the administrative cost of medicare is about 0.03 per dollar, and the comparable figure for insurance companies is about 0.40 on the dollar, would not your policies mean that more would be spent in the health system for the same coverage—and the insurance companies will receive the additional amount. I think that's a factor we have to keep in mind here.

Also why wouldn't DRGs lead hospitals and doctors to reduce length of stay and therefore cut down at least on part A hospital costs?

Dr. RUBIN. The goal is to get as many parties in the equation as is feasible and all working toward the same goal. DRG's really put the emphasis on the hospitals. But the patient would still be indifferent to the hospitals' needs, therefore, I think our proposal is complementary to the DRG proposal. And, indeed, it gets two of the major actors in the equation working to the same goal; namely, to decrease length of stay.

Senator BAUCUS. I guess the question in my mind is the degree to which improper utilization is going to be eliminated by additional copayments. That's a hard point to clarify.

Dr. RUBIN. I'm not sure as a physician I understand what improper utilization is.

Senator BAUCUS. Well, improper in the sense that we are trying to cut down on unnecessary use.

Dr. RUBIN. Clearly, at the end of an illness there is some discretion as to when the patient goes home. If this decision involves spending $18 to sit in the hospital or zero dollars to sit in the hospital, it's pretty clear which is more likely to cause you to stay in the hospital. So there is no question in my mind that we would see a decrease in the length of stay on the part of the beneficiaries. One would hope that that would be appropriate—that the length of stay would be appropriately short rather than inappropriately shortened.

Senator BAUCUS. Why did you not cost out the degree to which your part A copay proposal is going to help reduce the problem facing the HI Trust fund? You say you hope it is going to have a favorable impact but it was not costed out.

Dr. RUBIN. I'm just speaking now for the department and not for any other part of the executive. I think it is foolhardy to do budgets using a pie in the sky guestimate and then show a budget reduction.

Our estimate as to the savings to the trust fund is really based on a "dollars in, dollars out" kind of judgment rather than predicting some effect on utilization and what effect that might have on the rate of increase in hospital payment. Maybe we should have made an estimate, but we felt that we were treading in such murky waters that it was best to be cautions.

Senator BAUCUS. I find it kind of murky too. The difficult part is to quantify it. You don't have a quantification here. It's hard for us to get some kind of a——

Dr. RUBIN. Well, it's certainly not going to increase utilization, and to the extent that it decreases utilization it will be cost effective.

Senator BAUCUS. Well, it may be, but it might shift dollars where we don't want them shifted or it may have some other effects that we don't necessarily want. It may more adversely affect lower income beneficiaries, for example.

Dr. RUBIN. Well, it certainly would not affect the lowest income of the medicare beneficiaries.

Senator BAUCUS. No, but it may discourage lower income beneficiaries and others from getting health coverage, but not discourage upper income beneficiaries. You have come up with a proposal for more part A copayments, and, frankly, I find it based too much on theory than on hard analysis.

Dr. RUBIN. There is no evidence, Senator, that cost sharing in anyway adversely affects health status and that people do not go to see a physician or go to the hospital when they need care. There is abundant evidence to suggest that what people do is make more prudent decisions. And they seem fully capable of doing that.

Senator BAUCUS. But if medigap insurance takes up the gap, then where are we? And under medicare part B we already have significant copays. These part B beneficiary costs represent roughly 40 percent of the bill for physicians' services. You, in your testimony, said that physician fees are increasing faster than hospital costs.

Dr. RUBIN. But they still represent a tiny piece of the total cost.

Senator BAUCUS. That's right. But if we already have 40-percent copays on part B, the question that comes to my mind is this: do increased copays make that much difference.

Dr. RUBIN. The copay is only 20 percent of the part B.

Senator BAUCUS. It's not 20 percent in all cases. It's 40 percent in nonassignment cases and 20 percent in assignment cases.

I hope that in the future we can get a little more precise quantification about your proposals so we know where we are going.

Dr. RUBIN. We will after this has been implemented for a few years. We will be able to come back and tell you precisely.

Senator BAUCUS. Thank you.

Senator DURENBERGER. Let me go into a couple of other issues. Bob, is there a reason we should be mandating copayments in medicaid? Right now we are not, as I recall, mandating medicaid copayments. We are permissive of copayments. we are trying to free up the hands of the States. As I recall, the administration's dollar-a-day or dollar-a-visit proposal was a mandate. Is there some reason to mandate rather than to leave the flexibility to the States?

Dr. RUBIN. Well, I think it's important to recall that we pay over 0.50 on every medicaid dollar that is spent.

The principle underlying the proposal is that everybody ought to bear some responsibility for their actions and that there ought to be some recognition that health care is not free. When one looks at the average medicaid beneficiary, these copayments will mean less than $12 a year in added out-of-pocket payments. So this is not an onerous burden to the medicaid beneficiary. And I think that again there is reasonable evidence to suggest that this will create more responsible use of medical services than just providing services it free.

Senator DURENBERGER. Well, I don't want to put you to the proof of that statement right now. I think a lot of people would find it hard to believe that $1 is going to make a great deal of difference.

Dr. RUBIN. Frequently it's the people that don't believe that that are the very people that say that the dollar is too much. Now I think you need to have it one way or the other. It's hard to have it both ways.

Senator DURENBERGER. Well, I could take the position that the dollar is not enough. The question that I asked you is who should be making the decisions about $1, $2, $10, or no dollars. Isn't this just an effort to save money on the Federal side of the Medicaid budget? Isn't that pure and simple what it's all about?

Dr. RUBIN. No; I think it's an attempt to try to rationalize the delivery of services in a program where we know that inappropriate utilization as to site of service is a significant problem.

Senator DURENBERGER. And, again, I don't want to put you orally to the proof of that, but can you demonstrate that that is the case? That a dollar copay will have a positive impact on overutilization?

Dr. RUBIN. My guess is that if one looks at the kinds of coinsurance that were tried in other places that it did have a significant effect on decreasing utilization. I can tell you from my own experience—and I'm sure that anecdotal evidence is never utilized in this body, but for what it's worth——

Senator DURENBERGER. It depends on how long it takes to do it.

Dr. RUBIN. I used to moonlight, when I was a fellow. A friend of mine and I took care of an emergency room on Friday nights and Saturday nights. Not infrequently at this time of the year we would be awakened at about 2 in the morning on Sunday or Saturday to take care of someone with sunburn. Now taking care of sunburn is not a difficult issue. It usually is achieved by going to the drug store and getting some sort of local anesthetic and spraying it.

But people would come in, engage a $50 hospital emergency room fee charge, $25 physician charge, and $5 or something close to that for the Xylocaine ointment that the nurse would put over their bodies.

I once asked somebody why they did that rather than going to the drug store where they wouldn't have to wait, et cetera. And the answer was that it was free; and the drug store they had to pay, I don't know, $2.25 or $3.25 or something like that. It turns out that that is not an unusual kind of phenomenon. Why do people go to emergency rooms rather than doctors' offices?

There are some interesting things we can do by taking a look at site of care. And I think the administration and others are moving in that direction.

Senator DURENBERGER. Let me take you now over to the part B side, and the issue of physician assignment. Let me put aside that fee freeze issue and look at some of the other questions.

First is the reimbursement system. We continue to pay specialists higher amounts for the same procedure that we pay nonspecialists. Is there a reason to continue this practice, given the direction we have taken in hospital reimbursement toward a single payment level?

Dr. RUBIN. Well, speaking as a board certified nephrologist with a specialty in hypertension, I know I do a better job than a general internist in taking care of those conditions. And, obviously, get paid more for it.

But speaking more broadly, there is a place for a specialist, and I think the real issue is how does one reimburse for those special talents? For example, if you have a heart attack and you have a complicated arrhythmia, do you want to be taken care of by a cardiologist or do you want to be taken care of by a family physician? I think I know what my answer to that question is. And we know that the cardiologist had to put in more time for training, et cetera, et cetera.

I think that we need to be more precise about how we define specialists and under what circumstances we are willing to pay them

more. I think that it's not appropriate to reimburse an orthopedist more than an internist when he is taking care of somebody that has a breathing problem or a pulmonary problem. But I do think it is appropriate to pay him more to set somebody's leg than if I set that leg.

One of the things we are doing at the request of the Congress in the prospective payment legislation is to take a look at the advisability and feasibility of rationalizing the payment schedule to physicians.

Senator DURENBERGER. Physicians would appear to have a legitimate complaint about the age of the data we use to calculate their fee levels. Is that an appropriate concern on their part and is anything being done to improve that situation?

Dr. RUBIN. Well, one of my colleagues from Boston wrote an article in the New England Journal of Medicine that suggested that while the data is rather old, physicians had already taken the lag into account when determining their fees.

Senator DURENBERGER. In many cases we currently pay physicians caring for end stage renal disease patients a monthly fee. And that, hopefully, is supposed to remove many of the incentives to do too much. Is this particular methodology applicable anywhere else in the system?

Dr. RUBIN. I think that one needs to look very carefully at how the alternative method of payment in the end stage renal disease program is actually implemented. While you do pay a monthly fee, it's for a very narrow range of services. And if the physician chooses to practice a la carte medicine rather than "prix fixe" medicine, you can substantially augment that monthly fee. And I say that as a nephrologist who has been reimbursed under the alternative method.

I think that for certain broad categories, yes, global fees are not unreasonable as long as we have the same kind of flexibility that we do in the ESRD program.

Senator DURENBERGER. I wonder if you would very briefly tell us what it is that we really know about this whole issue of physician assignment and why certain physicians accept assignment and others do not. That might be helpful to us in coming to grips with this issue.

Dr. RUBIN. I'm not really sure I can do that in an adequate way. I think that what we are seeing, though, is the growth of physicians taking assignment over the last several years. And I think that is both predictable and a trend that will continue for the following reasons.

There is clearly a surplus of physicians, particularly in the larger cities in this country. And to the extent that medicare assignment is a reasonable rate of reimbursement—that is a rate that is greater than the physician's marginal costs—and to the extent that physicians have unfilled appointment books, they make a profit by taking medicare assignment. It also improves their penetration of the market, if you will. And, indeed, what we are beginning to see are groups of physicians—I think this was reported in the Wall Street Journal about a year and a half ago—groups of physicians forming specialized practices with the agreement that they would all take medicare assignment.

I think that as the surplus of physicians continues to grow, again particularly in our large urban areas, that this type of practice will increase as physicians continue to make efforts to increase their patient population.

Senator DURENBERGER. Senator Baucus, do you have additional questions?

Senator BAUCUS. I'd like to ask one question. I have a chart which shows the various age groups over 65 and it indicates the percent hospitalization for each of these groups. For example, age 65 to age 69, 18 percent are hospitalized; age 70 to 74, 21 percent, and then it goes up. The point being that the older you are, the more likely it is that you are going to be hospitalized.

Correlated with this information is the median income for each of these age brackets. The income is in 1980 figures, and for married couples age 65 to 68 the median income is $16,000, for singles $8,000. This chart shows that the older the couple or the single person, the lower the income. In sum, the chart shows that the greater the age, the greater the likelihood of being hospitalized; but the chart also shows that the greater the age, the lower one's income.

Well, under present law the average Medicare-age hospital patient will pay $2,000. On another chart I have before me these costs are broken down as follows: part B $174; hospital deductible $350; copay for medical services, $505; part B deductible $75; disallowed charges, $250; dental, $131; drugs, $306; other, $134. The total is $1,925.

Now the question I have is this: if the older you are, the more likely it is you will be in the hospital, and the older you are the lower your income—and copayments already average $2,000—do you have any figures that would give some indication of what the net effect of your cost sharing proposal is on each of the grouping of medicare-age people I referred to earlier?

For example, what's the average length of stay for a 67 year old? And have that compared to a 68 year old and so forth. Do you have those figures, by chance?

Dr. RUBIN. Not off the top of my head.

Senator BAUCUS. Does the department have those figures?

Dr. RUBIN. We should be able to develop those certainly.

Senator BAUCUS. Would you please get them to me? It would help me if you could get those figures.

Dr. RUBIN. Perhaps we could negotiate for 5-year-age brackets rather than 1-year-age brackets.

Senator BAUCUS. Five-year-age brackets would be OK; one would be better. But 5 will be OK.

Dr. RUBIN. OK.

Senator BAUCUS. Thanks a lot.

[The information from Dr. Rubin follows:]

CY 1979 - Medicare Short Stay Hospitals

| Age | HI Enrollment 7-1-79 | Discharges | Dischg rate/ 1000 enrolled | Average Length of Stay (Days) |
|---|---|---|---|---|
| 65-69 | 8,305,784 (33.3%) | 2,191,470 (25.8%) | 264 | 9.7 |
| 70-74 | 6,610,847 (26.5%) | 2,077,675 (24.5%) | 314 | 10.3 |
| 75-79 | 4,703,850 (18.9%) | 1,787,875 (21.1%) | 380 | 10.8 |
| 80-84 | 3,020,723 (12.1%) | 1,329,410 15.7%) | 440 | 11.4 |
| 85+ | 2,306,750 (9.2%) | 1,096,655 (12.9%) | 475 | 11.9 |
| All | 24,947,954 (100%) | 8,483,085 (100%) | 340 | 10.6 |

Source: HCFA/BDMS

Dr. RUBIN. If I could just comment. I had a little difficulty following that chart. I think it's important to keep a few things in mind when examining income of the elderly. You are right; generally, median income decreases the older you get. But most of those tables—and the one you are looking at may be an exception—only take into account cash. And they don't necessarily take into account wealth. And they don't necessarily take into account the difference between taxable income and nontaxable income. And it goes without saying that because of the laws that the Congress has passed, the older you are the less likely you are to pay taxes on that kind of income. And, of course, it doesn't take into account any in-kind benefits, which a lot of these folks have. So that I think that those tables do not teel the whole story.

The other point I would make is, as you know, real income for those over 65 in the last 10 years has grown at a positive rate, whereas real income for those below 65 has declined.

Senator DURENBERGER. Is that a message from home or——

[Laughter.]

Dr. RUBIN. No ET does not——

Senator DURENBERGER. Or additional input? Otherwise, we thank you very much for your testimony.

Dr. RUBIN. Thank you very much.

Senator DURENBERGER. Our next witness will be Dr. Alice Rivlin, Director of the Congressional Budget Office. Thank you for being here. Thank you for the effort that CBO has put in on these health policy issues. And we welcome your input this morning on the subject of cost sharing and some of the recommendations that have been made relative to the role that cost sharing will play on health policy.

We have a statement of yours which will be made part of the record. You may read it, summarize it or do as your expertise moves you.

## STATEMENT OF DR. ALICE RIVLIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, D.C.

Dr. RIVLIN. It's not terribly long, Mr. Chairman. I think probably the easiest thing to do would be to read it unless you would prefer otherwise.

I have with me this morning Dr. Marilyn Moon who has worked on this statement and prepared a longer report on cost sharing.

Total medicare outlays have been growing at an average annual rate of 17.7 percent since 1970, largely because of the rapidly rising medical care costs, and CBO projections suggest that high growth will continue. This projected growth in outlays threatens the solvency of the 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 can 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. Although SMI does not face insolvency in its trust fund, because transfer 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 cost of medicare-covered services. 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.

My testimony today will cover three areas as requested: general considerations regarding cost sharing in medicare; issues and options for designing a specific proposal; and 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. 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, 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 1 day. They are then not liable for any additional HI cost sharing until they have been hospitalized more than 60 days. 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 the SMI deduct-

ible amount, 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 average about $550 in 1984. Altogether, medical expenditures on noninstitutional care will consume 14 percent of the typical elderly family's income and range from 21 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 income.

A few beneficiaries will experience much larger than average medicare-related costs 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 because many have private insurance to supplement medicare.

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 cost 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.

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 insure 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 average costs of insuring against the greater cost sharing. The one-fourth of beneficiares who are not protected by medigap policies or medicaid would face a very large increase in out-of-pocket costs, however, if they require 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.

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

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, insuring 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. 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—would raise the monthly cost to enrollees by about $6 and yield total Federal savings in fiscal year 1984 of $1.4 billion. These are shown in attachment A. 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 the costs widely, since in any one year only about a 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 for 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 the 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 great-

er 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 of days has been exhausted. If the cap was financed by a mandatory monthly premium, each beneficiary would pay about $4 a 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 with a premium.

Mr. Chairman, if you are short of time, I can skip over—although I think it's very important—the question of whether cost sharing should vary with income or we could come back to that in questions, and to the description of the administration's plan.

Senator DURENBERGER. I think we are going to ask you about that anyway.

Senator BAUCUS. Mr. Chairman, I'd prefer she go ahead and read it. I think it's an important issue.

Dr. RIVLIN. I'd be happy to.

Senator DURENBERGER. All right. Go ahead.

### SHOULD THE AMOUNT OF COST SHARING VARY WITH INCOME?

Dr. RIVLIN. 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 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's likely to be more feasible to use the previous year's tax form.

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 where 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.

Do you want to go on to the discussion of the administration plan?

Senator DURENBERGER. No. Thank you very much.

Dr. RIVLIN. Fine.

[The prepared statement of Dr. Rivlin follows:]

STATEMENT OF ALICE M. RIVLIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

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.

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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,

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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

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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.

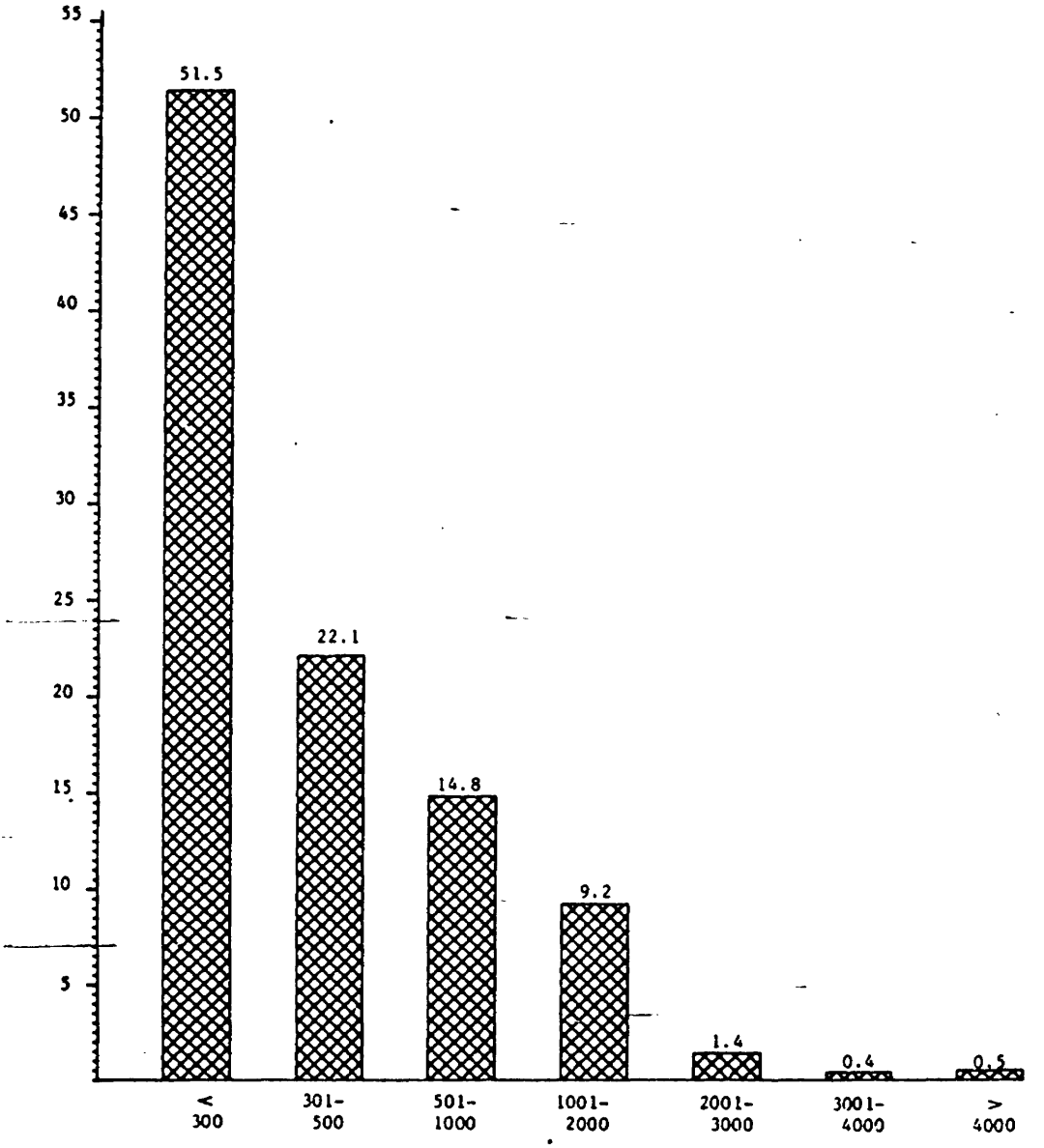
percent of income for those with incomes under $5,000 to 2 percent for those above $30,000. This range reflects both the fact that the elderly who are poor have greater actual health expenditures and the fact that these expenditures constitute a larger share of their incomes.

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

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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 premjum 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.

Senator DURENBERGER. I may leave specific questions on that subject to my colleague. But first an observation. We raised the issue of means testing or income testing with Dr. Rubin on the catastrophic issue. I'm afraid that if we try to tackle means testing in legislation we are going to goof it up. If we could design a system in which those with substantial means might contribute on top of some basic system, that's fine. It was relatively easy to include cash payments from social security in someone's income for tax purposes. But it seems to me that it is much more difficult for us to means test a system in which expenses are based on choice, availability of technology, utilization patterns, and so on. I may choose to spend more on medicare than the next guy.

If the choice is between means testing at the point people utilize services and when they purchase their coverage, it seems to me that the purchase point makes more sense and is easier to do. What do you think?

Dr. RIVLIN. Yes; I think I would both on grounds of principle and on grounds of complexity. And it is complicated enough to be in a hospital now even if you are not under medicare. And adding means testing as an additional complication in determining how much your bill is going to be seems to me something that should be entered into only with great trepidation.

Senator DURENBERGER. Since this hearing is broadened beyond the specifics of the administration's proposal on cost sharing let me ask you another question. I would be curious as to your views on what it is that cost sharing actually accomplishes when it is done at the premium level, when it is done at the copayment or coinsurance level or when it is done at the deductible level. Aren't there some different kinds of behavior that we try to effect when we do cost sharing at those three levels?

Dr. RIVLIN. Yes. If cost sharing is done at the premium level, the effect is literally to share the cost between the taxpayer and the patient. However, if cost sharing is done at the point of use of services through coinsurance and deductibles, then there is the additional effect that, if people have to pay more for their health care out of their own pockets, they will be more careful about the use of it. They will be more demanding customers of the health care system. They will ask the doctor, "Is that really necessary?" And the doctor, knowing that the patient has to pay a substantial part of the cost, will be conscious himself of deciding whether an additional test is really necessary.

There is evidence that higher cost sharing does make people more careful about the use of medical care. But as we said in the statement, most of that evidence relates not to the aged and the disabled, which are the population we are talking about today, but to the rest of the population. The aged and disabled may have less scope for choice in their use of medical care. Also a very large proportion of them do have additional insurance so that, in fact, higher cost sharing at the point of use would not necessarily come out of their pockets—it would only do so except for those who are not covered by medicaid or medigap.

Senator DURENBERGER. It seems to me that there's another function for cost sharing at the premium level. If I'm 65 or 70 and I qualify for medicare I'm going to take a look at medigap premiums

and benefits, and I'm going to ask if I get rewarded for staying healthy. Isn't there somebody out there that will give me a deal if I stay healthy?

It seems to me that this kind of consumer sensitivity is one of the benefits of trying to put more cost sharing up front. Wouldn't you agree?

Dr. RIVLIN. Yes; I would.

Senator DURENBERGER. Now let me ask you about what cost sharing we use to accomplish what end. Over the last few years we have seen a decrease in the length of a hospital stay. In other words, if I have to go in, I get out more quickly today.

But on the other side, it seems that we have an increase in admissions and an increase in services that are being provided. It looks to me as though the hospitals are seeing a situation in which people are not sitting around utilizing services very much. What is the reality of what is going on out there in the marketplace today?

Dr. RIVLIN. I think it's several things. Not so much that hospitals are going out marketing their services and saying please get sick. But much more that two things are going on. One is that, because hospital care is covered by third-party payment for most people, the patient and the doctor may be less reluctant to hospitalize the patient in order to get what is perceived to be a higher quality service than would be available outside the hospital. The biggest thing, though, is that once the patient is in the hospital the services are simply more intensive, more elaborate, and more expensive. And it is that, rather than the increased admissions or the increased number of people, that is driving the bills up so rapidly. It's the increased technology.

Senator DURENBERGER. So we can repeat this question with the American Hospital Association. But it seems to me that hospitals are also expanding their business. They are now getting into chemical dependency treatment and alcoholism and a variety of new forms of care. And, obviously, that means that there is always pressure to expand third-party coverage whether it's in the private sector or in the public sector to cover all these things. Is that generally one of the things that is going on out there?

Dr. RIVLIN. Yes.

Senator DURENBERGER. One of the points we discussed before you arrived with Dr. Rubin, and I think we will get this from the American Hospital Association today, is that now that we have moved to a DRG-based prospective payment system, does a 8- or 10-percent per diem copayment make sense? The DRG system may have all the incentives we need at the hospital level in order to move people on more quickly. Perhaps the traditional function of a copayment—which is to get the individual more sensitive to utilization—really isn't necessary. What is your view on that?

Dr. RIVLIN. I regard the move to prospective reimbursement as a good thing. It is certainly a first step, and one maybe long overdue, toward getting our reimbursement system on a more sensible basis. It may be true that this move has solved part of the financing problem, but the fact remains that even with the prospective reimbursement we are going to have a very large gap between what is spent out of the HI trust fund and what is coming in. So I do think the arguments for cost sharing shift to who is going to pay the bill.

And that may well be the more important than putting additional pressure on hospitals.

Senator DURENBERGER. In effect that says that we are not going to get much utilization impact out of cost sharing, but we are going to get a little more money out of the pockets of the hospitalized person to help share the cost of the medicare system. And then that would get us back to whether or not service utilization is the best place to achieve cost sharing or is the premium a better place? Is that not correct?

Dr. RIVLIN. I think that's right. I mean I don't think we can discount entirely the effect of cost sharing on reluctance to utilize services. But given the proportion of the population that has supplementary insurance or medicaid, that seems not to be one of the strongest arguments for doing it.

Senator DURENBERGER. On the whole issue of the role that medigap plays—and this is something that my colleague from Montana has been sensitive to over the years also—you point out that about 75 percent of the folks out there are covered by either medigap or medicaid. And you suggest that much of the remainder, the other 25 percent, falls in an income level above the medicaid level and below the medigap affordability level. What do we accomplish with cost sharing when there is already such extensive gap filling? Those who can't get gap fillers will be hit especially hard, and for the rest the premiums will simple go up on medigap insurance and the cost of medicaid will rise. Isn't that kind of a circuitous unproductive route to follow?

Dr. RIVLIN. Since the premiums do go up, it means that people are paying a higher share of their hospitalization costs themselves. You could accomplish that in other ways such as by charging a HI premium, as we suggest.

Senator DURENBERGER. All right. Max, I'm taking too much time.

Senator BAUCUS. Dr. Rivlin, I think your testimony is very good. It holds to the point, and I appreciate it. I have a couple of questions. First, do you have any objective data that would indicate the degree to which older people use more expensive health care than is necessary?

Dr. RIVLIN. Let me buck that one to Marilyn. The problem, of course, is how do you define "than is necessary."

Senator BAUCUS. That's the problem.

Dr. RIVLIN. Marilyn, do we have any data?

Ms. MOON. No. And to my knowledge there has not been a careful look at that question. I think the issue is, as Dr. Rivlin indicated, how to define what is "necessary". We know that expenditures for the elderly are higher. But we also know that they, as well as the disabled represent a sicker group.

Senator BAUCUS. And do you know the degree to which the request for those health care services is at the request of the older person or his family rather than physician or hospital or somebody else?

Dr. RIVLIN. No. I don't think we do.

Senator BAUCUS. Maybe I didn't quite understand what your earlier answer was, Alice. What about the DRG's? Won't the institution of DRG's in respect to reimbursement sufficiently cut down the length of stay? My concern is this: If somebody is over 65 and

sick, and if hospitals under prospective reimbursement try to limit the length of stay—I assume they would have some incentive to limit the length of stay—then won't the physicians hospitalize patients or encourage patients to be in the hospital based upon medical need of that patient rather than whether someone else is paying for it? Because I would think that the hospital administrators would talk to the physicans and encourage physicians not to keep patients in hospitals too long. And the physicians would be sensitive to that and would act accordingly except to the degree to which they have a paramount concern, which is the health of the patients. It would seem to me that in that situation physicians would probably not admit too many patients or keep patients in hospitals too long. As a patient needs to be hospitalized, the patient will be hospitalized. If the patient doesn't, the patient will not be. It does not have that much to do with copayment, frankly.

And I am just curious as to what data you have that has any bearing on that subject.

Dr. Rivlin. I think that the use of DRG's will probably at the margin discourage keeping people in hospitals longer than is medically necessary. I would expect that copayments would add additional discouragement to that from the side of the patient who is going to say to the doctor, "Get me out of here as fast as you can."

Senator BAUCUS. Except when medigap is paying for it.

Dr. RIVLIN. That's true. But you are dealing at the margin. My own expectations since I regard doctors and hospitals as reasonably responsible people is not that we are going to have them throwing out patients who really need to be there. I think that one of the dangers of going to prospective reimbursement for medicare only is that the payment will not fully cover the cost of the care and that the hospital will then load the rest of the cost onto other patients. There is that temptation.

Senator BAUCUS. I understand the CBO has commissioned various studies to try to get at the problems of the hospital insurance trust fund and different alternatives that address the problem of medicare—projected increased cost in medicare generally. Is that correct? I mean is CBO farming out some studies to try to get a fair handle on this?

Dr. RIVLIN. I don't know that we are farming any studies out. Maybe Marilyn can enlighten you. We have just produced a report that looks at options for medicare. This testimony was largely based on that report.

Ms. MOON. Perhaps what you are referring to is that we are planning to sponsor with the House Ways and Means Committee and the Congressional Research Service, a conference looking at global options for the financing problems facing medicare.

Senator BAUCUS. Global?

Ms. MOON. We hope that the papers will analyze options that will not be shortsighted but will be looking at the long-run problem.

Senator BAUCUS. So that in addition to the recent report then you are doing another study with the House Ways and Means Committee?

Dr. RIVLIN. Right. I forgot about that one.

Senator BAUCUS. Thank you.

Senator DURENBERGER. As I recall there was a fairly good analysis of the catastrophic options in the CBO report. And while CBO is not in the business of going through an analysis and coming up with a single recommendation, I recall there being suggestions of a practical way to approach catastrophic. And that was to look at it the way people do, which is a combination of medically related cases meaning hospital, doctor, drugs and so on. Am I fairly stating the concensus of the CBO report that if we move toward catastrophic we should take that fear out of the people on fixed incomes by looking beyond just the hospital catastrophic to a larger, more encompassing catastrophic proposal?

Dr. RIVLIN. Yes. And in terms of what we are talking about today, I think it certainly would make sense to look at both HI and SMI together. If you were going to put a cap on cost sharing, it would make sense to have that apply to both, not just to the hospital portion.

Senator DURENBERGER. Do you have some general observations that weren't included in your statement about where we ought to be headed on part B, the physician side of this program? We discussed earlier, I think perhaps after you came in at the end of Dr. Rubin's testimony, the problems associated with the freeze on physician assignment and so forth. Are there some observations in that area that you wish to leave with us?

Dr. RIVLIN. I really don't have any, although Marilyn may. No, I don't think so.

Senator DURENBERGER. Is it fair to say that CBO does not have any strong objections to linking hospital catastrophic with hospital copays?

Dr. RIVLIN. I think that's fair to say. But the thing that we did point out is that another way of paying for the catastrophic would be to share the burden more widely through a premium rather than to load it all on those who are already sick.

Senator DURENBERGER. All right. Max?

Senator BAUCUS. Alice, as I remember one of your studies, you said that one-fifth of the increase in medicare's hospital insurance trust fund deficit in future years is attributable to longer age. And there are a fair number of people who are living past the age of 65. Four-fifths of the problem is attributable to rising health care costs. The question is: To what degree is this proposal, the administration's proposal we have in front of us, going to cut into that four-fifths?

Dr. RIVLIN. I don't think we know.

Senator BAUCUS. A guess?

Dr. RIVLIN. No. Not off the top of my head.

Senator BAUCUS. Do you think it will make any difference?

Dr. RIVLIN. It will certainly help some at the margin. But, again, you are back to the extent to which cost sharing really does decrease the demand for services.

Senator BAUCUS. What's your best guess? What practical effect is this going to have when you add it altogether? Medigap coverage will be increased probably. I don't want to prejudice you, but I would like your best guess as to the degree to which this proposal is going to have any effect.

Dr. RIVLIN. The degree to which it would mitigate the cost rise as opposed to just shifting the burden of who pays for it? My guess would be not very much. But let me see what Marilyn has to say.

Ms. MOON. I think that's reasonable. Certainly we would expect that if you introduce very high cost sharing you will see a large decline in use for some people. But those affected will be a small number because of the presence of medigap.

Senator BAUCUS. What you are saying is it may shift the incidence of who bears the cost and the total cost is not going to have that much of an effect?

Dr. RIVLIN. I think that's generally right, but I wouldn't make too strong a statement. It will do some of each.

Senator BAUCUS. Thank you.

Senator DURENBERGER. Could I ask you one last question that I think I have already asked, but we didn't get around to the answer? Could you elaborate on the value of a deductible? I understand premiums, and I understand coinsurance of so many dollars a day, but what is the value of a $304 deductible to go into the hospital?

Dr. RIVLIN. In principle, a deductible would work at the moment of deciding whether to go into the hospital at all, if you have a choice. There certainly are some procedures where you can either go in the hospital or you can have it done at a doctor's office. And generally, the doctor would rather do it in the hospital if there is any significant risk. And this does shift the balance the other way. If you do have to pay for that first day on something that is only going to mean hospitalization for a day or two, then there's a lot of difference.

Senator DURENBERGER. Can you think of a second reason?

Dr. RIVLIN. No. I think that's the main one. If you are going to be in the hospital for a week or two and you don't have a choice, it just means you pay a little more than you would otherwise pay.

Senator DURENBERGER. Thank you very much.

Senator BAUCUS. It probably does have some effect. One of my best friends in Montana runs marathons. He's a marathon freak, in fact. And he was in his first marathon several years ago. Roughly 1976 or 1977 in Montana. And as is usually the case, at least in those years, if somebody ran a marathon for the first time you do it all wrong. Ran too fast too soon. This guy has got the courage. He doesn't know what pain is. He finally did finish. When he finished he collapsed. Some friends picked him up and took him to the hospital. He was shivering and shaking and so forth.

Before he went into the hospital, he turned to his friends and said "Before you take me in, find out how much it costs." So they went inside and found out how much it cost. And he said "That's too much. Take me home." And they took him home and put him in a tub of hot water and he survived. [Laughter.]

Senator BAUCUS. But the fact of the matter is he did decide not to go into the hospital because it cost too much.

Senator DURENBERGER. Thank you, Dr. Rivlin.

Dr. RIVLIN. Thank you, Mr. Chairman.

Senator DURENBERGER. Next we have a panel—Dr. Gail Wilensky, Director, Center for Health Information, Research and

Analysis, Project HOPE; and Dr. Joseph P. Newhouse, economics department, Rand Corp.

We have been looking forward to taking testimony from both of you for a long time. And we appreciate your being here. If you don't mind, we can start with Gail.

I believe we have statements from both of you that will be made part of the record. And you may approach your testimony in any way you desire.

**STATEMENT OF DR. GAIL R. WILENSKY, DIRECTOR, CENTER FOR HEALTH INFORMATION, RESEARCH AND ANALYSIS, PROJECT HOPE, MILLWOOD, VA.**

Dr. WILENSKY. Mr. Chairman and members of the committee, it is an honor to appear before you today. Although I am now head of the domestic division of Project HOPE, the information I am presenting is based on work I did at the National Center for Health Services Research. It, however, represents work I did as a researcher and should not be interpreted as representing departmental policy.

I will be presenting information based on a study I prepared by myself and Marc Berk, which I would like submitted to the record.

Dr. WILENSKY. In addition, I have two short studies on medicaid entitled "Health Care and the Poor, the Role of Medicaid," and "Poor, Sick and Uninsured," which I would also like submitted to the record.

Senator DURENBERGER. It will be made part of the record.

[The prepared statement and material from Dr. Gail R. Wilensky follows:]

STATEMENT BY GAIL R. WILENSKY

Mr. Chairman and Members of the Committee

It is an honor to appear before you today.

Although I am now the head of the domestic division of Project Hope, the information I am pesenting is based on work I did at the National Center for Health Services Research. It, however, represents work I did as a researcher and should not be regarded as reflecting departmental policy. I will be presenting information based on a paper prepared by myself and Marc Berk which I would like submitted to the record.

Medicare and the Elderly Poor

Gail Wilensky and Marc Berk

National Center for Health Services Research

There is a general consensus that since the enactment of Medicare in 1965, the health care of the elderly has improved substantially. In 1958, 32% of those 65 years of age or more did not see a physician. This was reduced to 24% by 1970 and to 21% by 1976.[1] Moreover, during this time period, mortality among the aged has also been decreasing. Since this mortality decline began prior to the advent of Medicare, it is difficult to determine how much of the decline in mortality among the aged is due to improved medical care and how much is due to improvement in other factors which affect longevity. It is clear, however, that the Medicare program has had a dramatic effect on the manner in which medical care for the elderly is used and paid for. This is particularly evident for the poor and near-poor elderly who are more likely to be dependent on government health programs.

The analysis I will present today focuses specifically on the role of public insurance programs for those elderly whose incomes are less than 125% of the poverty line. In this analysis, the poor elderly population are categorized into three groups. The first group consists of the approximately 1.4 million Medicare beneficiaries who lack private health insurance and do not receive Medicaid assistance. The second group includes Medicare recipients who also have Medicaid but who lack any private coverage. In 1977 there were approximately 1.5 million such beneficiaries. The third group is the 3 million poor elderly Americans who have private or Champus coverage to supplement their government financed insurance. Although the focus of this presentation is on the elderly poor, it should be noted that there are substantial differences across income groups in the relative numbers of elderly who supplement their Medicare with other types of insurance, particularly with private insurance. Overall, 66% of the elderly supplement their Medicare with private insurance. However, this percentage varies substantially across income groups with 47% of the poor/near poor having private insurance compared with 78% of the high income elderly. There is much less variation across income groups among those with "only Medicare" -- from 23% for the poor to 14% for the high income. The reason is that the poor and other low income groups are much more likely to have other forms of public insurance, particularly Medicaid.

Data Sources

The data used in this analysis come from the 1977 National Medical Care Expenditure Survey (NMCES), which provided detailed national estimates of the use of health services, health expenditures, and health insurance coverage. The survey was undertaken to provide data for research currently being conducted by the National Center for Health Services Research and was cosponsored by the National Center for Health Statistics.

The sample and design of the surveys and the instruments and procedures are described elsewhere (Bonham and Corder; Cohen and Kalsbeek 1981).[2,3] Information on types of insurance coverage, use of health services, expenditures and sources of payment for each service by type of service, and the number of types of disability days was collected every two to three months from a national sample of 40,000 individuals. Extensive economic and demographic data concerning the sample was collected as well. Specific information on the way in which particular variables used in this paper were constructed can be obtained from the authors.

Profiles of Insurance Groups

Table 1 provides some basic demographic data on the characteristics of the elderly poor according to the three insurance groups. Those whose Medicare coverage is supplemented by either Medicaid or private insurance are more likely to be female than are those with Medicare only. Non-whites are much less likely than whites to have private coverage; they comprise 21 percent of the Medicare Only group and 34 percent of the Medicare and Medicaid group but only about 5 percent of the group with private insurance. The people 75 years of age and older are a little less likely than those in the 65-74 age cohort to supplement Medicare. Those who lack supplemental coverage are also more likely than others to still be living with a spouse.

Health Status

Three indicators of health status were used in comparing the different insurance groups. First we examined the proportion of people that considered themselves in fair or poor health. Although such a measure is subjective, it has previously been shown[4,5] that such assessments by the elderly are closely correlated with the evaluations made by their physicians. We also examined the ability to perform usual activity or outside activities as well as the

number of elderly people with 8 or more bed days. Finally, we considered those people who indicated a health problem on any of these three indicators.

The findings reported in Table 2 show that the population with both Medicare and Medicaid is generally sicker than those with private insurance or those with only Medicare. There were, however, no major differences in health status between those with private insurance and those who depend on Medicare.

Utilization

It is clear that insurance coverage has a major impact on the utilization of health services by the elderly poor. Those who do not have additional coverage to supplement Medicare average only 4.2 physician visits a year. This compares to 7 visits for the Medicare and Medicaid group and 6.5 visits for those with private insurance. In fact, those in the Medicare only group have about the same number of physician visits as all persons between 25 and 54 years of age, a group that is presumably in much better health than the poor elderly. The role of supplementary insurance in explaining the use of physician services by the elderly poor is made even clearer by the use of multivariate analysis. What we find is that after holding constant for health status, age and sex, the elderly poor with Medicaid have about one more physician visit on average than those with private insurance whereas the elderly poor with only Medicare have about two visits less.

Similar differences were found when the use of prescription drugs was considered. Those with Medicaid to supplement Medicare filled an average of more than 15 prescriptions while those with only Medicare had 8.7. Elderly people with private health insurance had an average of more than 12 drug prescriptions. Differences in the probability of having a hospital stay were also observed. Over 22 percent of those with Medicaid or private supplementary coverage had a hospital stay compared to 18 percent of those with only Medicare.

The Medicare Only group therefore had much lower utilization levels than did the other groups. The elderly with Medicaid and the elderly with private had generally comparable levels of utilization. The difference between the Medicare Only group and the elderly with Medicaid can be attributed, at least partially, to the poorer health status of the Medicaid elderly. The health status of the privately insured group, however, was very similar to that of the Medicare only groups. This would indicate that the utilization differences between the Medicare only group and the privately insured elderly are primarily a function of the financial barriers to care experienced by those lacking supplementary private coverage.

Out-of-Pocket Expenses

Out-of-pocket expenses for the poor and near poor are shown in Table 4. Those with Medicare and Medicaid but no private insurance had relatively low out-of-pocket expense; their per capita expense was $97 and by using the medical cost component of the Consumer Price Index, we can estimate their 1982 out-of-pocket expense at $157. The Medicare only group had much higher expense. We estimate they paid $290 out of pocket in 1977 and $470 in 1982. Even higher out-of-pocket expense is found among those with private health insurance. They paid $329 in out-of-pocket expenses in 1977 and we estimate the per capita costs in 1982 to be almost $533. In addition, they paid an average of $105 out of pocket for health insurance premiums. Using the medical care component of the CPI to adjust our figures, this would be equivalent to $170 in 1982. Including the SMI premium, the out-of-pocket health care cost of the poor elderly with private insurance was about $488 in 1977 and about $810 in 1982.

Conclusions

The purpose of increased cost sharing for Medicare is both to reduce the Federal share of Medicare and to lower overall expenditures on health care for the elderly Whether or not increased cost sharing is likely to have a significant effect on the Federal share of Medicare is beyond the scope of this paper. What is clear is that the basic problem is not how to control the health care costs of the elderly as much as how to control the rapid rate of increase in all health care costs in the U.S and how to protect the poor, particularly the elderly poor, in the process.

The analysis presented here compares levels of illness, use of health services, and out-of-pocket expenses among the elderly poor who supplement their Medicare coverage with public or private insurance and those who do not. The latter group is of particular concern given the current interest in increased cost sharing as a way of reducing the Federal share of Medicare costs. While we have not tried to estimate the effects of increased cost sharing directly, the figures discussed here suggest that increased cost sharing could raise serious problems for the low income elderly.

With the exception of those receiving Medicaid, the elderly poor already appear to be facing considerable hardships. Those with only Medicare coverage incur substantial out-of-pocket expense, which may account for their comparatively low levels of health service utilization. The elderly poor with private insurance do not appear to be similarly deprived of health services, but their ability to obtain health care appears to carry a heavy financial cost. Absorbing additional out-of-pocket expense from increased cost sharing will be very difficult for them.

We suggest that if increased cost sharing in the Medicare system is enacted, careful consideration be given to exempting the almost 6 million poor and near poor Medicare beneficiaries. Such an exemption might prove to be particularly important to those who lack supplementary coverage since this group already uses substantially fewer physician, drug, and hospital services.

FOOTNOTES

1. Aday, L., Andersen, R., and Fleming, G., Health Care in the U.S., Equitable for Whom? Beverly Hills: Sage 1980, pg. 100.

2. Bonham, G. and Corder, L., National Medical Care Expenditure Survey: Household Interview Instruments, Instruments and Procedures 1, Hyattsville, National Center for Health Services Research, 1981.

3. Cohen, S.B. and Kalsbeek, NMCES Estimation and Sampling Variances in the Household Survey, Instruments and Procedures 2, Hyattsville, National Center for Health Services Research, 1981.

4. Blazer, D. G. and Houpt, J. L. "Perception of Poor Health in the Healthy Older Adult" Journal of the American Geratrics Society 27:330, 1979.

5. Maddox, G. L. and Douglass, E. B. "Self Assessment of Health: A Longitudinal Study of Elderly Subjects." Journal of Health and Social Behavior 14:87, 1973.

Table 1. Demographic Characteristics of the Poor and Near-Poor Elderly by Insurance Coverage (United States, 1977)

| | Total population | Percent female | Percent non-white | Percent age 75+ | Percent married living with spouse |
|---|---|---|---|---|---|
| Medicare Only | 1,364,000 | 62.6 | 21.0 | 50.2 | 36.4 |
| Medicare and Medicaid | 1,484,000 | 74.8 | 33.9 | 45.3 | 20.3 |
| Private and Champus | 3,031,000 | 77.7 | 5.4 | 46.2 | 28.3 |

(Source: National Medical Care Expenditure Survey, National Center for Health Services Research)

Table 2. Health Status of the Poor and Near Poor Elderly by Insurance Coverage (United States 1977)

| | Percent with fair or poor perceived health status | Percent limited in activity | Percent with 8 or more bad days | Percent with any of the 3 |
|---|---|---|---|---|
| Medicare Only | 37.4 | 31.9 | 24.5 | 60.6 |
| Medicare and Medicaid | 50.5 | 45.3 | 39.3 | 77.3 |
| Private and other | 33.0 | 30.5 | 27.5 | 60.3 |

(Source: National Medical Care Expenditure Survey, National Center for Health Services Research)

Table 3. Utilization of Health Services by the Poor and Near-Poor Elderly by Type of Insurance-Coverage (United States 1977)

| | Mean number physician visits | Mean number prescription drugs | Percent with hospital stay |
|---|---|---|---|
| Medicare only | 4.2 | 8.7 | 18.0 |
| Medicare and Medicaid | 7.0 | 15.3 | 23.3 |
| Private and Other | 6.5 | 12.2 | 22.0 |

(Source: National Medical Care Expenditures Survey, National Center for Health Services Research)

Table 4: Out-of-Pocket Expense by the Poor and Near-Poor Elderly by Type of Insurance Coverage (United States 1977)

| | Mean Out-of-Pocket Expense | |
|---|---|---|
| | 1977 | 1982 (estimated) |
| Medicare Only | $290 | $470 |
| Medicare and Medicaid | $97 | $157 |
| Private and Champus | $329 | $533 |

(Source: National Medical Care Expenditure Survey, National Center for Health Services Research)

# The Health Care of the Poor and the Role of Medicaid

Gail R. Wilensky and Marc L. Berk

National Center for Health Services Research

July, 1982

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BSJC/S

That marked improvements in the provision of health care to the poor in the United States have taken place over the past 15 years is beyond doubt. Prior to the enactment of Medicaid in 1966, the poor used substantially fewer medical services than other groups (Madans and Kleinman, 1980), even though, as a group, they demonstrated lower levels of health status. By 1976, they were reported to be using more physician services than those with high incomes (4.6 versus 3.8 visits, respectively, Aday, et al., 1980). However, whether the poor are now using as much health care as the nonpoor after adjustments are made for differences in health status is subject to some debate (Davis, Gold, Makuc, 1981). Comparing ratios of utilization of physician services relative to days of medical disability, Aday et al. reported no difference across income groups in 1976. Using a different measure and different data the ratio of physician visits to bed-disability days, Kleinman et al. (1981) found that the higher income groups were still using more health services than the poor during 1976-78.

Many of the studies finding changes in health care patterns of the poor relative to the nonpoor have attributed the higher rates of use to the introduction of various Federal programs, particularly Medicaid. There is a tendency, however, to treat the poverty population as if it were approximately synonymous with the Medicaid population (i.e., Monteiro, 1973), even though it has been estimated that only about one third of this population is on Medicaid (Davis and Schoen, 1978) and that Medicaid covers many who are not poor. In order to understand the role which Medicaid has played in the use of health services, we must distinguish first the poor who are covered by Medicaid from those who

are not, and subsequently examine their levels of illness and their use of services given these levels of illness. Those poor not covered by Medicaid nor any other insurance mechanism represent a group of particular concern. Being uninsured, what happens to them when they are sick? How much health care do they use and how much does it cost them? These are the primary questions addressed in this paper.

## Data Sources

The data used in this paper come from the 1977 National Medical Care Expenditure Survey (NMCES), which provided detailed national estimates of the use of health services, health expenditures, and health insurance coverage. The survey was undertaken to provide data for research currently being conducted by the National Center for Health Services Research and was cosponsored by the National Center for Health Statistics. The sample and design of the surveys and the instruments and procedures are described elsewhere (Bonham and Corder, 1981, Cohen and Kalsbeek 1981). Information on types of insurance coverage, use of health services, expenditures and sources of payment for each service by type of service, and the number and types of disability days was collected every two to three months from a national sample of 40,000 individuals. Extensive economic and demographic data concerning the sample was collected as well. Specific information on the way in which particular variables used in this paper were constructed can be obtained from the authors.

## The Insurance Status of the Poor and Near Poor

Table 1 presents findings on the insurance coverage of particular segments of the poor and near poor population. In order to identify this group, the U.S. population was categorized by family income level

adjusted for family size. The term "poor, near poor" used throughout this paper is a combined category which includes those whose family income was less than or equal to the 1977 poverty level as well as those whose income was between 101 and 125 percent of that level. For a family of four in 1977, the poor included those with an income less than $8,000; the near poor those with an income between $8,000 and $10,000.

Five insurance categories are used for this group: those on Medicaid all year; those on Medicaid part of the year but with other insurance (such as private coverage or Medicare) during the rest of the year; those on Medicaid part of the year but otherwise uninsured; those with without Medicaid but other insurance all or at least part of the year; and those uninsured throughout the year. The term "uninsured" in this paper refers to this last group. A distinction has been made between those on Medicaid all year and those on Medicaid only part of the year because there is a tendency to assume that coverage by Medicaid at any time eliminates financial risk with regard to major medical expenses. This is not true for those who are on Medicaid only part of the year and who are otherwise uninsured.

Of the 35 million poor and near poor in 1977, 12.4 million (or 35 percent) were on Medicaid at least part of the year. About 50 percent (17.8 million) had some insurance other than Medicaid, most of it private, and almost all of these (more than 16 million persons) were insured all year. However, almost 5 million or about 15 percent of the poor or near poor had no insurance whatever throughout 1977. It is this group which is of concern to policymakers.

Overall, children and adolescents were most likely to have Medicaid at least part of the year or to be always uninsured. Half of adults

18-64 years of age had private insurance, the remainder being more likely to be always uninsured than to be on Medicaid all year. Virtually none of the poor over 65 were without insurance. There was almost no difference by sex, but the poor or near poor in only fair or poor health were 40 percent more likely than than those in excellent or good health to have been on Medicaid at least part of 1977.

Of the 26 million poor and near poor whites, well over half (58 percent) had private insurance, and 29 percent were on Medicaid at least part of the time. These percentages were almost exactly reversed for the 8.7 million nonwhites, but there was no difference by race in the proportion of those uninsured all year.

The Northeast and West had a relatively high percent on Medicaid; in the South and West, twice as many as elsewhere were uninsured in 1977; and in the North Central region, 60 percent of the poor had private insurance, compared to half or less elsewhere. There was an almost even split between those with Medicaid and private insurance in SMSAs, whereas the poor living in less urban areas were more likely to have some other type of insurance or be always uninsured.

The Uninsured Among the Poor

As to the group of particular concern in this paper, the uninsured, their relative proportion among the poor and near poor varied by age and region and place of residence but was stable across race groups and perceived health status. In absolute terms, they tended to be adults (65 percent were between ages 18-64), white (75 percent), evenly split by sex, mostly in excellent or good health (76 percent), from the South (46 percent) and from SMSA's (55 percent).

The question then is: What do these uninsured do when they are sick? At present, they have three options. They can forego medical care, spend money out-of-pocket, or use free sources of care. (The latter includes visits where the source of payment for the visit was regarded as the Indian Health Services, community health centers, State and local government, VA health care, military health care or philanthropy.)

Table 2 compares the financial burdens experienced by the insured and uninsured poor in paying for medical services. Average out-of-pocket expenditure for health care by the poor in 1977 was $136; when insurance premiums were included, the average rose to $165. In financial terms, those on Medicaid all year appear to do best; those with some private insurance, worst, even when premiums are disregarded. The latter finding is not unexpected in view of Medicare and private insurance deductibles. However, the always uninsured had out-of-pocket expenditures equal to the average despite their use of free sources of care. This use was at least twice as frequent as for any other group, although still accounting for only a fraction of their total use.

The use of health care services by the insured and uninsured poor is compared in Table 3. Overall, the uninsured do use the least amount of services among the poor, regardless of the type of service examined (hospital stays, ambulatory visits to physicians and other providers of care, or use of prescribed medicines). The differences were largest for hospital stays (a threefold range between the uninsured and those always or sometimes on Medicaid but otherwise insured) and in the number of visits to non- physician providers of care; they were less but still substantial for physician visits and prescribed medicine use. The only

exception to this pattern was dental care, where relatively little variation existed across insurance groups. This is not surprising, since Medicaid often does not cover dental care.

While it is clear that the uninsured poor use far fewer medical services, this may be attributable to the fact that they appear to be in better health. Whether measured by the number of bed days experienced during the year, the percent of population with some chronic limitation of usual activity, or of the percent who report only fair or poor health status, the uninsured poor tend to be less sick than the other poor or near poor groups, while those on Medicaid all year or part of the year but otherwise insured tend to be least healthy (Table 4). In general, the poor who had Medicaid part of the year but who were otherwise uninsured were more like the always uninsured in terms of illness levels.

The question that remains is what happens to the poor in these two groups who <u>are</u> sick. Table 5 examines utilization levels for the sickest among the poor and near poor. It includes only those with more than 8 bed days in the course of the year; in fair or poor health; or with a chronic limitation of activity.

The findings indicate that among the poor population who are sick, the full and part year uninsured use fewer medical services than do those covered by Medicaid all year. Among those having more than 8 bed days, the difference in physician visits and prescription drugs is twofold, in nonphysician ambulatory visits fourfold, and it remains even for hospital stays, which are presumed to be less discretionary. This pattern persists for other definitions of illness. In addition, this group may be at even greater disadvantage than appears from Table 5 since an earlier analysis based on these data (Wilensky and Walden,

1981) indicated that persons insured only part of the year use substantially fewer services when they are uninsured, but are not any less sick during the period without coverage.

The foregoing clearly suggests that Medicaid has had a major impact on the use of health services by the poor and near poor particularly among the sick. Individuals in poverty who are not on Medicaid but who have some other form of insurance are not using as many services as those on Medicaid all year and on average are paying three to four times more out-of-pocket; as a group, they might thus be regarded with concern. But the group who clearly represent the greatest concern are the always uninsured, particularly those who are sick by the measures used in this paper and in similar discussions. Although their number varies according to the definition of illness used, this group is not large -- 800,000 to 900,000 persons using the first two definitions in Table 5, less than 500,000 using the third definition. Those on Medicaid but otherwise uninsured also use substantially fewer services than the Medicaid population at comparable levels of illness. As we have seen, these people do indeed forego medical care when they are sick.

Summary

The use of health services by the poor has increased markedly since the enactment of Medicaid. Medicaid, however, covers only 35 percent of the poor/ near poor population. Even among this group, financial and medical vulnerability remains since one third are covered by Medicaid only part of the year and are otherwise uninsured. Also, while most of the poor/near poor not on Medicaid were covered by private insurance or Medicare, almost 5 million were entirely without insurance in 1977.

In their use of health services, the biggest differences were found between the always uninsured and those on Medicaid all year. The former used half as many physician services and prescription drugs and had fewer hospital stays than those always on Medicaid. People on Medicaid part year but otherwise uninsured also used fewer services than those always on Medicaid, but the difference was smaller.

There also were substantial differences in the amounts these groups spent out-of-pocket. Those on Medicaid all year spent about one-third of those with private insurance (including Medicare), and the always uninsured spend about twice as much as those on Medicaid. In addition, the always uninsured obtained a higher proportion of their visits from sources offering free care, e.g., municipal or county clinics.

It was noted that while the always uninsured used fewer services, they also appeared to be less sick: they had half as many bed days and fewer were limited in their usual activity or had only fair or poor health status. The sick among the uninsured poor, however, were at a severe disadvantage. They used no more than half the medical services used by full-year Medicaid population at comparable levels of illness.

Thus, the uninsured among the poor/near poor who are sick are clearly of concern. They were a relatively small group at the time of the study from which these data are derived (1977) and could be reached through the use of targeted programs. Another small group of similar size (less than one million) could also be targeted, those who were ill and on Medicaid part of the year but were otherwise uninsured. Future analytical work by National Health Care Expenditure Study staff will be directed towards estimating the costs of alternative strategies which might be designed to reach these particular groups.

Table 1: INSURANCE STATUS OF THE POOR/NEAR POOR
By Selected Characteristics, 1977

| Population characteristics | Poor/near poor (in millions) | Always Medicaid | Sometimes Medicaid otherwise insured[a] | Sometimes Medicaid otherwise uninsured | Always or sometimes private insurance[b] | Always uninsured |
|---|---|---|---|---|---|---|
| | | | | (in millions) | | |
| Total | 33.1 | 7.5 | 1.6 | 3.3 | 17.8 | 4.9 |
| | | | | (in percents) | | |
| **Age** | | | | | | |
| Under 18 | 12.6 | 31 | 3 | 14 | 27 | 34 |
| 18-64 | 16.6 | 16 | 5 | 9 | 53 | 19 |
| Over 65 | 5.9 | 16 | 14 | 0 | 70 | 0 |
| **Sex** | | | | | | |
| Male | 14.7 | 19 | 4 | 9 | 53 | 17 |
| Female | 20.4 | 23 | 5 | 10 | 49 | 12 |
| **Race** | | | | | | |
| White | 26.4 | 17 | 4 | 8 | 58 | 14 |
| Nonwhite | 8.7 | 36 | 6 | 15 | 28 | 14 |
| **Health Status** | | | | | | |
| Excellent/Good | 25.4 | 18 | 4 | 9 | 54 | 15 |
| Fair/Poor | 7.5 | 32 | 7 | 10 | 39 | 12 |
| **Region** | | | | | | |
| Northeast | 6.9 | 28 | 3 | 11 | 50 | 8 |
| North Central | 9.1 | 18 | 4 | 8 | 60 | 10 |
| South | 12.2 | 18 | 6 | 10 | 47 | 19 |
| West | 6.9 | 29 | 4 | 8 | 45 | 17 |
| **Residence** | | | | | | |
| SMSA | 22.5 | 25 | 4 | 10 | 49 | 12 |
| Other | 12.6 | 15 | 5 | 9 | 54 | 18 |

[a]Includes private, Medicare etc.
[b]Also includes individuals who had only Medicare

SOURCE: National Center for Health Services Research

Table 2: Financial Burden of the Poor/Near Poor Population By Insurance Status, 1977

| | Average per person | Always Medicaid | Sometimes Medicaid/ otherwise insured[a] | Sometimes Medicaid/ otherwise uninsured | Always or sometimes private insurance[b] | Always uninsured |
|---|---|---|---|---|---|---|
| OUT OF POCKET EXPENSES | | | | (Dollars) | | |
| Average out-of-Pocket expenses | $136 | 62 | 132 | 54 | 183 | 136 |
| Average out-of-pocket expense plus self-paid premiums | $165 | 62 | 171 | 54 | 236 | 136 |
| USE OF FREE CARE | | | | (Percent) | | |
| As % of hospital stays | 4 | 5 | 0 | 8 | 2 | 12 |
| As % of ambulatory physician visits | 9 | 5 | 7 | 10 | 10 | 20 |
| As % of ambulatory non-physician visits | 20 | 11 | 38 | 12 | 23 | 41 |

[a] Includes private, Medicare, etc.
[b] Also includes individuals who had only Medicare

SOURCE: National Center for Health Services Research

Table 3: Medical Care Use by the Poor/Near Poor Across Selected Insurance Categories, 1977

| Services | Always Medicaid | Sometimes Medicaid/ otherwise insured[a] | Sometimes Medicaid/ otherwise uninsured | Always or sometimes private insurance[b] | Always uninsured |
|---|---|---|---|---|---|
| Hospital Stays | | | | | |
| Probability of Stays | .17 | .20 | .14 | .11 | .06 |
| Average Number of Stays | .23 | .29 | .18 | .18 | .09 |
| Average Number Per User | 1.4 | 1.5 | 1.3 | 1.5 | 1.5 |
| Ambulatory Physician Visit | | | | | |
| Probability of Visit | .70 | .76 | .66 | .64 | .50 |
| Average Number of Visits | 4.5 | 4.4 | 3.1 | 3.5 | 2.4 |
| Average Number Per User | 6.4 | 5.8 | 4.7 | 5.4 | 4.6 |
| Ambulatory Non-Physician Visits | | | | | |
| Probability of Visit | .18 | .20 | .20 | .22 | .14 |
| Average Number of Visits | 1.7 | 1.1 | .90 | 1.7 | .52 |
| Average Number Per User | 9.4 | 5.4 | 4.6 | 5.6 | 3.7 |
| Dental Visits | | | | | |
| Probability of Visit | .25 | .17 | .29 | .32 | .23 |
| Average Number of Visits | .8 | .45 | .74 | 1.1 | .69 |
| Average Number Per User | 3.2 | 7.7 | 2.6 | 3.3 | 3.0 |
| Prescription Drugs | | | | | |
| Probability of Use | .59 | .72 | .55 | .55 | .41 |
| Average Number of Drugs | 6.8 | 8.4 | 3.8 | 5.1 | 2.2 |
| Average Number Per User | 10.1 | 11.7 | 5.5 | 9.3 | 5.4 |

[a] Includes private, Medicare, etc.
[b] Also includes individuals who had only Medicare

SOURCE: National Center for Health Services Research

Table 4: Sickness Levels for Selected Insurance Groups Among the Poor and Near Poor Populations

| | Overall average | Always Medicaid | Sometimes Medicaid/ otherwise insured[a] | Sometimes Medicaid/ otherwise uninsured | Always or some private insurance[b] | Always uninsured |
|---|---|---|---|---|---|---|
| Average number of bed days | 8 | 11 | 12 | 7 | 7 | 5 |
| % with limited activity | 18 | 21 | 22 | 10 | 19 | 12 |
| % with fair or poor health | 23 | 34 | 35 | 25 | 18 | 19 |

[a] Includes private, Medicare, etc.
[b] Also includes individuals who had only Medicare

SOURCE: National Center for Health Services Research

Table 5: Use of Health Services Among the Sick by Selected Insurance Categories for the poor and near poor, 1977

| Indicators of Health Status and Use of Services | Overall average | Always Medicaid | Sometimes Medicaid/ otherwise insured[a] | Sometimes Medicaid/ otherwise uninsured | Always or sometimes private insurance[b] | Always uninsured |
|---|---|---|---|---|---|---|
| I. More Than 8 Bad Days | | | | | | |
| Average physician visits | 7.1 | 8.1 | 8.2 | 6.2 | 7.8 | 4.6 |
| Average non-physician visits | 2.4 | 3.9 | 1.7 | 2.5 | 1.8 | 1.0 |
| Average number of prescription drugs | 10.6 | 11.6 | 15.4 | 6.1 | 11.3 | 5.9 |
| Average hospital | .67 | .64 | .82 | .58 | .73 | .45 |
| II. Fair or Poor Perceived Health Status | | | | | | |
| Average physician visits | 6.0 | 7.1 | 6.6 | 5.2 | 5.7 | 3.9 |
| Average non-physician visits | 2.0 | 2.8 | 2.1 | 1.3 | 2.0 | 0.6 |
| Average number of prescription drugs | 11.3 | 12.1 | 15.1 | 6.8 | 12.9 | 5.6 |
| Average hospital | .3 | .33 | .32 | .19 | .33 | .20 |
| III. With Limited Activity | | | | | | |
| Average physician visits | 7.5 | 9.7 | 6.7 | 5.9 | 7.2 | 3.8 |
| Average non-physician visits | 2.0 | 2.8 | 1.1 | 0.9 | 2.1 | 0.8 |
| Average number of prescription drugs | 15.3 | 16.7 | 15.6 | 10.6 | 16.4 | 6.9 |
| Average hospital | .40 | .39 | .34 | .32 | .47 | .18 |

[a]Includes private, Medicare, etc.
[b]Also includes individuals who had only Medicare

SOURCE: National Center for Health Services Research

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# Poor, Sick and Uninsured

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## Abstract

Given the current political and economic environment, it is unlikely that any major new health initiatives will be implemented. An earlier study indicated that about 15% or 5 million of the poor in the late 1970's were completely without health insurance coverage. Only a fraction of this group, however, reported being sick. We estimate that it would have cost about $1 billion in 1977 to have covered in a Medicaid type program the 1.4 million uninsured poor who were sick. To cover this same group in 1982 would cost about $1.6 billion. However, the poverty population increased substantially since 1977. We estimate that at least an additional 4.8 million of the increase in the poverty population are uninsured and that about 30 percent or 1.4 million are likely to be in poor health. The cost of extending a Medicaid type program to this population would be an additional $1.6 billion. Although $3.2 billion is a large sum of money, half of this amount is due to a doubling of the population in jeopardy. Thus, as the economy begins to recover from the current recession, the cost of the program should decline substantially.

During the 1960's and 1970's there was a continuing debate over whether the United States should adopt a National Health Insurance program and the dimensions which such a program might take. Health policy researchers analyzed the pros and cons of the many variations being considered in the legislative arena and provided estimates of the costs of such programs, some of which represented a several fold increase in the level of government involvement. While this still continues in some quarters, it seems quite clear that given the massive deficits forecast for the next several years and the philosophical orientation of the present administration, a movement toward universal coverage or major expansions of existing programs is highly unlikely. It therefore seems appropriate to examine the merits of a less comprehensive health care initiative which would nevertheless target coverage to those in greatest jeopardy. A recent study by Wilensky and Berk identified a group of special concern; those who are poor/near poor and who lack health insurance coverage during the entire year.[1]

In 1977 there were almost 5 million people who were without any health insurance during the entire year. Relative to others in poverty, they tended to be less sick: they had half as many bed days and fewer were limited in their usual activity or perceived themselves to have fair or poor health. Those who were sick, however, appeared to be at a severe disadvantage. They used no more than half the medical services used by the full year Medicaid population at comparable levels of illness.

In this paper we concentrate on the uninsured poor who are sick -- their demographic characteristics and their illnesses. We estimate what it would have cost to include them in a Medicaid type program in 1977 and

what it would have cost to cover this population in 1982. Finally we speculate on how much this population has increased as a result of the current recession and how much it might now cost to cover this much larger group.

## Data Sources

The data used in this paper come from the 1977 National Medical Care Expenditure Survey (NMCES), which provided detailed national estimates of the use of health services, health expenditures, and health insurance coverage. The survey was undertaken to provide data for research currently being conducted by the National Center for Health Services Resarch and was cosponsored by the National Center for Health Statistics.

The sample and design of the surveys and the instruments and procedures are described elsewhere (Bonham and Corder; Cohen and Kalsbeek 1981).[2,3] Information on types of insurance coverage, use of health services, expenditures and sources of payment for each service by type of service, and the number of types of disability days was collected every two to three months from a national sample of 40,000 individuals. Extensive economic and demographic data concerning the sample was collected as well. Specific information on the way in which particular variables used in this paper were constructed can be obtained from the authors.

## Characteristics of the Sick Poor and Well Poor

Table 1 presents findings on the demographic characteristics of the sick poor and the well poor who were either uninsured all year or were on Medicaid all year. We focus on the all year Medicaid group because these individuals provide measures of the medical services utilization of a poor population which does not face financial barriers regarding their use of medical services. It excludes the poor who were on Medicaid

part of the year or who had private insurance or some other form of coverage all or part of the year. We exclude the part year insured because their use relative to coverage patterns are more complex. They are also less reliable for purposes of comparison because of the intervening complexities changing insurance patterns implies. For purposes of this paper, we have defined "poor" to include individuals with incomes up to 125% of the poverty line. Individuals were defined as sick if they met any one of the three measures which were regarded as reflecting ill health; at least 8 bed days, a limitation in their usual activity or a self reported health status of fair or poor.

Using the criteria described above 1.4 million of the almost 5 million uninsured poor were classified as being sick while 3.5 million of the insured poor were classified as being well. The division between sick and well for the all year Medicaid was more equal; 5.7 million sick; 6.5 million well. Clearly, those on Medicaid all year are much more likely to be sick than those who are uninsured all year.

The poor who are both uninsured and sick are heavily concentrated in the 19-64 year old category: almost three-fourths of the uninsured sick poor are in the 19-64 age group versus 45 percent of the sick Medicaid population. As would be expected, the poor population which is well tends to be a younger population although those on Medicaid are much more likely to be under 18 than the uninsured (67 percent versus 42 percent).

The uninsured poor who are sick are much more likely to be employed than the Medicaid population who are sick, 51 percent versus 15 percent. Excluding those who are over 65 or ineligible, the uninsured poor who are sick are still more likely to be employed (51 percent versus 18

percent). Furthermore, those who are sick and uninsured are about as likely to be employed as those who are well and uninsured even after adjusting for the differences in the ineligible populations.

Medical Characteristics of the Uninsured Poor

The three measures used to classify individuals as being sick are all self reported and therefore reflect perceptions of illness. In order to increase our understanding of the illness characteristics of the uninsured poor we reviewed the conditions they reported for their medical visits and disability days. The medical conditions reported by the uninsured sick poor are not trivial ones. The four conditions reported most frequently are diabetes, depression, hypertension and fractures. In addition, the poor who are uninsured and sick report a substantial amount of chronic illness; not as much as the sick who are on Medicaid but more than the poor who are uninsured and well.

Costs of Covering the Uninsured Poor who are sick under a Medicaid Program

If the decision were made to provide some type of coverage to individuals who are poor, uninsured and sick, there are at least three types of programs which could be considered: direct provision of services, an income related catastrophic insurance program and an extension of a Medicaid type program. In the discussion which follows we have chosen to focus on the latter, primarily because the administrative mechanism is already in place and because we felt the cost estimates for this type of program would be the most accurate. We also think they provide a higher cost estimate than would need in fact occur, in part because there may be cheaper ways to provide coverage than by using the traditional Medicaid system and in part because some number of the self defined sick population would not be certified as sick if an independent physician verification were required as it surely would be.

We estimate that including the 1.4 million uninsured poor who were sick under any of the three definitions of illness in a Medicaid type program would have cost $987 million in 1977. This cost estimate was calculated on the basis of observed per capita Medicaid expenditures for the poor sick population in 1977. First we estimated per capita Medicaid costs for the poor sick population in 6 demographic groups a) males under 18 years of age; b) females under 18 years of age, c) adult males with at least 8 bed days, d) adult females with at least 8 bed days, e) adult males with less than 8 bed days and f) adult females with less than 8 bed days. Each of these per capita Medicaid estimates was then multiplied by the number of uninsured sick people in each corresponding group. To cover this same group of individuals in 1982, it would cost about $1.6 billion. This estimate was arrived at by using the medical cost component of the Consumer Price Index and represents a per capita cost of $1128.

The poverty population has changed dramatically since 1977. Current estimates indicate the poor/near poor population has increased by about 8 million over the past 5 years. Most of these individuals represent the increased number of unemployed and their dependents. We estimate that about 60% of the 8 million or 4.8 million are uncovered by either public or private insurance. This number is the percentage of the poor/near poor who became unemployed during 1977 and were no longer covered by private insurance at the end of the year. It is not surprising that many would lose their insurance coverage since most workers lose their employment related insurance when they are unemployed. Some, however, will or may become covered by a spouse's insurance; others may

purchase some private insurance directly. Nonetheless, most will be uninsured. It is also unlikely that a significant proportion of the unemployed would obtain Medicaid since Medicaid beneficiaries have declined from 22.9 million in 1977 to 20.5 million in 1981.

Since most of the new poor/near poor came from individuals who were other low income and middle class groups in 1977, we used their 1977 illness rates to generate current illness rates. The result was that about 30 percent of them, or 1.4 million, are predicted to be in poor health. This is the same illness rate that was observed for the uninsured poor as of 1977. The cost of extending Medicaid to these newly poor is therefore approximately $1.6 billion. When added to the $1.6 billion needed to insure the 1.4 million uninsured sick as of 1977 the cost of extending Medicaid coverage to the uninsured poor who are sick as of 1982 increases to $3.2 billion. This almost 4-fold increase in costs from the 1977 level, while partly attributable to the increase in medical costs since 1977 is half due to a doubling of the population in jeopardy during the last 5 years. Thus, as the economy begins to recover, the cost of the program should decline substantially.

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Table 1. The Sick, Poor, Uninsured by Selected Characteristics, 1977.

| Population characteristics | Sick Poor | | Well Poor | |
|---|---|---|---|---|
| | Uninsured | Medicaid | Uninsured | Medicaid |
| | (in millions) | | | |
| Total[a] | 1.4 | 5.7 | 3.5 | 6.5 |
| | (in percents) | | | |
| Age | | | | |
| Under 18 | 25 | 33 | 42 | 67 |
| 19-64 | 74 | 45 | 58 | 27 |
| Over 65 | 1 | 22 | 0 | 6 |
| | 100% | 100% | 100% | 100% |
| Employment | | | | |
| Employed | 51 | 15 | 43 | 16 |
| Not employed[b] | 31 | 59 | 29 | 30 |
| Ineligible[c] | 18 | 26 | 29 | 53 |
| | 100% | 100% | 100% | 100% |

[a] Includes only the sick poor and well poor covered by Medicaid or uninsured all year; does not include the sick and well poor covered by private insurance, Medicare or CHAMPUS.
[b] All individuals 14 years and older who did not work in 1977.
[c] Individuals who were under 14 years of age plus those whose work status could not be ascertained.

SOURCE: National Medical Care Expenditure Survey, National Center for Health Services Research.

Dr. WILENSKY. There is a general consensus that since the enactment of medicare in 1965, the health care of the elderly has improved substantially. Moreover, during this time period, mortality among the aged has also been decreasing. Since this mortality decline began prior to the advent of medicare, it is difficult to determine how much of the decline in mortality among the aged is due to improved medical care and how much is due to other factors which affect longevity. It is clear, however, that the medicare program has had a dramatic effect on the manner in which health care for the elderly is used and paid for. This is particularly evident for the poor and near-poor elderly who are more likely to be dependent on governmental programs.

In the analysis I will present today, I will be focusing specifically on the role of public insurance programs for those elderly whose incomes are less than 125 percent of poverty. In this analysis, the poor elderly population are categorized into three groups. The first is the approximately 1.4 million medicare beneficiaries who lack both private health insurance and medicaid assistance. The second group includes medicare recipients who also have medicaid but who lack any private insurance coverage. In 1977 there were about 1.5 million such beneficiaries. Then there is a third group of approximately 3 million poor elderly Americans who also have private or Champus coverage to supplement their Government financed program. Although the focus of the presentation is on the elderly poor, we should note that there are substantial differences across income groups and the relative numbers of elderly who supplement their medicare with other types of insurance; particularly, with private insurance. Overall, 66 percent of the elderly supplement their medicare with private insurance.

However, this percentage varies dramatically with only 47 percent of the poor/near poor having private insurance, and 78 percent of the high income having private insurance in addition to medicare. There is much less variation among those with only medicare from 23 percent for the poor to 14 percent for the high income. And the reason, of course, is that the poor and near poor are much more likely to have other forms of public insurance; particularly, medicaid.

First, we need to consider the basic demographic information about the characteristics of the elderly poor according to these three insurance groups. Those whose medicare is supplemented by either medicaid or private insurance are more likely to be female than the medicare only. Non-whites are much less likely than whites to have private coverage. The people 75 years or older, the old elderly, are little less likely than those in the younger group to supplement their medicare. But in addition to some basic demographic information we need to consider indicators of health status among these three groups.

To do so, we look at three different measures of health status: People who consider themselves in fair or poor health; those who have problems performing usual activities or outside activities; and, third, the number of elderly people with 8 or more bed days.

Using these three measures, we find that the population with both medicare and medicaid is generally sicker than those with private insurance or with only medicare. There, however, is essential-

ly no difference in health status between those with private insurance and those who only depend on medicare.

It is clear, however, that their insurance coverage has a major impact on the utilization across these three groups. Those who do not have additional coverage to supplement medicare average only 4.2 physician visits a year. This compares to 7 visits for the medicare/medicaid group, and 6.5 visits for those with private insurance. In fact, those in the medicare only group have about the same number of physician visits as all people between 25 and 54 years of age, a group which we presume to be in much better health than the aged.

Similar differences are found when you look at the use of prescription drugs. Those with medicaid to supplement medicare filled an average of more than 15 prescription drugs while those with only medicare had 8.7. The elderly with private insurance had an average of more than 12 drug prescriptions. Differences in the probability of having hospitalization are also evident, although the differences are smaller than with prescription drug use.

The medicare only group, therefore, has a much lower utilization level than did the other groups. And while we know that the medicaid/medicare group are sicker, we also know that the medicare/private insurance group is roughly of the same health status as the medicare only group. This indicates that the utilization differences between the medicare only group and the privately insured elderly are primarily a function of the financial barriers to care experienced by those lacking supplementary private coverage.

In addition to use, we also need to look at out-of-pocket expenses. Those with medicare and medicaid but no private insurance had relatively low out-of-pocket expenses. Their per capita expense was about $97 in 1977. And we estimate that in 1982 it was about $157. The medicare only group had a higher expense. We estimate they paid about $290 out of pocket in 1977, and about $470 in 1982.

The group with private health insurance had by far the highest out-of-pocket expenses. Their direct out-of-pocket expense, we estimate to be about $330 in 1977, and about $533 in 1982. But when we include their health insurance premiums and their SMI premium in addition to their direct out-of-pocket expense, we estimate that in 1982 this group of poor elderly paid about $810 out of their own pockets for medical care use.

The purpose of increased cost sharing for medicare is both to reduce the Federal share of medicare and to lower overall expenditures on health care for the elderly. Whether or not increased cost sharing is likely to have a significant effect on the Federal share of medicare is beyond the scope of this paper. What is clear is that the basic problem is not how to control the health care cost of the elderly as much as how to control the rapid rate of increase in all health care costs in the United States, and how to protect the poor, particularly, the elderly poor, in the process.

The analysis presented here compares levels of illness, use of health services, and out-of-pocket expenses among the elderly poor who supplement their medicare coverage with public or private insurance, and those who do not. The latter group is of particular concern given the current interest in increased cost sharing as a way of reducing the Federal share of medicare costs.

While we have not tried to estimate the effect of increased cost sharing directly, the figures discussed here suggest that increased cost sharing could raise serious problems for the low-income elderly. With the exception of those receiving medicare, the elderly poor already appear to be facing considerable hardships. Those with only medicare incur substantial out-of-pocket expense, which may account for the substantially low or comparatively low levels of health service utilization.

The elderly poor with private insurance do not appear to be similarly deprived of health services, but their ability to obtain health care appears to have come at a heavy financial cost. Absorbing additional out of pocket expense from increased cost sharing will be very difficult for them. We suggest that if increased cost sharing in the medicare system is enacted, careful consideration be given to exempting the almost 6 million poor and near poor medicare beneficiaries. Such an exemption might prove to be particularly important to those who lack supplementary coverage since this group already uses substantially fewer physician, drug and hospital services.

While my presentation focused on the elderly poor, I would like to make a few brief comments about the proposed copayments for medicaid. These individuals by definition are low income, but some justification can be offered for the low levels of copayments which are being proposed both because it would introduce a small amount of cost consciousness into a system which is otherwise providing first dollar coverage, and also because it might enable us to provide some coverage for those who are poor and who are entirely without health insurance.

Prior to the current recession, we estimated that about 15 percent of the poor/near poor were without any coverage whatsoever. While this group appears to be less sick as a group than the rest of the poor, they are financially vulnerable to major medical expenses. And, furthermore, the sick among the uninsured poor are particularly disadvantaged in that they use no more than half of the medical services used by the full year medicaid people at comparable levels of illness.

Elsewhere we have estimated what it would have cost to reach those among the poor who were sick and uninsured prior to the current recession, and what we think it would cost at current levels of unemployment. This is the other material I have asked to have submitted into the record.

Thank you.

Senator DURENBERGER. Thank you very much. We will go to the rest of our panel and then go to our questioning.

## STATEMENT OF DR. JOSEPH P. NEWHOUSE, HEAD, ECONOMICS DEPARTMENT, RAND CORPORATION, SANTA MONICA, CALIF.

Dr. NEWHOUSE. Thank you, Mr. Chairman, very much for inviting me here today. I'm reporting on the initial reports of an experiment that my colleagues and I have conducted to study the effects of cost sharing in health insurance. The Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services has supported this work, and it is gratifying

to all of us who have worked on the project to be able to report some returns from this investment. But the conclusions I draw from the work as well as my additional comments are my personal views, and they do not necessarily reflect those of the Rand Corporation or the sponsors of its research.

The experiment enrolled 7,706 individuals in 2,756 families in six different places in the United States—Seattle, Washington; Dayton, Ohio; Fitchburg, Mass.; Charleston, S.C.; Franklin County, Mass.; and Georgetown County, S.C.

Of these families, 70 percent participated for 3 years, and 30 percent participated for 5 years.

Families were randomly assigned to alternative health insurance plans that varied the amount of cost sharing. About 30 percent of the families received all their medical services free; there was no cost sharing. The remaining families had to pay 25, 50 or 95 percent of their medical bills.

All the plans had a catastrophic ceiling. Families could not be out-of-pocket more than $1,000 in a year. For the poor this $1,000 ceiling was scaled down. One of the plans applied the cost sharing only to outpatient services; inpatient services were free. This plan resembled a plan with a $150 per person deductible, and I will refer to it as the individual deductible. The results from the first 40 percent of the data, which come from four of the six sites, are now in and are described in the tables in the statement. They show that expenditure definitely responds to cost-sharing. Expenditure in the least generous plan is about a third less than when all care is free. The percentage reduction in expenditure was similar across income groups. The poor showed a bit greater reduction in expenditure in Dayton, but in the other three sites, the results are almost identical across income groups.

Because the ceiling on out-of-pocket expense was income related, however, the poor were more likely to exceed it. We can infer that there would be a greater reduction in use among the poor if the cost sharing were not income related.

The likelihood of both a visit and a hospital admission fell as the cost sharing increased. Once admitted to the hospital, however, expense per case did not vary among the plans. This was probably because 70 percent of those hospitalized exceeded the ceiling on out of pocket expenditure, and, therefore, received all the additional services at no charge.

What bearing do these results have on proposals to alter the Medicare program? Unfortunately for our purposes today, the experiment included no medicare eligibles. Hence, a purist might assert that the results can shed no light on proposals that apply to the medicare program. I think most people, however, would find such a position unreasonable. Although the utilization response among the elderly, had they been included, might have been somewhat different, I personally doubt that it would have been vastly different. Assuming that a roughly similar response would have been obtained among the elderly, what should we make of these results?

Those favoring greater reliance on cost sharing have traditionally argued that it makes individuals and their physicians more prudent buyers of care. In particular, they argue that cost sharing les-

sens the likelihood that expensive medical resources will be used to treat trivial problems. The experimental results certainly demonstrate that individuals are cost conscious and can markedly reduce the use of care. But, of course, this is not the end of the issue.

One hears several different objections to greater use of cost sharing. One of the most important relates to who pays. More cost sharing in part A of medicare clearly does more than reduce demand. It also shifts costs from payroll taxes paid by the nonelderly to those elderly who are sufficiently sick to require hospitalization. Figure 1 in my statement illustrates this shift. It shows an illustrative effect of increasing the deductible from $100 per person per year to $2,000 per person per year. Demand falls by about a third, but the payout by the insurer falls by a factor of 5. If the insurer is the Government, as in the case of the medicare program, the shift in costs is a strong tonic for deficits in the medicare trust fund. It lessens the burden on the labor force at the expense of increasing the burden upon those whom the program was designed to aid. Whether this shift of burden is desirable is a political question of the first order.

A second, most important objection to cost sharing is that it may damage people's health by deterring them from seeking necessary care. The experiment is designed to address this question, but unfortunately the results are not yet in. The degree to which the health status findings will apply to the elderly with their different mix of disease is open to debate as well.

A third objection to cost sharing is that it may leave families whom illness strikes financially devastated. This could happen if there were no ceiling on out-of-pocket expense. In the experiment, however, there was such a ceiling. The administration is proposing such a ceiling for part A of the medicare program. I personally welcome such a proprosal and consider it long overdue. Indeed, I would have preferred an analogous proposal for part B. The costs of such a ceiling must, of course, be financed; more initial cost sharing is one reasonable method for doing so. In effect, it shifts the premium paid by the nonelderly toward financial risks that are more serious, and leaves the costs that the elderly must finance themselves to those first dollar expenditures that household budgets can more readily bear. Exactly how much of the first dollar expenditure the elderly themselves should finance, and whether those charges should be related to income, are questions that Congress must decide.

But even if out-of-pocket ceilings were added to the medicare program, an important financial risk would remain. Because medicare does not pay for chronic long-term care, an elderly person would still face the possibility of a large financial liability if he or she could no longer care for herself. In fact, long-term care expenditures are growing percentagewise faster than any other health expenditure. Because of the increased number of elderly, especially the frail elderly, the issue of financing long-term care is likely to become steadily more prominent.

But the issue before us today is initial cost sharing for acute medical services. Whatever its other merits or demerits, more initial cost sharing probably will not have much effect on the steadily rising trend of hospital costs. We do not want cost sharing to apply

very much to the last dollars of very large bills, precisely because we want insurance against financial devastation. But insurance of the last dollar—and I include both public and private insurance—sends a signal to those who are developing new medical procedures and equipment that anything with positive benefits for health will be demanded; it matters little how much it costs. The proposed ceilings, by the way, on part A cost sharing would add negligibly to this problem; most hospitalized patients, and almost all the medicare eligible hospitalized patients, already have their last dollar covered.

Some of the new procedures and equipment, of course, we very much want. But others may not be worth the cost. If, in fact, all the new developments were worth the cost, we probably would not be agonizing so much over the trend in health costs. The problem, of course, is how to distinguish that technology and those procedures that we want from that we do not find worth the price. And even more, to whom the new technology once available should be applied.

If more initial cost sharing is not likely to bend the trend in hospital cost per day down, what are the alternatives for dealing with the impending deficits in the medicare trust fund? One obvious alternative is to accept the upward trend and steadily increase revenues from either payroll taxes, general revenues, premiums, or more initial cost sharing. Those supporting this view—a seemingly shrinking group—implicitly assume that the great bulk of hospitals' increased capabilities is worth the cost. The Congress must then decide how to allocate the burden among the working age population through taxes, the healthy or relatively healthy elderly through premiums, and the sick elderly through cost sharing. Alternatively, one might increase price competition in medicine. The idea would be to let the market determine the rapidity with which new technology comes on stream. But it will not be easy to increase competition in a manner that deflects the trend in hospital costs—even if consumers do not want to pay for those costs.

Another frequently heard alternative is some sort of regulation or legislation to contain hospital costs. Some who advocate hospital costs containment appear to believe that there is a great deal of waste or fat in the hospital system, and that if we limited hospital revenues through legislation we would really give up very little of value. This view assumes not only the existence of substantial waste, but also that a legislated ceiling would have the effect of cutting mostly waste rather than services offering real benefit. Both assumptions are problematical.

We may gain some perspective by looking beyond our shores. In the United Kingdom health care budgets are much more constrained than is being contemplated here. Nonetheless, the rate of dialysis for kidney failure among people under 45 is approximately the same as it is in the United States. But among people over 65, the rate is only about 10 percent of the United States. One can only conclude that in the United Kingdom cost containment does not come without a sacrifice, in this case among the elderly with kidney failure. One may argue that the benefits foregone from a revenue ceiling are not worth the costs, but we are probably deluding ourselves if we think a revenue ceiling will only trim waste.

Thus, we can choose among variants of three alternatives. We can accept the cost increases, in which case the principal issue is who finances those costs. We can try to increase competition, but any change in the trend of hospital costs from increased competition is not likely to come quickly. Or we can attempt to regulate hospital revenues, in which case a principal issue is who does not receive treatment who otherwise would have received it, or who is treated differently than he or she otherwise would have been treated.

I do not put forward a recommendation among these various ways of proceeding; those judgments must be yours. And I am painfully aware that if there is little outright waste, those judgments are all the more difficult. I do not envy you your job.

Senator DURENBERGER. Thank you very much, Dr. Newhouse.

[The prepared statement of Dr. Newhouse follows:]

Statement of Joseph P. Newhouse, Ph.D., Head of the
Economics Department, The Rand Corporation, to
Subcommittee on Health, Finance Committee, United States Senate
May 16, 1983

Thank you very much for inviting me here today. I wish to report on the initial results of an experiment that my colleagues and I have conducted to study the effects of cost sharing in health insurance. The Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services has supported this work, and it is gratifying to all of us who have worked on the project to be able to report some returns from this investment. Nonetheless, the conclusions I draw from that work, as well as my additional comments, are my personal views and do not necessarily reflect those of The Rand Corporation or the sponsors of its research.

The experiment enrolled 7706 individuals in 2756 families in six different places in the United States. The families came from Seattle, Washington; Dayton, Ohio; Charleston, South Carolina; Fitchburg, Massachusetts; Franklin County, Massachusetts; and Georgetown County, South Carolina. Of these families, 70 percent participated for three years and the remainder for five years.

These families were randomly assigned to alternative health insurance plans that varied the amount of cost sharing. About 30 percent of the families received all medical services free; there was no cost sharing. The remaining families had to pay 25, 50, or 95 percent of their medical bills.

All the plans had a catastrophic ceiling; families could not be out of pocket more than $1000 in a year. For the poor this $1000 ceiling was scaled down. Specifically, the families were randomly assigned to plans that limited their out-of-pocket liability to 5, 10, or 15 percent of their income, or $1000, whichever was less. In the results described below, the families with different ceilings are grouped together; the plans are distinguished only by the fraction of the bill the family had to pay (the coinsurance rate).

One of the plans applied the cost sharing only to outpatient services; inpatient services were free. This plan resembled a plan with a $150 per person deductible; I will refer to it as the Individual Deductible plan. It was included to test the hypothesis that failure to fully cover office visits and other outpatient expenditures had the perverse effect of increasing expenditure, as individuals either delayed seeking care or as physicians hospitalized them to treat conditions that could have been managed on an outpatient basis.

The results from the first 40 percent of the data, which come from four of the six sites, are now in (see Table 1). They show that expenditure definitely responds to cost sharing; expenditure in the least generous plan (the plan with the 95 percent coinsurance up to a $1000 maximum, which is called Family Deductible in the table) is about one third less than when all care is free. Interestingly, the plan with cost sharing for outpatient services only, the Individual Deductible plan, showed lower expenditures than did the plan with free care; cost sharing only for outpatient services did not have the perverse effect of raising expenditures.

The percentage reduction in expenditure was similar across income groups; Table 2 compares the percentage reductions between the lowest third and the highest third of the income distribution in four of the sites. The poor show a bit greater reduction in expenditure in Dayton, but the other three sites show almost identical results. Because the ceiling on out-of-pocket expense was income-related, however, the poor were more likely to exceed it. We can infer that there would be a greater reduction in use among the poor if the cost sharing were not income-related.

The likelihood of both a visit and a hospital admission fell as the cost sharing increased (see Table 3). Once admitted to the hospital, however, expense per case did not vary among the plans. This was probably because 70 percent of those hospitalized exceeded the ceiling on out-of-pocket expenditure and therefore received all additional services at no charge.

Table 1

## Actual Annual Total and Ambulatory Expenditure Per Person, by Plan: Nine Site-Years

| Plan | Total Expenditure | Ambulatory Expenditure | Number of Person-Years for Total Expenditure | Number of Person-Years for Ambulatory Expenditure[a] |
|---|---|---|---|---|
| Free care | $401 (±52) | $186 (±9) | 2825 | 2834 |
| 25-percent coinsurance | 346 (±58) | 149 (±10) | 1787 | 1792 |
| 50-percent coinsurance | 328 (±149) | 120 (±12) | 766 | 766 |
| Family Deductible, 95-percent coinsurance | 254 (±37) | 114 (±10) | 1763 | 1764 |
| Individual Deductible, 95-percent coinsurance[b] | 333 (±74) | 140 (±11) | 1605 | 1609 |

NOTE: 95-percent confidence intervals are shown in parentheses. Dollars are current dollars, beginning in late 1974 and extending through late 1978. The figures are uncorrected for site price-level differences or for small differences in allocation to plan by site. Confidence intervals are uncorrected for intertemporal and intrafamily correlation; such a correction cannot be made without imposing strong assumptions about the nature of the correlation. Ignoring intertemporal and intrafamily correlation, the F-value to test the null hypothesis of no differences among the plans in total expenditure with 4,8741 degrees of freedom is 3.14, significant at the 5-percent level. The F-value to test the null hypothesis of no differences among the plans in ambulatory expenditure is 33.4, significant at well under the 1-percent level.

[a]The sample for ambulatory expenditure includes 19 individuals with a known hospital admission for whom the amount of inpatient expenditure is missing.

[b]Coinsurance in this plan applies to outpatient care only; inpatient care is free.

Source: J. P. Newhouse et al., Some Interim Results from a Controlled Trial in Health Insurance, Santa Monica, The Rand Corporation, Publ. No. R-2847-HHS, 1982.

Table 2

## Predicted Expenditure, by Income Tertile and Plan: Year 1

(Dollars for free plan; percentage of free plan elsewhere)

| Plan | Dayton | | Seattle | | Fitchburg | | Franklin County | |
|---|---|---|---|---|---|---|---|---|
| | Low | High | Low | High | Low | High | Low | High |
| Free care | $395 (±67) | $446 (±69) | $384 (±59) | $381 (±57) | $403 (±73) | $367 (±65) | $391 (±69) | $368 (±64) |
| 25-percent coinsurance | 71% | 78% | 85%* | 85%* | 89%† | 90%† | 82%* | 83%* |
| 50-percent coinsurance | 60 | 67 | — | — | 71 | 71 | 77* | 78* |
| 95-percent coinsurance | 65 | 72 | 72 | 73 | 75 | 76 | 65 | 67 |
| Individual Deductible, 95-percent coinsurance[a] | 73 | 78 | 86* | 86* | 81* | 82* | 81 | 82* |

NOTE: 95-percent confidence intervals are shown in parentheses. Comparisons do not hold factors constant other than income; they simply compare predictions for actual families with incomes below $9548 and above $15,264 (1972 dollars) in Dayton; below $8222 and above $13,882 (1973 dollars) in Seattle; below $8884 and above $13,033 (1973 dollars) in Fitchburg; and below $9374 and above $13,155 (1973 dollars) in Franklin County. These values define the lower third and upper third of the income distribution for the site. If no symbol appears to the right of the number, the difference from the free plan is significant at the 1-percent level. An asterisk (*) indicates that the difference is significant at the 5-percent level; a dagger (†) indicates that the difference is not significant at the 5-percent level. All tests are one-tail tests. Standard errors are corrected for intrafamily correlations.

[a]Coinsurance applies to outpatient care only; inpatient care is free.

Source: J. P. Newhouse et al., Some Interim Results from a Controlled Trial in Health Insurance, Santa Monica, The Rand Corporation, Publ. No. R-2847-HHS, 1982.

Table 3

## Annual Probability of One or More Physician Visits or Hospital Admissions, Nine Site-Years

| Plan | Physician Visits | Hospital Admissions |
|---|---|---|
| Free care | .84 (±.02) | .102 (±.013) |
| 25-percent coinsurance | .78 (±.03) | .081 (±.014) |
| 50-percent coinsurance | .75 (±.05) | .072 (±.021) |
| 95-percent coinsurance | .69 (±.04) | .076 (±.014) |
| Individual Deductible, 95-percent coinsurance[a] | .73 (±.04) | .090 (±.016) |

NOTE: 95-percent confidence intervals are shown in parentheses. The differences in the likelihood of a physician visit between the free plan and the other plans are significant at well under the 1-percent level; the differences in hospital admissions between the free care plan and the other plans are also significant at the 1-percent level, except for the free-care 25-percent coinsurance difference, which is significant at the 5-percent level, and the free-care individual-deductible difference, which is not significant at the 5-percent level. All tests are one-tail tests. Standard errors are corrected for intrafamily and intertemporal correlations.

[a]This plan has zero coinsurance (free care) for inpatient services.

Source: J. P. Newhouse et al., Some Interim Results from a Controlled Trial in Health Insurance, Santa Monica, The Rand Corporation, Publ. No. R-2847-HHS, 1982.

What bearing do these results have on proposals to alter the Medicare program? Unfortunately for our purposes today, the experiment included no Medicare eligibles. Hence, a purist might assert that the results can shed no light on proposals that apply to the Medicare program. I think most people, however, would find such a position unreasonable. Although the utilization response among the elderly, had they been included, might have been somewhat different, I personally doubt that it would have been vastly different. Assuming that a roughly similar response would have been observed among the elderly, what should we make of these results?

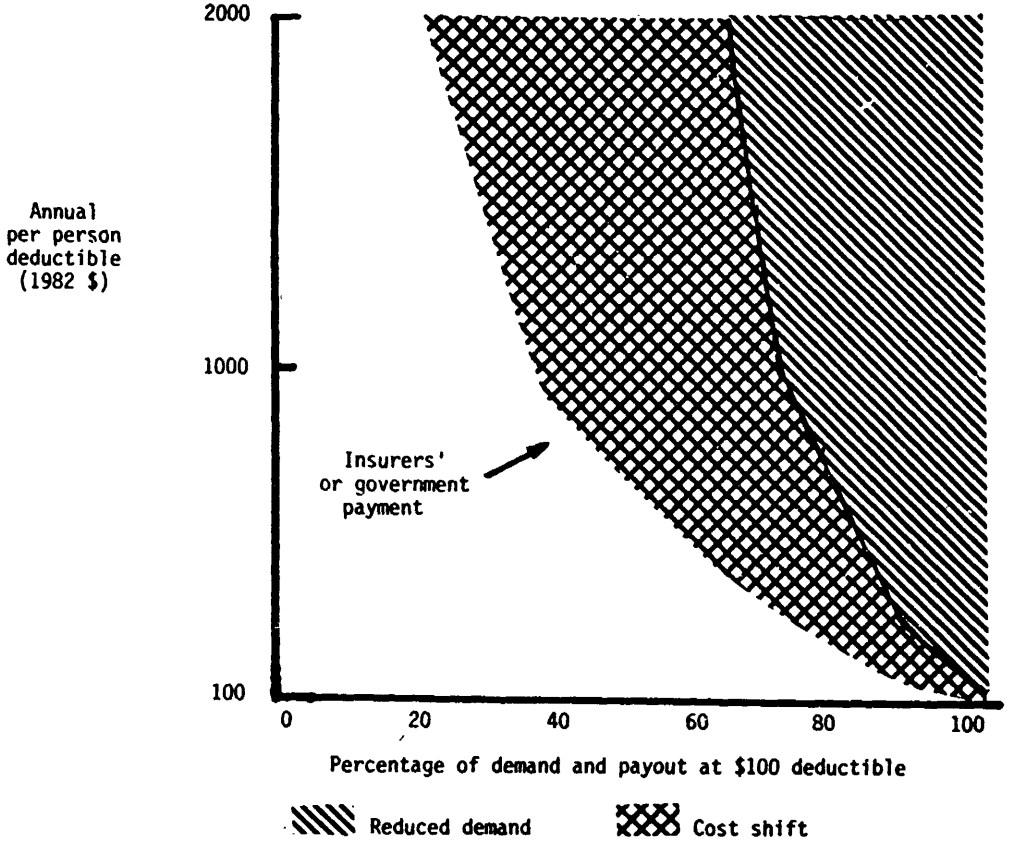
Those favoring greater reliance on cost sharing have traditionally argued that it makes individuals and their physicians more prudent buyers of care. In particular, they argue that cost sharing lessens the likelihood that expensive medical resources will be used to treat trivial problems. The experimental results certainly demonstrate that individuals are cost-conscious and can markedly reduce the use of care. But of course this is not the end of the issue.

One hears several different objections to greater use of cost sharing. One of the most important relates to who pays. More cost sharing in Part A of Medicare clearly does more than reduce demand; it also shifts costs from payroll taxes paid by the non-elderly to those elderly who are sufficiently sick to require hospitalization. Figure 1 illustrates this shift from taxpayer to user. It shows the effect of increasing a deductible from $100 per person per year to $2000 per person per year. Demand falls by about one-third, but the payout by the insurer falls by a factor of 5! If the insurer is the government, as in the case of the Medicare program, the shift in costs is a strong tonic for deficits in the Medicare trust fund. It lessens the burden on the labor force at the expense of increasing the burden upon those whom the program was designed to aid. Whether this shift of burden is desirable is a political question of the first order.

A second, most important objection to cost sharing is that it may damage people's health by deterring them from seeking necessary care. The experiment is designed to address this question, but unfortunately the results are not yet in. In the argot of the television networks on

Figure 1.

EFFECT OF VARYING DEDUCTIBLE ON INSURER (GOVERNMENT) PAYOUT



election night, more precincts must report for us to make a prediction. Thus, we do not yet know if the one-third decrease in use affected the participants' health status. But extensive measures of physical, mental, social, and physiologic health were taken, and analyses of those data should be available later this year. The degree to which these findings will apply to the elderly, with their different mix of disease, is open to debate.

A third objection to cost sharing is that it may leave families whom illness strikes financially devastated. This could happen if there were no ceiling on out-of-pocket expense. In the experiment, however, there was such a ceiling. The Administration is proposing such a ceiling for Part A of the Medicare program. I personally welcome such a proposal and consider it long overdue; indeed, I would have preferred an analogous proposal for Part B. The costs of such a ceiling must, of course, be financed; more initial cost sharing is one reasonable method for doing so; in effect, it shifts the premium paid by the non-elderly toward financial risks that are more serious, and leaves the costs that the elderly must finance themselves to those "first dollar" expenditures that household budgets can more readily bear. Exactly how much of the first dollar expenditure the elderly themselves should finance, and whether those charges should be related to income, are questions the Congress must decide.

But even if out-of-pocket ceilings were added to the Medicare program, an important financial risk would remain. Because Medicare does not pay for chronic long-term care, an elderly person would still face the possibility of a large financial liability if she (or he) could no longer care for herself. In fact, long-term care expenditures are growing percentagewise faster than any other health expenditure. Because of the increased number of elderly, especially the frail elderly, the issue of financing long-term care is likely to become steadily more prominent.

But the issue before us today is initial cost sharing for acute medical services. Whatever its other merits or demerits, more initial cost sharing probably will not have much effect on the steadily rising trend of hospital costs. We do not want cost sharing to apply very much to the last dollars of very large bills, precisely because we want

insurance against financial devastation. But insurance of the last dollar--and I include both public and private insurance--sends a signal to those who are developing new medical procedures and equipment that anything with positive benefits for health will be demanded; it really matters little how much it costs. (The proposed ceilings on Part A cost sharing, by the way, would add negligibly to this problem; most hospitalized patients, and almost all Medicare eligible hospitalized patients, already have their last dollar covered.)

Some of the new procedures and equipment, of course, we very much want. But some others may not be worth the cost. If, in fact, all the new developments were worth the cost, we probably would not be agonizing so much over the trend in health costs. The problem, of course, is how to distinguish that technology and those procedures that we want from that we do not find worth the price and even more, to whom the technology, once available, should be applied.

How does one know that new technology (including new medical procedures) is an important force behind the rapid increase in hospital expenditure? One sign is that cost per day accounts for most of the increase in hospital costs; admission rates and length of stay are comparatively little changed. Indeed, increasing hospital costs per day accounts for around half the increase in overall health care costs in the last two decades. This is not price inflation in the classic sense, because the product has changed; what can be done for people during a hospital stay is vastly different from what it was two or three decades ago.

If more initial cost sharing is not likely to bend the trend in hospital cost per day down, what are the alternatives for dealing with the impending deficits in the Medicare trust fund? One obvious alternative is to accept the upward trend and steadily increase revenues from either payroll taxes, general revenues, premiums, or more initial cost sharing. Those supporting this view--a seemingly shrinking group--implicitly assume that the great bulk of the hospitals' increased capabilities is worth the cost; the Congress must then decide how to allocate the burden among the working-age population through taxes, the healthy or relatively healthy elderly through premiums, and the sick elderly through cost sharing. Alternatively, one might argue that the

alternatives could introduce important new problems that are even worse.

One of those alternatives is to increase price competition in medicine. The idea would be to let the market determine the rapidity with which new technology comes on stream. Much could be and has been said on this subject, and I do not propose to add much here. I would point out, however, that it will not be easy to increase competition in a manner that deflects the trend in hospital costs--even if consumers do not want to pay for those costs. For example, one of the pro-competitive proposals, capping the amount of employer-paid health insurance premiums that can be excluded from taxable income, will probably leave the existing last-dollar coverage in place. Indeed, such coverage could remain mostly in place even if the entire premium were taxable, because the great majority of people probably want protection against large bills. Thus, the tax cap proposal, however desirable on other grounds, does not promise to much affect the trend in hospital cost per day anytime soon.

Another frequently heard alternative is some sort of regulation or legislation to "contain" hospital costs. If such containment were applied only to the Medicare program (such as tighter limits on what Medicare may reimburse hospitals), and if it were effective, I think the net result would be a tendency to segregate Medicare beneficiaries in hospitals that have fewer resources. Hospitals that serve a large Medicare population would find themselves receiving lower revenues than other hospitals with relatively few elderly, and the latter hospitals would be able to add new staff and equipment over time in a manner that should permit them to become more attractive hospitals. The non-elderly would tend to use these hospitals. Thus, I think this approach would place the burden of Medicare cost containment on the sick elderly.

Cost-containment regulation could be applied to the entire population, of course, rather than be limited to the Medicare population. In that case the Medicare population probably would not be segregated. As with competition, many things have been said about this proposal, and I do not propose to add much to this subject either. But I would like to point out that this approach is not likely to be costless, and I do not have in mind the salaries of the regulators and the attorneys that represent potential litigants, although they too are costs.

Some who advocate hospital cost containment appear to believe that there is a great deal of waste or "fat" in the hospital system, and that if we limited hospital revenues through legislation, we would really give up very little of value. This view assumes not only the existence of substantial waste, but also that a legislated ceiling would have the effect of cutting mostly waste rather than services offering real benefit. Both assumptions are problematical.

We may gain some perspective by looking beyond our shores. In the United Kingdom health care budgets are much more constrained than is being contemplated here. Nonetheless, the rate of dialysis for kidney failure among people under 45 is approximately the same as it is in the United States. But among people over 65, the rate is only about 10 percent of that in the United States. One can only conclude that in the United Kingdom cost containment does not come without a sacrifice, in this case among the elderly with kidney failure. If sufficiently stringent cost containment were applied to our End Stage Renal Program, similar results could well obtain here, as indeed they did prior to the Renal Program's existence. One may argue that the benefits foregone from a revenue ceiling are not worth the costs, but we are very probably deluding ourselves if we think a revenue ceiling will only trim waste.

Thus, we can choose among variants of three alternatives. We can accept the cost increases, in which case the principal issue is who finances those costs. We can try to increase competition, but any change in the trend of hospital costs from increased competition is not likely to come quickly. Or we can attempt to regulate hospital revenues, in which case a principal issue is who does not receive treatment who otherwise would have received it, or who is treated differently than he or she otherwise would have been treated.

I do not put forward a recommendation among these various ways of proceeding; those judgments must be yours. And I am painfully aware that if there is little outright waste, those judgments are all the more difficult. I do not envy your job.

Senator DURENBERGER. Thank both of you for your testimonies.

Dr. Newhouse outlines the three perceived options that we can go about if we are going to try to get control of costs.

If we want price competition and other forms of competition to have the quickest impact on the most costly part of the delivery system, which I believed you alleged to be the hospitals, then how do we get there most quickly? Do you get there by leveraging the hospitals as we have done? Last year we started the process of vouchers. This year we passed the DRG based prospective system.

That's one way to look at it. Second, we have the person who actually makes all these decisions for us anyway—the physician. We as patients don't make the hospital decisions. It's the doctors that are making those decisions. So we could approach it in that way. Go after the docs; do something on part B that might leverage cost and use.

The third approach, which is the major focus of our analysis this morning, i how do we change the behavior of you and me?

If we could make some dramatic changes in all of our behaviors, that would ripple back into the hospital system very, very quickly. And you would see those changes. You would see the good hospitals looking for all of us price-sensitive people, and the others folding up, I suppose.

So the issue before us seems to be mainly how we get the best kind of behavior. How do we relieve Dr. Rubin of the burden of 200 phone calls from the sunburn victims? And one of the issues that underlies that, as I think maybe you could sense from some of the questions that I was asking, is what kind of cost sharing gives us the best kind of results in terms of our own personal behaviors. Is it cost sharing at the time, we decide on a health plan? Or is it cost sharing after we've become sick and we have to make a decision as to whether or not to go in the hospital or some place else? There is that big deductible flag out there—$304—saying, be careful; don't go to the hospital unless you really need to."

Or is the best approach perhaps a combination of all of these?

So I guess the presumption that I start from with regard to people who are over 65 and have decided they aren't going to work at the same pace they were working before, is that they start out not wanting to be sick. The most dangerous time in your life to get sick is when you don't have a job and to pay off your illness. So you start with the notion that people in that condition just don't want to be sick.

Second, that they particularly fear the cost of the illness because there is no cap. It seems to me, that those are two things that people would really be looking for if they had any kind of a choice—namely a plan that rewards them for staying healthy and provides catastrophic protection.

What else should we look for in our medicare insurance program by way of cost sharing that would help provide the right kind of incentives in the system?

Dr. NEWHOUSE. Let me take a crack at that. The numbers that I have shown you, I think, demonstrate that cost sharing—initial cost sharing of having the person pay for the first dollar—does affect hospital admissions. Admissions are down by some 30 or 40

percent in the cost sharing plans relative to the plan where everything is free.

So there can be an effect. I would characterize the effect from changing cost sharing as a once and for all change in admissions.

However, the great bulk of increased costs in medical care has come from increased cost per day in the hospital. And cost sharing is simply not well suited to change that trend. We want protection against very large bills, the catastrophic protection you alluded to. Once that is in place, it's very hard to have very much cost sharing for anything extra that is done in the hospital. So if there is a new machine that is going to help a certain patient, the patient wants it, the doctor wants it, everybody wants it. The only thing I can think of in the way of incentives, the kind you were talking about, that would bear on this would be if there were an incentive to select a cheaper hospital or cheaper HMO or a cheaper group of providers that didn't necessarily provide all this. Then, we would be back to a more normal market kind of incentive.

But I think it's very difficult to organize the medical system that way. We've been trying to promote HMO's for 10 years, and we are still only up to about 4 or 5 percent of the country enrolled in HMO's. And, in fact, the rate of increase in premiums in HMO's is not very different than the rate of increase in health care costs nationally, which may indicate either that existing HMO's are simply captives, as it were, of the system, and more or less have to take the prices and the technology as givens, or it may indicate that people want to buy what the system is providing. That is people apparently aren't finding it attractive to establish an HMO that doesn't provide all of this technology and charges less. I'm not sure that people have tried to establish such an HMO, but even if they haven't tried, maybe that's telling us something.

I'm not persuaded that there is any easy answer to increased cost per day. One can come back to revenue caps and say to physicians and hospitals, all right, this is what you have to work with; do the best you can with it. And then I think the issue there is what, in fact, do we give up? I don't think we know very much about that, as I tried to indicate.

Senator DURENBERGER. Gail?

Dr. WILENSKY. I think you need to look at this question in the way that you have outlined it. It is basically a problem of the health care system, and only in a secondary way a problem of the elderly, except that there is an impending crisis in the HI trust fund. And one might want to say, well, the trust fund is one question, and then the second issue is what do we do about health care costs in general.

If the only issue is how to increase revenue in the fund, there are lots of way to do this. But if we also want to lower the rate of expenditures, then we are basically saying, how do we affect the health care costs in the United States. In fact, we are likely to end up having to do both. I think that at least initially there is a real reluctance to accepts a 13- or 15-percent annual increase in health care costs on a permanent basis, although eventually people may come to the conclusion that it is better then the available alternatives.

I very strongly support what Joe Newhouse said. If we are going to substantially reduce the rate of increase in health care costs, it will be by giving up some things which are currently available. I don't think that there is so much inefficiency in the system or even if there is, that it is the ineffciencies which will be affected. It may be that what we give up has a relatively low payoff, but it is not strictly flat of the curve medicine where there are no benefits.

Having said that, I also believe that the system would be helped substantially with more incentives. And I think that the incentives would impact the system in a synergistic way. Trying to increase cost sharing would not only lead the patient to demand less services, but there is also empirical evidence that increased cost sharing leads the physician to do less on behalf of the patient. Thus policies which increase cost sharing either directly by mandate as in the case of medicare, or indirectly through tax capping or other means, will, in fact, not only affect the patient, but will also likely affect the physician and what the physician does. This point has not been made this morning—that it is not just the patient who is affected by increased cost sharing.

Furthermore, I think that some of the proposals which you and others have introduced to increase choice for the nonaged population, to limit the tax subsidy for the nonaged population, would encourage a general sense of cost consciousness on the part of both the consumer and the provider and would do so more than the sum of its individual parts. These measures would stimulate HMO's, the introduction of preferred provider organizations, IPA's and other innovative financing mechanisms because of increased pressure on cost conscious behavior.

Thus, while recognizing that direct cost sharing is much more effective on first earlier dollar expenditures than on catastrophic or late dollar expenditures, we also need to recognize that cost sharing and other incentives can have a generalized role by increasing cost consciousness.

Having said that, I think that the technology issue and the high cost expenditures in hospitals associated with last days of life are not ever going to be affected by cost sharing because that is precisely the type of expenditure that insurance is supposed to cover—the low probability, very high cost occurrence. Furthermore, part of the expenditure problem may only be addressed through some type of regulatory mechanism such as the DRG which puts a generalized pressure on the hospital. But when we are all done, we had better go back and look to see what putting that cap on hospital expenditures has done and make sure that we are willing to make the resulting tradeoff because I do think it will come at a positive tradeoff. And people will have to make sure that they are willing to pay the price that the DRG or other regulatory mechanisms produce.

Senator DURENBERGER. I appreciate you making that last point because it has been bothering me as I look at the lack of cost sharing in the employment sector. I say to myself why can we insist on lots of cost sharing when you leave employment, and reach age 65, when you haven't been used to that for 40 years. And it makes it very difficult.

But on the other hand, when I go back and I look at the opportunities that lie out there if we just recognize how normal people react to incentives—my parents who are in their 70's, want to know why their Metropolitan Senior Federation medigap insurance costs are going up so much each year. This year it's $51 a month. And 2 years ago when they bought it I think it was $27 or something like that. So I went back and looked at what kind of choices they had, and they have one other medigap choice which costs only $32.94, and that's an IPA. But if they want to visit some of the other—and this gets to your point about HMO's—if they want to go and look at some of the other opportunities that are available to them, and visit some of these elderly folks like I have, they can buy one of three voucher programs in the Twin Cities ranging in price from $16.50 to $19.95 apiece.

And, obviously, I have some concerns that the Metropolitan Senior Federation, now that it's in the insurance business, might get like the Farm Bureau. Once it got in the insurance business it starting losing sight of agriculture and got to be a big insurance organization.

But there are opportunities and there are options out there if you step back and recognize what it is that goes through the minds of people. When I have asked the people in those competitive medical plan programs why they are there; how is it that they abandon their doctor for all of these young people and the bright colored HMO's and so forth, they said it's because there is no paperwork. That's how simple it was.

So we sometimes tend to get very complicated in the way we analyze the way people make decisions. And a lot of people make decisions for some very basic reasons. And that's what we are trying to come to grips with here in this system.

Well, I'm afraid we are running out of time today, and I appreciate very much the effort that both of you have put into your testimony, and the contributions that your studies have made, and will make. I guess I can't let you go, Dr. Newhouse, without telling you that whenever I go to speak to the dentists your study is thrown at me as a rationale for why the tax cap is all bad. I am told that if we adopt the version of the tax cap, all the dentists are going to go out of business—as well as the mental health people—because your study proves that when you put in a tax cap people will back down to first dollar coverage for hospitals and doctors, and they will forego all the wonderful benefits of dental care and mental health.

Is that what your study proved?

Dr. NEWHOUSE. I'd like to think that what we have done—and we haven't even published the data yet—what we will show is the tradeoff between the cost of insurance plans with different kinds of cost sharing for dental services and the extent of improved dental health as one spends more. Then the public sector as well as employers and unions can decide whether they want to spend their money that way or not. In short, we are trying to make the choice more informed.

Dr. WILENSKY. Mr. Newhouse, excuse me. One of the recent papers from the National Medical Care Expenditure Survey, in fact, looks at what people who spend more on insurance buy relative to those who spend a little less on insurance. And, in fact, we

find that one of the areas that is most vulnerable to change at the margin is dental coverage. I will send a copy to John Tillotsin.

[The information from Dr. Wilensky follows:]

# Variations in Health Insurance Coverage: Benefits Versus Premiums

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## Introduction

The 1980s have been marked by a great interest in competition and market forces to moderate the rate of increase in health care spending. This has occurred at a time when recent events have made clear that lowering the overall rate of inflation is likely to have only a modest effect on the growth of expenditures in the health care sector. Between 1980 and 1981, health care costs increased by over 15 percent. In 1982, when prices throughout the rest of the economy rose at a much slower rate than at any time during the previous decade, prices in the medical care sector continued to increase at an annual rate of over 12 percent.

While there are many reasons for the continued increase, such as advances in expensive technology and the aging of the society, one that is frequently cited is the widespread reliance on insurance as a way of financing and prepaying health expenditures. Recent estimates indicate, for example, that about half of consumer expenditures on physicians' services and about 80 percent of expenditures on hospital services were paid through private insurance (Gibson and Waldo, 1981). The interest in increased reliance on market forces has brought renewed interest in encouraging the purchase of less comprehensive health insurance benefits. This would better allow price signals and financial incentives to operate in the market for health care. The intention is to promote more efficient and cost conscious behavior on the part of patients and providers, through insurance plans that utilize cost-sharing or enrollment in HMO's and capitation fees for providers to discourage excessive spending.

To influence the structure of private health insurance benefits means focusing on employment-related insurance, since employers are the source of most private insurance. In 1977, for example, 89 percent of the privately insured population under 65 and 85 percent of the entire privately insured population were enrolled in employment-related group plans. In numerical terms, these plans covered 137.7 million employees and their dependents. While 16.4 million individuals under 65 were enrolled only in nongroup plans or only in non-employer groups, it is clear that the appropriate focus of concern is employment-related insurance groups.

The "pro-competitive" legislative proposals which have been introduced with respect to health insurance over the past few years encompass a variety of approaches, although they are all designed with the ultimate goal of making consumers and providers more cost conscious about health care purchases. The most direct approach is to mandate cost-sharing as an integral part of the law (as, for example, in the Schweiker bill, S.1590). A second approach is to require employers to offer more choices to their employees, in order to allow employees who would prefer less coverage and/or more cost-sharing the opportunity to purchase it. As we reported in an earlier paper (Farley and Wilensky, 1983), most people with employment-related insurance (82 percent in 1977) have no choice of insurance plans. Of course, as we noted then, some people if offered a choice might actually purchase more insurance than under the current system.

A third approach, and the most common one, is to limit the current exclusion of employer-paid health insurance premiums from the taxable income of employees. The value of this exclusion is estimated at about

$31 billion dollars in 1983 (Taylor and Wilensky, 1983). It effectively reduces the price of insurance, thereby introducing incentives for employees to purchase more insurance than if they were using taxable income. Their more comprehensive insurance tends to distort the purchase of medical services, in turn, particularly where there is little incentive for providers to oppose these increased demands. Some observers think that the resulting increase in insurance has also influenced physicians and hospitals to provide a qualitatively different and more expensive "style" of care (see Pauly, 1980; Feldstein and Taylor, 1977).

Two features of these pro-competitive legislative proposals are considered in this paper, where we examine the effects of offering employees more options in their choice of insurance plans and of taxing some portion of employer-paid health insurance. We are specifically concerned about the likely effect on health insurance benefits.

Although the most immediate effect of a ceiling on tax-free insurance premiums would be to increase revenues, the more important concern in terms of health policy is to make consumers more aware of the insurance they are purchasing. The reductions in health insurance premiums that are likely to result will be greater in the long run (that is, after everyone has a chance to learn and adjust to the change) than in the immediate future and will depend on the particular tax cap that is implemented. Depending on the tax-free limit, we have estimated elsewhere that the reduction in premiums would range between $1.8 billion and $7.5 billion in the short run, and between $3.6 billion and $16.7 billion in the long run (Taylor and Wilensky, 1983). The Reagan administration's proposal, $2100 for family and $840 for individual

coverage, can be expected to result in a reduction of $3-6 billion in total employee premiums. To assess the effect of these reductions on heath care costs and the out-of-pocket medical expenses for which the population would be at risk, it is important to understand the changes in insurance and employee health insurance expenses which are likely to result.

The introduction of more choices within insurance groups would also affect patterns of coverage and the health-related expenses of employees and their families. One commonly expressed concern is that the availability of choices would cause a break-down of risk-pooling across healthy and sick individuals which is the very purpose of insurance. If individuals at low risk in terms of their medical expenditures were able to form their own plan, leaving high risks to pool among themselves, the two groups would clearly pay different premiums. Under the present system where most workers are offered only one insurance plan, however, some employees systematically subsidize the medical expenses of others by paying premiums for benefits that they have very little expectation of receiving. Yet because they have the insurance, they have an incentive to make use of whatever benefits they can. This leads to a further distortion of health care spending. If the purpose of insurance is to pool <u>unpredictable</u> risks, then the issue at stake is not a matter of insurance but a matter of equity. If people with <u>predictably</u> higher utilization (such as the chronically ill or the elderly) are not to bear the full cost of their continuing high expenses, one must ask whether single-option insurance groups are the best arrangement for compensating them. This paper will take a first step in addressing the question by looking at the present extent of cross-subsidization.

Because it is necessary to have a clear picture of the present system in order to say how it might change, we first present information from the 1977 National Medical Care Expenditure Survey on the types of benefits now purchased through employer groups.[1] Second, we examine the benefits held at different levels of total premiums or employer contributions, as an indication of the type of insurance that employees who were encouraged to reduce their premium expenditures might purchase. Third, we analyze systematic differences in health insurance benefits that some high-risk families now receive in relation to their premium expenses. These families would presumably pay higher premiums under a system that offered low risks the chance to enroll in a separate plan within the group. Under the present single-option system, their predictably higher medical expenses are subsidized by those who expect to have lower expenses. We also take the public tax subsidy into account in this analysis as well. In a final section, we consider the policy implications of our observations as they relate to the equity and efficiency of the proposed restructuring of employment-related health insurance.

Benefits Under the Present System

Table 1 provides a description of insurance coverage under the present system of employment-related group insurance, based on the 1977 NMCES data. The private health insurance[2] held by people under 65 with any employment-related group coverage is summarized in terms of the type and breadth of each person's coverage, his or her hospital and outpatient physician benefits, the depth of any major medical coverage, and the protection that major medical coverage offered against high out-

Table 1: Characteristics of benefits held by persons under age 65 with any employment-related group insurance.

(NMCES, Health Insurance/Employer Survey: United States, 1977)

| | Number with benefit (in thousands) | Percent with benefit |
|---|---|---|
| Any employment related group coverage | 137,700 | 100.0 |
| Type of coverage | | |
| Any HMO | 5,900 | 4.3 |
| Basic only | 13,200 | 9.6 |
| Major medical only | 21,700 | 15.8 |
| Basic and major medical | 95,600 | 69.4 |
| Other/unknown | 1,200 | 0.9 |
| Breadth of coverage | | |
| Coverage for dental care | 39,000 | 28.3 |
| Coverage for vision or hearing care | 16,100 | 11.7 |
| Coverage for outpatient prescription drugs | 120,500 | 87.5 |
| Coverage for routine physical | 8,700 | 6.3 |
| Coverage for outpatient psychiatric care | 106,400 | 77.3 |
| Identical to other outpatient physician benefits | 10,600 | 7.7 |
| Different from other outpatient benefits | 95,800 | 69.6 |
| Hospital benefits[a] | | |
| No deductible, semiprivate, generous limit | 57,700 | 42.0 |
| No deductible, semiprivate, less generous limit | 41,000 | 29.9 |
| No deductible, less than semi-private | 20,900 | 15.3 |
| Deductible, semiprivate, generous limit | 4,100 | 3.0 |
| Deductible, semiprivate, less generous limit | 3,600 | 2.6 |
| Deductible, less than semi-private | 7,900 | 5.8 |
| No hospital coverage | 2,000 | 1.5 |
| Physician office benefits[b] | | |
| No deductible, less than 20% co-insurance | 10,700 | 7.8 |
| No deductible, 20% or more co-insurance | 9,500 | 6.9 |
| Deductible, less than 20% co-insurance | 18,200 | 13.2 |
| Deductible, 20% or more coinsurance | 82,800 | 60.1 |
| No physician office coverage | 16,500 | 12.0 |
| Maximum major medical benefit[c] | | |
| Less than $250,000 | 51,100 | 37.1 |
| $250,000 or more | 55,000 | 39.9 |
| Unlimited | 13,800 | 10.1 |
| No major medical coverage | 17,800 | 12.9 |
| Out-of-pocket maximum under major medical[d] | | |
| $750 or less | 30,800 | 22.3 |
| $751 or more | 32,000 | 23.3 |
| Unlimited | 57,100 | 41.5 |
| No major medical coverage | 17,800 | 12.9 |

[a] A "generous" limit is defined as 365 days or more of basic benefits, or $250,000 of major medical coverage for those with no basic hospital benefits. See text for definition of coinsurance rate.

[b] See text for definition of coinsurance rate.

[c] Maximum benefit for hospital room and board charges, miscellaneous hospital expenses, surgery, inpatient physician visits, outpatient physician visits, outpatient diagnostic and laboratory tests, and any other expenses included under the maximum benefit for those services.

[d] Out-of-pocket maximum applicable to most of the services covered under the policy.

SOURCE: National Center for Health Services Research
National Medical Care Expenditure Survey

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of-pocket expenses. Each person's semiprivate hospital and outpatient physician benefits are described in terms of the presence of deductibles, other cost-sharing provisions stated as a coinsurance rate, and (for complete semiprivate hospital coverage) the depth of the benefit.[3]

First of all, the present system appears to provide a reasonably high level of protection against catastrophic expenses. Eighty-five percent of insured employees and their families were covered under a major medical policy in 1977, mostly in combination with basic benefits. Among those with major medical coverage over half were also protected by a limit on their out-of-pocket expenses.[4] Except perhaps for a deductible, 45 percent of those with work-related coverage were fully insured for semiprivate hospital accommodations with up to 365 days of basic benefits or $250,000 in major medical benefits.

Virtually everyone was insured for hospital care. Only 12 percent of work-group enrollees were without coverage for physician office visits or outpatient prescription drugs. About 77 percent were insured for outpatient psychiatric visits, although the benefits were almost always different from the regular outpatient physician benefits. Coverage for dental care was much less common (30 percent), as was coverage for vision or hearing care, or routine physical exams.

A major feature of the present system is the great extent to which employees and their families are completely insured for hospital care. Seventy-two percent faced no deductible and no cost-sharing for a semi-private room in 1977. Another 6 percent faced only a deductible. Only 23 percent had a daily benefit that would not fully cover semiprivate accommodations.

Physician benefits, by contrast, were much less comprehensive. Sixty percent of enrollees in employment-related groups had benefits with both a deductible

and a coinsurance rate of 20 percent or more. These benefit provisions were mostly a reflection of the predominance of major medical plans as the source of outpatient physician coverage. Just 8 percent of enrollees had complete outpatient physician coverage, with no deductible and no cost-sharing.

Incremental Expenditures on Health Insurance and Incremental Benefits

Most proposals to restructure employment-related health insurance are designed to neutralize the financial incentives which presently encourage overinsurance, to promote greater opportunities for choice, and to rely on the decentralized decisions of employees and employers to determine where and how more cost-sharing would be appropriate. The benefits that employers and employees would sacrifice if they chose to spend less on health insurance is very important in this context. Some insight into this issue may come from comparing the benefits of employees whose total health insurance premiums or employer-paid premiums now differ.

Several comparisons of this sort are presented in Table 2. Part A of the table arrays the benefits of employees against the premiums for the policies they obtained through their employers. However, because employer-paid premiums and not total premiums are the actual target of most reform proposals, Part B also relates differences in benefits to employer contributions.

In both parts of the table, the last three columns approximately divide employees into the lowest 60 percent in terms of total or employer-paid premiums, the next 25 percent, and the group above the 85th percentile. The intervals considered in Part B correspond in 1977 premium dollars to alternative ceilings on tax-free employer contributions which we have analyzed elsewhere. (Wilensky and Taylor, 1982; Taylor and Wilensky, 1983). The corresponding intervals in 1983 are total family premiums under about $2200,

Table 2A: Characteristics of benefits held by subscribers under age 65 from employment-related group plans, by intervals of total premiums per subscriber

(NMCES, Health Insurance/Employer Survey: United States, 1977)

| | All subscribers under 65 in employment-related group plans | Less than $1,000 (family) or $400 (individual) | $1,001-$1,400 (family) $401-$560 (individual) | Over $1,400 (family) $560 (individual) |
|---|---|---|---|---|
| Number of subscribers (in thousands) | 58,300 | 34,400 | 14,900 | 9,000 |
| | | Percent with benefit | | |
| **Type of coverage** | | | | |
| Any HMO | 3.7 | 2.6 | 6.3 | 3.7 |
| Basic only | 10.6 | 11.7 | 6.2 | 13.6 |
| Major medical only | 17.4 | 21.1 | 12.6 | 11.3 |
| Basic and major medical | 67.8 | 63.8 | 74.8 | 71.5 |
| Other/unknown | 0.6 | 0.9 | (0.0) | (0.0) |
| **Breadth of coverage** | | | | |
| Coverage for dental care | 24.9 | 16.0 | 32.7 | 46.2 |
| Coverage for vision or hearing care | 9.8 | 6.8 | 11.0 | 19.4 |
| Coverage for outpatient prescription drugs | 86.4 | 83.4 | 90.2 | 91.9 |
| Coverage for routine physical | 5.8 | 4.4 | 7.5 | 8.3 |
| Coverage for outpatient psychiatric care | 75.6 | 73.3 | 78.4 | 79.6 |
| Identical to other outpatient physician benefits | 7.3 | 7.0 | 7.5 | 8.7 |
| Different | 68.2 | 66.3 | 70.9 | 70.9 |
| **Hospital benefits**[a] | | | | |
| No deductible, semiprivate, generous limit | 38.4 | 28.7 | 53.3 | 50.9 |
| No deductible, semiprivate, less generous limit | 29.3 | 31.9 | 23.6 | 28.9 |
| No deductible, less than semi-private | 18.2 | 21.8 | 13.5 | 12.3 |
| Deductible, semiprivate, generous limit | 3.3 | 3.9 | 2.8 | 1.8 |
| Deductible, semiprivate, less generous limit | 2.8 | 3.3 | 2.3 | 2.0 |
| Deductible, less than semi-private | 6.7 | 8.6 | 4.0 | 3.6 |
| No hospital coverage | 1.3 | 1.8 | 0.6 | 0.5 |
| **Physician office benefits**[b] | | | | |
| No deductible, less than 20% co-insurance | 7.4 | 5.1 | 9.5 | 12.8 |
| No deductible, 20% or more co-insurance | 6.8 | 6.1 | 8.3 | 7.1 |
| Deductible, less than 20% co-insurance | 11.4 | 9.2 | 14.2 | 15.0 |
| Deductible, 20% or more coinsurance | 62.1 | 65.3 | 60.4 | 52.9 |
| No physician office coverage | 12.3 | 14.4 | 7.6 | 12.2 |
| **Maximum major medical benefit**[c] | | | | |
| Less than $250,000 | 36.8 | 38.1 | 35.2 | 35.0 |
| $250,000 or more | 39.6 | 38.4 | 43.4 | 37.8 |
| Unlimited | 9.5 | 8.9 | 10.0 | 11.1 |
| No major medical coverage | 14.0 | 14.6 | 11.5 | 16.1 |
| **Out-of-pocket maximum under major medical**[d] | | | | |
| $750 or less | 27.6 | 25.0 | 27.9 | 37.1 |
| $751 or more | 21.9 | 22.0 | 25.2 | 16.2 |
| Unlimited | 36.4 | 38.4 | 35.4 | 30.6 |
| No major medical coverage | 14.0 | 14.6 | 11.5 | 16.1 |

[a] A "generous" limit is defined as 365 days or more of basic benefits, or $250,000 of major medical coverage for those with no basic hospital benefits. See text for definition of coinsurance rate.

[b] See text for definition of coinsurance rate.

[c] Maximum benefit for hospital room and board charges, miscellaneous hospital expenses, surgery, inpatient physician visits, outpatient physician visits, outpatient diagnostic and laboratory tests, and any other expenses included under the maximum benefit for those services.

[d] Out-of-pocket maximum applicable to most of the services covered under the policy.

SOURCE: National Center for Health Services Research
National Medical Care Expenditure Survey

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$2200 to $3100, and over $3100. The 1983 intervals for employer-paid premiums would correspond to contributions under $1800, $1800 to $2400, and over $2400. The $2100 cap on tax-free employer contributions recently proposed by the Reagan Administration would, for example, fall on employees in the second and third columns of Table 2B. An estimated 17 percent, long-run reduction in premiums for employees affected by a cap (Taylor and Wilensky, 1983) would roughly correspond to the difference between the last two columns of the table.

Although the data relating both total premiums and employer-paid premiums to benefits are presented for the reader's consideration, it actually makes little difference whether employees are grouped by percentiles according to one or the other in comparing their benefits. The discussion which follows consequently concentrates on increments in total health insurance expenditures and Part A of the table.

First, consider the benefits held by the lower 60 percent of employees whose premiums were less than $1000, compared to those in the third and fourth columns who spent more than $1000. (The combined figures for the latter group, given below, are not explicitly shown in the table). One of the most significant differences between the 40 percent of employees whose premiums exceeded $1000 and the others was coverage for less commonly insured services like dental care, vision or hearing care, prescription drugs, routine physicals, and outpatient psychiatric care.[5] Thirty-eight percent of employees in the group with the higher total premiums had dental coverage, compared to 16 percent of those in the lower group. Fourteen percent were insured for vision or hearing services (compared to 7 percent), 91 percent for prescription drugs (compared to 83 percent), 8 percent for a routine physical

Table 28: Characteristics of benefits held by subscribers under age 65 from employment-related group plans, by intervals of premiums per subscriber contributed by employer

(NMCES, Health Insurance/Employer Survey: United States, 1977)

| | All subscribers under 65 in employment-related group plans | Less than $800 (family) or $320 (individual) | $801-1,075 (family) $321-430 (individual) | Over $1,075 (family) $430 (individual) |
|---|---|---|---|---|
| Number of subscribers (in thousands) | 58,300 | 34,300 | 11,200 | 12,700 |
| | | Percent with benefit | | |
| **Type of coverage** | | | | |
| Any HMO | 3.7 | 3.5 | 2.9 | 4.9 |
| Basic only | 10.6 | 11.7 | 6.9 | 10.8 |
| Major medical only | 17.4 | 21.1 | 13.5 | 11.0 |
| Basic and major medical | 67.8 | 62.8 | 76.7 | 73.3 |
| Other/unknown | 0.5 | 0.9 | (0.0) | (0.0) |
| **Breadth of coverage** | | | | |
| Coverage for dental care | 24.9 | 14.8 | 31.3 | 46.5 |
| Coverage for vision or hearing care | 9.8 | 6.1 | 12.9 | 16 [a] |
| Coverage for outpatient prescription drugs | 86.4 | 83.6 | 90.2 | 90.9 |
| Coverage for routine physical | 5.8 | 4.9 | 5.5 | 8.7 |
| Coverage for outpatient psychiatric care | 75.6 | 72.3 | 81.9 | 78.7 |
| Identical to other outpatient physician benefits | 7.3 | 5.9 | 8.6 | 10.0 |
| Different | 68.2 | 66.4 | 73.3 | 68.7 |
| **Hospital benefits**[a] | | | | |
| No deductible, semiprivate, generous limit | 38.4 | 32.3 | 44.2 | 49.5 |
| No deductible, semiprivate, less generous limit | 29.3 | 29.5 | 30.2 | 28.2 |
| No deductible, less than semi-private | 18.2 | 20.5 | 16.7 | 13.6 |
| Deductible, semiprivate, generous limit | 3.3 | 3.9 | 2.9 | 2.0 |
| Deductible, semiprivate, less generous limit | 2.8 | 3.3 | 1.8 | 2.5 |
| Deductible, less than semi-private | 6.7 | 8.7 | 4.1 | 3.4 |
| No hospital coverage | 1.3 | 1.9 | 0.1 | 0.8 |
| **Physician office benefits**[b] | | | | |
| No deductible, less than 20% co-insurance | 7.4 | 5.9 | 6.6 | 12.3 |
| No deductible, 20% or more co-insurance | 6.8 | 5.8 | 8.0 | 8.6 |
| Deductible, less than 20% co-insurance | 11.4 | 8.3 | 18.2 | 13.6 |
| Deductible, 20% or more coinsurance | 62.1 | 66.0 | 58.1 | 55.0 |
| No physician office coverage | 12.3 | 14.0 | 9.1 | 10.6 |
| **Maximum major medical benefit**[c] | | | | |
| Less than $250,000 | 36.8 | 35.4 | 38.3 | 39.5 |
| $250,000 or more | 39.6 | 40.3 | 42.5 | 35.2 |
| Unlimited | 9.5 | 8.9 | 10.2 | 10.8 |
| No major medical coverage | 14.0 | 15.4 | 9.2 | 14.5 |
| **Out-of-pocket maximum under major medical**[d] | | | | |
| $750 or less | 27.6 | 25.3 | 29.2 | 32.5 |
| $751 or more | 21.9 | 24.8 | 18.6 | 17.2 |
| Unlimited | 36.4 | 34.5 | 43.0 | 35.8 |
| No major medical coverage | 14.0 | 15.4 | 9.2 | 14.5 |

[a] A "generous" limit is defined as 365 days or more of basic benefits, or $250,000 of major medical coverage for those with no basic hospital benefits. See text for definition of coinsurance rate.

[b] See text for definition of coinsurance rate.

[c] Maximum benefit for hospital room and board charges, miscellaneous hospital expenses, surgery, inpatient physician visits, outpatient physician visits, outpatient diagnostic and laboratory tests, and any other expenses included under the maximum benefit for those services.

[d] Out-of-pocket maximum applicable to most of the services covered under the policy.

SOURCE: National Center for Health Services Research
National Medical Care Expenditure Survey

DIC/PFNESYA2

(compared to 4 percent), and 79 percent for outpatient psychiatric care (compared to 73 percent).

Employees whose total premiums exceeded $1000 were also less likely to have hospital and physician benefits with cost-sharing requirements. Only 17 percent did not have daily benefits covering the full cost of a semiprivate hospital room. Forty-one percent of employees with premiums below $1000 did not have semiprivate coverage, including 9 percent who also faced a hospital deductible and 2 percent who purchased no hospital coverage.[6] In the higher premium group 78 percent of employees faced no cost-sharing for hospital care while the figure for the lower group was 61 percent.

A similar picture emerges for physician office visits. Eleven percent of those in the higher premium category were completely insured, with no deductibles and no coinsurance, compared to 5 percent in the lower premium group. Similarly, there was a difference of about 7 percentage points between the two groups in the proportion who faced both a deductible and a coinsurance rate of 20 percent or more, and a 5 percentage point difference in the proportion with no coverage.

The one aspect of their health insurance where the two groups did not differ very greatly was in terms of catastrophic benefits. Eighty-five percent of employees with premiums below $1000 had major medical coverage; 86 percent of those with premiums above $1000 had major medical coverage, although more often in combination with basic benefits. Nor did the two groups differ significantly in their maximum major medical benefits. Employees with major medical coverage in the lower premium group were somewhat less likely to have a major medical limit on their out-of-pocket expenses that was below $750 (29 compared to 36 percent) and were also less likely to have an out-of-pocket limit (55 compared to 62 percent). However, according to

Part B of the table, in terms of premiums paid by employers the top 40 percent of employees were actually somewhat less likely to have major medical coverage, and if they did, were no more likely to have an out-of-pocket limit.

A comparison between the two groups with total premiums above $1000 leads to similar conclusions about the relationship between incremental premium expenditures and the extent of catastrophic coverage: additional expenditures bought a lower limit on out-of-pocket expenses but, among employees with major medical coverage, were not associated with significant differences in the existence of a limit on out-of-pocket expenses or the amount of the major medical maximum. Those in the category above $1400 were somewhat less likely to have major medical coverage. However, we believe that this was largely a reflection of very comprehensive basic benefits.[7]

More generally, the essential differences between employees in the 60th to 85th percentiles by total premiums and the highest 15 percent seemed to be the dental and vision coverage of the top group, their tendency towards basic (but complete) benefits, and their lower limits on out-of-pocket expenses. The proportions with dental and vision benefits in the highest premium group were respectively about 50 percent and 30 percent greater than the proportions in the second highest group. Twice as many employees in the highest premium category had only basic benefits. There were no significant difference between the two highest groups with respect to their hospital benefits, nor with respect to coverage for prescription drugs, outpatient psychiatric services, or even routine physicals. The last appears to reflect the significantly higher percentage of HMO enrollees in the group with premiums between $1000 and $1400, not the very highest premium group.

Differences in cost-sharing for physician office visits were not significant with respect to total premiums. Yet Table B suggests a different

story with respect to employer contributions, where it appears that employees with the highest employer-paid premiums were almost twice as likely to have complete coverage for physician care (12 percent compared to 7 percent).

In summary, it appears that incremental health insurance expenditures generally purchased coverage for smaller, often more discretionary health expenses such as dental and vision benefits in contrast, say, to hospital care. Employees with more expensive coverage were also more likely to have complete benefits for hospital and physician expenses, although complete hospital benefits were equally common among employees with total premiums exceeding $1000 and those with premiums exceeding $1400. In general, additional expenditures on health insurance benefits were associated with a reduction in front-end out-of-pocket liabilities. What was least affected by differences in employees' health insurance premiums was their protection against very large, clearly catastrophic expenses.

Public and Private Subsidies Under the Present System

As noted in our earlier discussion, two of the most commonly proposed changes in the present system of employment-related health insurance are to reduce the subsidy implicit in the tax treatment of employer-paid premiums and to encourage a greater choice of plans within employee groups. The latter proposal would most likely result in different plans and premium expenditures for high-risk and low-risk individuals. This change would partially eliminate private cross-subsidies from the latter to the former under the present system of single option, single premium groups.[8] Table 3 illustrates the systematic transfer of income from certain types of families to others under the present system, and also the effect of the tax subsidy in reducing private expenditures for both health insurance and health care.

Table 3A. Private health insurance premiums and benefits, medical expenses, and tax benefits of families with nonelderly members enrolled in employment-related groups.
(NMCES, Household and Health Insurance/Employer Survey: United States, 1977)

| Family characteristics[1] | Number of families[1] (1) | Mean family medical expenses (2) | Mean family health insurance benefits (3) | Mean family out-of-pocket medical expenses (4) | Mean family health insurance premiums (5) | Mean family health insurance premiums paid by family (6) | Mean tax subsidy to employer contributions[2] (7) |
|---|---|---|---|---|---|---|---|
| Total | 45,633 | $1,198 | $654 | $418 | $1,054 | $253 | $222 |
| Age of oldest member | | | | | | | |
| <35 | 17,980 | 884 | 476 | 301 | 919 | 212 | 196 |
| 35-44 | 9,756 | 1,252 | 622 | 491 | 1,084 | 261 | 235 |
| 45-54 | 9,218 | 1,471 | 809 | 510 | 1,245 | 296 | 264 |
| 55-64 | 8,679 | 1,495 | 852 | 479 | 1,095 | 281 | 215 |
| Family income | | | | | | | |
| <10,000 | 8,439 | 961 | 468 | 326 | 764 | 220 | 92 |
| 10,000-<15,000 | 8,733 | 1,142 | 615 | 365 | 921 | 251 | 156 |
| 15,000-<20,000 | 8,975 | 1,113 | 627 | 410 | 1,073 | 259 | 213 |
| 20,000-<30,000 | 11,363 | 1,300 | 771 | 441 | 1,200 | 256 | 280 |
| 30,000-<50,000 | 5,880 | 1,492 | 803 | 528 | 1,278 | 259 | 340 |
| 50,000+ | 2,244 | 1,351 | 636 | 594 | 1,252 | 327 | 395 |
| Family type | | | | | | | |
| One person | | | | | | | |
| Male | 6,059 | 501 | 254 | 154 | 716 | 154 | 152 |
| Female | 8,053 | 657 | 327 | 250 | 529 | 132 | 91 |
| More than one | | | | | | | |
| Without children | 9,336 | 1,315 | 762 | 396 | 1,228 | 300 | 277 |
| With children | 22,185 | 1,535 | 837 | 560 | 1,263 | 304 | 264 |
| Family with member limited in activity | | | | | | | |
| No | 40,220 | 1,048 | 556 | 394 | 1,037 | 248 | 221 |
| Yes | 5,413 | 2,312 | 1,389 | 593 | 1,178 | 292 | 228 |

[1] Families with at least one member under 65 who was covered by employment-related group insurance. Family characteristics, medical expenses, and insurance premiums exclude members of such families who were over 65 or had no employment-related group coverage, although the benefits and premiums of coverage purchased outside such groups for anyone was also enrolled in one of them are included.

[2] Includes federal income tax, employee's share of FICA and state income tax.

SOURCE: National Center for Health Services Research
National Medical Care Expenditure Survey DIC/PFNE5YA2

Table 38. Total health care and health insurance expenditures and net cost of insurance for families with nonelderly members enrolled in employment-related groups.
(NMCES: Household and Health Insurance/Employer Surveys: United States, 1977)

| | Excess premiums over benefits (5)-(3) | Excess premiums benefits less tax subsidy (5)-(3)-(7) | Medical & premium expense borne by family (4)+(5) | Medical & premium expense borne family, less tax subsidy (4)+(5)-(7) |
|---|---|---|---|---|
| Total | $399 | $178 | $1,472 | $1,250 |
| Age of oldest member | | | | |
| <35 | 443 | 248 | 1,221 | 2,025 |
| 35-44 | 422 | 187 | 1,575 | 1,339 |
| 45-54 | 437 | 175 | 1,756 | 1,492 |
| 55-64 | 243 | 28 | 1,574 | 1,358 |
| Family income | | | | |
| <10,000 | 296 | 204 | 1,090 | 998 |
| 10,000-<15,000 | 306 | 151 | 1,286 | 1,131 |
| 15,000-<20,000 | 446 | 233 | 1,483 | 1,270 |
| 20,000-<30,000 | 429 | 148 | 1,641 | 1,361 |
| 30,000-<50,000 | 475 | 136 | 1,806 | 1,466 |
| 50,000+ | 616 | 221 | 1,847 | 1,452 |
| Family type | | | | |
| One person | | | | |
| Male | 462 | 310 | 870 | 718 |
| Female | 201 | 110 | 779 | 688 |
| More than one | | | | |
| Without children | 426 | 162 | 1,823 | 1,559 |
| With children | 465 | 188 | 1,624 | 1,347 |
| Family with member limited in activity | | | | |
| No | 481 | 261 | 1,431 | 1,211 |
| Yes | -211 | -439 | 1,771 | 1,542 |

[1] Families with at least one member under 65 who was covered by employment-related group insurance. Family characteristics, medical expenses, and insurance premiums exclude members of such families who were over 65 or had no employment-related group coverage, although the benefits and premiums of coverage purchased outside such groups for anyone was also enrolled in one of the ire included.

[2] Includes federal income tax, employee's share of FICA and state income tax.

SOURCE: National Center for Health Services Research
National Medical Care Expenditure Survey

DIC/PFNE5YA2

Part A of the table shows, first of all, that a family's total medical expenses varied predictably with the age of its members, its income, its composition, and the presence of an individual with an activity limitation. Average health insurance benefits per family also differed in accordance with the pattern of total expenses. Mean out-of-pocket expenses, by contrast, varied more narrowly within a range of about $200. Families enrolled in employment-related groups also did not differ much in terms of their direct, out-of-pocket expenditures on health insurance, given their purchase of family or individual coverage. Nor, except for the wide variation with respect to income and the greater health insurance expenditures for single males compared to females, were the difference in total premiums very substantial. On average, the tax subsidy differed among families within a limited range of about a hundred dollars. The exception was, of course, with respect to income where the high marginal tax rates of high income families made the tax exclusion more valuable.

These patterns are what one would expect to see under the present system of single-option insurance groups, where each group enrolls essentially a cross-section of the working population and their families. The most striking example of the resulting equalization of medical and insurance expenses is the $1260 difference in total expenses, $830 difference in health insurance benefits, $200 difference in out-of-pocket medical expense, $40 difference in family-paid premiums, $140 difference in total premiums, and $7 difference in tax subsidy for families with and without a person having an activity limitation.

Part B of the table provides an indication of the relative net cost of health insurance under this single-plan system to different types of families, taking into account differences in their average benefits. Also shown in Part

B are the total health care and health insurance expenses of different types of families with and without the tax subsidy. Here it is assumed that a family actually bears the full cost (in lower wages) of premiums contributed by employers less the tax savings. It should be noted that the private insurance benefits shown in Part A tend to understate the actuarial value of protection against very low probability, but very large medical expenses for a number of reasons. Therefore, the differences between premiums and expected benefits in Part B are somewhat overstated.[9] However the figures in Table 2 should provide a relatively accurate picture of the expected pay-off from insurance for families with no institutionalized members and all but the most unusual of medical expenses. Nor should the understatement of benefits systematically affect rough comparisons across families.

As one would expect in light of the small differences in their premiums, the net cost of insurance (after taking expected benefits into account) was significantly lower for those who were high risks in terms of their expected health expenses. Families with members nearing retirement age lost about $200 less on their health insurance relative to their benefits. The difference between families with a member limited in activity and other families was almost $700 in the difference between premiums and benefits. Interestingly, although the excess of premiums over benefits was less for individual women than men, the difference between them was not their benefits (which were not significantly different) but rather the higher premiums paid for the coverage of men. The same pattern, slightly more benefits for significantly lower premiums, also accounted for the lower net cost of insurance to families with older members.

The difference between premiums and benefits as it relates to income is particularly worth noting. Family medical expenses, health insurance

benefits, and health insurance premiums increased rapidly with respect to income at low levels, then tended to level off somewhat, and eventually declined among families with incomes of $50,000 or more. (See Table 3A). Yet, because premiums tended to vary more drastically than benefits, the difference between premiums and benefits increased with income. Overall, the coverage of richer families cost more relative to the benefits they received. However, when the regressive nature of the tax subsidy is taken into account, the difference between premiums and benefits was essentially horizontal. Families at all levels of income enjoyed essentially the same net benefits from the insurance system. With respect to average total family expenditures for health insurance and direct payments for medical care, the effect of the tax subsidy was to reduce but not eliminate the positive relationship between all health-related expenses and income.

Discussion

To evaluate the desirability of the likely changes in health insurance benefits and premium expenses that we have outlined, it is necessary to identify the features that characterize an efficient and equitable health insurance system.[10]

Note, first of all, that the security provided by insurance is most valuable when the potential loss is great. Under such circumstances, the certain expense of the insurance premium is far preferable to the alternative risk of a disastrously large outlay of income. The gains from insurance also increase as the probability of a given loss declines, because a smaller premium is required to cover the anticipated losses of the insurance pool. Yet, no matter how small the risk or how likely the probability of the loss, risk averse individuals will always benefit from complete insurance against all risks if it is available to them at a cost which averages their potential

loss without insurance over the entire group (i.e., an actuarily fair price). For example, at a cost of $16, the gain from insuring against an 80 percent chance without insurance of a $20 physician visit might, only amount to a few cents, compared to the security gained by paying $10 for insurance against a 0.1 percent chance of a $10,000 hospital admission. But the added security is still worth something.

Unfortunately, health insurance cannot be made available on such favorable terms. First, there are costs associated with collecting premiums, paying claims, and compensating firms for administering the insurance system which average about 10 percent of total premiums for group policies (Carroll and Arnett, 1979). Because of these transaction costs, small losses are not worth insuring. Since the potential loss is small, the gains in terms of security are outweighed by the costs of providing the insurance. If administrative costs are exacerbated by the number of claims, then it is also worthwhile to eliminate small, high frequency claims which clutter up the system.

Second, and perhaps more significantly, insured individuals will not incur the same medical expenses as those without insurance. Because insurance lowers the cost to a patient of obtaining medical services, both patients and providers have less reason to refrain from marginally beneficial use of the health care system. They also have less reason to worry about the reasonableness of the charges. Restraint on the part of any one individual, given no assurance that other people in the insurance group will behave similarly, can have little or no effect on that person's premiums. The expenses of the insurance pool consequently include expenditures on services that its members would not purchase if they had to pay the full cost of these services directly. In particular, if offered a choice between those services or a refund equal to their cost, people would take the money instead. The

costs created by insurance are obviously greater when the expenditures are more discretionary and the decisions of patients and providers are more sensitive to financial considerations. Cost-sharing provisions may be desirable in order to curb the cost of these distortions. Yet, the need for controls must be weighed against the increased risk of out-of-pocket expenditures to determine optimal levels of cost sharing and insurance coverage.

Because of the administrative costs and increased demand for health services associated with insurance, individuals spend more for routine medical care if they pay for it through insurance. However, the subsidy that the tax system provides for insurance purchases now largely offsets these increased costs . The net cost of insurance premiums is greatly reduced, and may in some cases be less than the expected benefits from the policy. For many families this means that it is cheaper to prepay for medical care through insurance than to pay for it directly. More complete insurance coverage is purchased than is appropriate for avoiding the risk of large medical expenses. Thus, limiting the tax subsidy is likely to discourage the costly practice of purchasing routine health services through the insurance system, a practice that also distorts expenditures on less routine types of care because of the comprehensive benefit structure that results.

Judging from the benefits now purchased by employees who spend the most on health insurance, compared to others, the reduction in premiums brought about by taxing employer-paid premiums is most likely to affect coverage for more discretionary health expenses such as dental and vision benefits than for hospital care. Such a change would probably not have much of an effect on major medical coverage for high expense, low probability illnesses where the gains from insurance are greatest. Nor, unless the ceiling on tax-free

employer premiums is fairly low or the response in terms of a reduction in premiums is great, would the comprehensiveness of hospital benefits be greatly affected. One characteristic that distinguishes the most expensive insurance policies, and might be sacrificed without the tax subsidy, is their relatively comprehensive coverage for physician outpatient visits. The greatest effect of a reduction in premiums would consequently be a reduction in coverage for dental services, vision and hearing care, routine physician visits, and other relatively less costly services. Because these also appear to be services where expenditures are more discretionary[11] and the probability of use is high, reduction of the tax subsidy would indeed target those areas where the benefits of insurance are least likely to outweigh its direct and indirect costs. Without the tax subsidy, one would expect more employees to forego these benefits, as employees who now buy less insurance apparently choose to do.

More generally, incremental expenditures on health insurance serve to reduce front-end out-of-pocket liabilities. In the case of hospital coverage, this was particularly evident in the differences in benefits between the bottom 60 percent of employees and the others. More of the employees whose policies cost less than $1000 in 1977 had a deductible for hospital services and were insured for less than the daily cost of a semiprivate room. In addition, their less expensive policies also had less generous reimbursement limits.

Thus, proposed changes in tax policy that introduce more cost consciousness in the purchase of health insurance will apparently encourage changes in coverage that will more accurately reflect the costs and benefits of insurance. In particular, it appears that a reduction in premiums will encourage consumers to buy health insurance policies with more cost sharing to

control the distortions caused by insurance and to eliminate coverage for some less expensive and more discretionary health services altogether. These changes in health insurance benefits are likely to have beneficial effects on the health sector as a whole. Decreasing the level of insurance coverage can be expected to reduce the demands for medical care and thus moderate the increase in prices. In addition, competition in the market for health services will be enhanced as insurance is reduced and consumers pay for more of their health services directly. Both patients and physicians have more incentive to weigh carefully the costs and benefits of various medical procedures. An increase in the general level of cost-consciousness may be one of the most important effects of a change in tax policy.

The data presented here, suggest that changes in the tax treatment of employer provided health insurance will have a significant impact on some characteristics of health insurance benefits, but may not radically change the coverage for hospital care now bought by consumers. A limited increase in cost sharing for hospital care would perhaps result from the proposed policy, with resulting gains from more efficient use of hospitals in terms of short stays. But a significant increase in cost sharing for major hospital expenses cannot be expected from likely changes in tax policy. Protection against catastrophic expenses is one of the major purposes of insurance, so it is appropriate that benefits to cover extraordinarily high medical expenses should be maintained or even extended as an important element of any health insurance plan. Yet these benefits have important implications for total health care expenditures, since hospital costs are their largest single component. Policy makers may consequently need to consider additional avenues of health care policy to deal more directly with hospital expenditures.

These observations suggest that the effect of a change in tax policy on total health expenditures may not be very great in the short run. Some savings would result from reductions in coverage for the less expensive, routine services where the change in benefits is likely to be greatest. However, the coverage for such services is already rather limited, and they do not account for the greatest expenditures on health care. Where the greatest expenditures are at stake is in paying for hospital care and the treatment of a relatively few individuals whose extraordinarily high medical expenses account for an important share of the total. Cost-sharing for relatively routine hospital expenditures may increase if the tax subsidy is significantly reduced. Yet small increases in cost-sharing cannot be expected to control the expenses associated with the increasingly sophisticated treatment of patients with major illnesses.

For certain segments of the population who are curently subsidized by the single-choice system, the data presented here also suggest that the introduction of multiple options within employer groups, either by direct mandate or as a possible consequence of the taxation of health insurance benefits, is indeed likely to mean higher expenditures on health insurance and perhaps higher out-of-pocket expenditures on health care. It is in the very nature of health insurance that income is transferred between those whom unpredictable events determine to be healthy or sick. However, different groups who face predictably different risks are now locked into buying the same insurance at the same premium. As a result, better risks have more insurance than the costs and benefits warrant. Since they have the insurance, they have every incentive to make use of the benefits it offers. One of the advantages of this system is the fact that poorer risks do not have to bear the full cost of their higher expected expenses. Now, for example, older

employees and those whose families include someone with an activity limitation systematically receive more benefits in relation to their premiums. If the availability of choices allows younger, healthier families to form their own separate insurance pool, families who expect to have higher medical expenses will either pay more for their coverage and/or settle for less insurance and the possibility of higher out-of-pocket expenses.

This leads to several questions. Who should bear the burden of the predictably higher medical expenses of, say, the chronically ill or the elderly? Also, is it best to redistribute these expenses by means of a single-option health insurance system? The costs of the single-option approach are the distorted expenditures of the low-risk population and the potential inequities of an implicit subsidy which, is not specifically based on ability to pay. Nor are all differences in expected utilization or insurance choices a matter of differences in the risk of ill health. They may also be a matter of individual preference, reflecting different employees' willingness to bear risk, their decision to have children, their attitudes toward using health services, and their ability to pay.

Perhaps the question comes down to whether or not the same institutional arrangement should do double-duty for two different kinds of risk: the risk of unpredictable medical expenses that vary from year to year in the general population, and the risk of becoming one of the high-risk individuals who can always expect to have unusually high medical expenses.[12] Medicare and disability insurance programs already make special provisions for some of the most seriously disadvantaged individuals in the latter group. The remaining disparities may not be more serious than the costs of other differences in natural advantage that individuals are allowed to bear. However, if some employees are to be compensated for their health risks, then explicit compensation mechanisms like tax credits for excesive out-of-pocket expenses as a percentage of income or actuarially-based tax credits for health insurance premiums (Ginsburg, 1981) are likely to be more efficient and equitable than continued reliance on single-option benefit plans.

NOTES

[1]The insurance data are described in S. Cohen and P. Farley, National Medical Care Expenditure Survey: Estimation and Sampling in the Component Health Insurance Surveys, U.S. Department of Health and Human Services, National Center for Health Services Research (forthcoming). The data are derived from the policies of the 14,000 households who were interviewed in the 1977 National Medical Care Expenditure Survey (NMCES). The collection of these policies from employees, insurance companies, and other sources of the households' private health insurance was undertaken as a follow-up to the main survey. NMCES provides detailed national estimates for the civilian non-institutionalized population of the use of health services, health expenditures, and health insurance coverage.

[2]In a small number of cases, the person's benefits included coverage from policies purchased outside of employer groups. However, only 4 percent of those under 65 with employment-related group coverage were also enrolled in a nongroup or non-work plan.

[3]Basic benefits, which would have provided the person's first-dollar coverage, were considered for hospital or physician services if there were any. The deductible which is shown may have related specifically to expenses associated with the particular service, or to major medical coverage under which the service was insured. The deductible for individuals with multiple policies was defined as the lowest deductible, including zero, among their different plans. Coinsurance rates were defined as the share of the next dollar of expense, after the deductible was satisfied, that an individual would pay for

a semiprivate hospital room or a physician office visit. Where a policy actually specified some other type of benefit, (e.g. an allowance per day or visit, or a copayment), a coinsurance rate was constructed by assuming a $20 fee for an office visit or a $90 semiprivate hospital room charge. The former figure is based on the NMCES national estimate of the mean charge for a visit without tests or diagnostic procedures; the latter comes from a 1977 survey conducted by the Health Insurance Association of America (Survey of Hospital Semi-private Room Charges as of January 1977. New York: HIAA, 1977). Days of basic coverage for hospital care were converted from dollars of coverage, where necessary, by assuming a $90 expenditure per day and taking into account combined maximums for room and board and miscellaneous expenses as appropriate. Because different major medical maximums sometimes apply to different services, the major medical maximum was defined as the maximum benefit for hospital, physician, and outpatient ancillary services and whatever other services were included under that maximum. The out-of-pocket limit was defined as the maximum liability specified for the majority of services under the plan.

[4]More recent estimates from the Health Insurance Association of America (1982) suggest that the percent of employees with an out-of-pocket limit has increased substantially since 1977, and that maximum benefits have also increased.

[5]Because the numbers in Table 2 and others which we present are based on a survey, they are estimates of the true population parameters which are subject to a standard error. The underlying sample size for Table 1 is 13,916, for Table 2 is 5,994 and for Table 3 is 5,792. All differences identified in the

discussion are statistically significant at a 5 percent level of significance. Because NMCES is a complex rather than a simple random sample, the standard errors were not estimated by conventional means.

[6]Recall that subscribers who did not buy hospital coverage from their own employer may have been covered under another family member's plan.

[7]They were also less likely to have physican office benefits. Our closer examination of the data revealed that the very highest expenditure group included a number of employees with virtually complete basic benefits for a set of servics, many of them inpatient-related, which did not include physician office visits. The highest expenditure category also included a disproportionate number of employees with multiple plans which, in some cases, individually may have offered rather limited benefits.

[8]Obviously, the function of insurance is to even out the expenses associated with random, unpredictable risks by transferring income from the healthy to the sick. But the groups which we consider here differ systematically in their expected expenses, and those differences are a function of characteristics which the randomness of events is not likely to change.

[9]Most importantly, NMCES is a survey of the noninstitutionalized population; the insurance benefits reflected in the survey exclude both institutional expenses and the other medical expenses of institutionalized individuals. Also, although the NMCES sample is quite large for a survey of its kind, it is not large enough to analyze the extreme right-hand tail of the expenditure distribution with much precision. A few families with extraordinarily high

expenses have a great effect on the population mean. Even among the sample of families reflected in Table 3, the top 10 percent accounted for half of all expenditures. Finally, the one-year time frame of the survey excludes benefits which policies in force in 1977 paid for utilization after that time period.

[10]Pauly (1980) offers an excellent and readable discussion of considerations in the design of an optimal insurance plan. The literature also includes Arrow (1963), Arrow (1976), Pauly (1974), Feldstein (1973), and Feldstein and Friedman (1977). Rothschild and Stiglitz (1976) is a standard reference on the problem of differential risks and the possibility of a complete breakdown of the insurance market.

[11]Consider, for example, the following effects of the coinsurance rate or price on utilization which have been estimated for hospital, physician, and dental services by researchers at the Rand Corporation, using similar data from the Center for Health Administration Studies surveys:

| | elasticity |
|---|---|
| Hospital (Newhouse and Phelps, 1976) | -.19 |
| Outpatient physician (Newhouse and Phelps, 1976) | -.37 |
| Dental (Manning and Phelps, 1979) | -.65 (adult males) to -1.40 (children) |

[12]Arrow (1963) made this observation twenty years ago, describing community rating as insurance against the risk of being reclassified into a different risk category.

Senator DURENBERGER. I wish you would. Because, again, I always seem to be too logical. And I say "What will people want to buy?" And particularly with a little cost sharing on it. It's the kind of thing I know they are going to use all the time.

But I guess the point that should be made here is that often those decisions get made between the employer and the employee. They negotiate what kind of coverage and how much they want to pay. The cap itself is not going to cause those decisions to take place. There is going to be another process by which people sit down and negotiate.

Dr. WILENSKY. Although it is likely that the tax cap will provide an incentive for employers to offer more choices even if the law does not require options because it will force people at the margin to think about what they want in an insurance package.

Dr. NEWHOUSE. In a way this is the other side of the coin from my point that the tax cap would not likely affect the last dollar coverage in the hospital. It probably will affect something. And the question is what is the least valuable part of the current insurance package. That's presumably what will be given up.

Senator DURENBERGER. Thank you both very much for your testimony.

Our next panel is Jim Hacking, assistant legislative counsel, American Association of Retired Persons; and Jacob Clayman, president of the National Council of Senior Citizens, both of whom have been before this subcommittee and the full committee on many occasions, and we always welcome their testimony.

Jim, I guess you can proceed while Jake is getting out his water.

## STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C.

Mr. HACKING. Thank you, Mr. Chairman. On my right and accompanying me is Jack Christy who is one of our legislative representatives.

We are appearing on behalf of the American Association of Retired Persons, which is a nonprofit organization having a membership well in excess of 14,300,000 persons aged 50 and older.

I shall submit the association's statement for the record and summarize.

Senator DURNBERGER. It will be made part of the record.

[The prepared statement of Mr. Hacking follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS ON PROPOSALS TO REVISE BENEFICIARY COST-SHARING REQUIREMENTS UNDER THE MEDICARE AND MEDICAID PROGRAMS

Thank you, Mr. Chairman, for this opportunity to state our views regarding the beneficiary cost sharing proposals for Medicare and Medicaid contained in the Administration's FY '84 budget request. Our testimony will focus first on Medicare and then on Medicaid.

MEDICARE

The Administration's proposals for greater beneficiary cost sharing in Medicare are based on the notion that the elderly are not health cost conscious -- that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or abuse the system and thereby increase Medicare costs. AARP flatly rejects that theory.

The elderly are the most cost conscious health care consumers in this country. They have to be. Though less than 12 percent of the population, the elderly account for 31 percent of all expenditures for hospital service, 28 percent of physician services, 24 percent of prescription drugs and 80 percent of all nursing home expenditures. Since Medicare pays for less than half of the elderly's health care expenses, the elderly are painfully aware of the cost of paying for their health care needs. Moreover, AARP is not aware of any evidence to indicate that the elderly abuse or misuse the system. The escalating cost of Medicare is a

function of uncontrolled health sector inflation, particularly hospital cost inflation, not beneficiary use of the system. Measured against the elderly's limited, fixed incomes and their huge out-of-pocket expenditures for health care, the Administration's proposals for greater beneficiary cost sharing can only be characterized as punitive.

The Administration's budget requests $59.85 billion in Medicare outlays in fiscal year 1984, assuming legislated savings of approximately $2 billion from current policy. (This is in addition to approximately $5.1 billion in FY'84 cuts already on the books). These proposed cuts in Medicare increase to $4.3 billion by 1988. In addition, increases in Medicare premiums beneficiaries are required to pay will total $4.5 billion by 1988. Thus, by 1988, total program reductions and premium increases resulting just from the Administration's fiscal 1984 budget request will total $8.8 billion. Approximately 90 percent of the reductions will result in increased copayments, premiums and deductions to be paid directly by Medicare beneficiaries.

Beneficiary out-of-pocket costs

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. The elderly pay directly for the following:

1. Deductibles under Parts A & B:

   The Part A deductible has increased from $104.00 in 1976 to $304.00 in 1983, an increase of 192 percent over the past 7 years. The annual Part B deductible has increased from $60.00 in 1980 to $75.00 in 1983 (an increase of 25 percent).

2. Co-insurance (Part B):

   Actual per capita coinsurance charges borne personally by the elderly increased by 345 percent between 1972 and 1982.

3. Cost-sharing (Part A):

   In 1981, out-of-pocket payments for both the inpatient deductible and coinsurance liability constituted over 14 percent ($5.3 billion) of all hospital expenditures, a 23 percent increase in out-of-pocket payments since 1977.

4. Charge reductions on unassigned claims (i.e., the difference between the Medicare "allowed" charge and the actual charge by the physician for which the beneficiary is personally liable):

   Between 1977 and 1982, the total dollar amount of "charge reductions" passed on to elderly Medicare beneficiaries jumped from $674,000,000 to $2,006,000,000 (an increase of 198 percent over a five-year period).

   Approximately 48 percent of all Part B claims submitted to Medicare for reimbursement at this time are "unassigned", compared to an over-50 percent non-assignment rate in 1977. Nevertheless, beneficiary liability for "unassigned" claims has increased dramatically over the past five years even though the number of claims paid on assignment has increased during the same period.

5. Aged Medicare beneficiaries are personally liable for a significant number of critical non-covered services and products -- including dental services, dentures, prescription drugs, eye glasses, hearing aids, etc. -- for which they paid $7.1 billion out-of-pocket in 1981, a 60 percent increase in their out-of-pocket liability for such products and services since 1978.

6. Coinsurance for Skilled Nursing Home Care and charges for all ICF care:

Approximately half of all nursing home expenditures made on behalf of the aged were financed directly by out-of-pocket payments in 1981. As HCFA researchers have noted: "Even if other sources comprised half of the total payments, the average out-of-pocket expenditure for private-paying patients would still be over $100 per week."

7. SMI (Part B) Premiums:

Out-of-pocket premium payments by the elderly for Medicare Part B coverage totalled $78 annually in 1977 as compared with a current annual figure of $146, an 88 percent increase in SMI premium payments by the elderly over the past five years.

8. Private Health Insurance Premiums:

Approximately 65 percent of aged Medicare beneficiaries are sufficiently concerned about the gaps in Medicare coverage to purchase private health insurance policies designed to supplement medical expenses. Currently, low option private insurance plans cost aged Medicare beneficiaries approximately $230 per year, while high option plans cost roughly $600 per year. These figures compare with an annual private insurance premium rate of $90 just five years ago.

Finally, there is evidence to suggest that fewer and fewer of the elderly are financially able to retain such supplemental policies once they are purchased. Blue Cross/Blue Shield of Florida has recently pointed out that the "persistency rate" (i.e., the percentage of those aged beneficiaries who had coverage at the beginning of the year and continue to have coverage at the end of the year) has dropped from 93.3 percent in 1978 to 86.9 percent in 1982.

Persons aged 65 and over paid roughly $700 out-of-pocket per capita for medical expenses in 1977. By 1981, this amount had increased by 71 percent to $1200 per capita,

equalling 14 percent of the annual per capita income of the aged ($8638). The Administration's proposals to increase beneficiary cost sharing impact most directly those aged beneficiaries least able to bear the burden: they do nothing to address the forces driving health sector inflation--uncontrolled growth in health care costs.

The Administration's Cost Sharing Proposals

* Require Part A users to pay, in addition to the deductible, 8 percent of the deductible ($28) for the 2nd thru 15th day of hospitalization and 5 percent ($17.50) for the 16th thru 60th day of hospitalization for any spell of illness with catastrophic protection for Part A services only after the 60th day.

For an average Medicare hospital stay of eleven days, beneficiaries will pay an additional $280 (plus a $46 increase in Part A deductible, effective January 1, 1984), equaling a 107 percent increase in the average Part A user's out-of-pocket costs for hospitalization.

The Administration is "selling" this proposal as a good deal for beneficiaries because of the catastrophic stop-loss protection. But the catastrophic protection is a pretense. Only .6 percent of enrollees and only 2 percent of Part A users ever go beyond 60 days of hospitalization. The irony inherent in the Administration's proposed catastrophic trade-off is that less than one percent of Medicare beneficiaries ever experience the kind of catastrophic illness capable of triggering the catastrophic protection; however, each beneficiary who does enter the 61st day of hospitalization

will have already paid $1529 out-of-pocket compared with $304 under current law. Moreover, such stop-loss protection means little to Medicare beneficiaries because it applies only to inpatient hospital services. It ignores the huge out-of-pocket costs for physician services associated with long hospital stays and the major source of catastrophic health care costs for the aged -- long term (nursing home) care.

*Index the Part B deductible to the Medicare Economic Index (MEI)

The MEI is the index developed by HCFA to update the physician fee screen under Medicare. The Administration proposes to adjust the Part B deductible annually according to the increase in the MEI. HCFA estimates that the MEI will crease 6.4 percent in 1984. If this projection is correct, the cost of the Part B deductible would rise from $75.00 per year to approximately $80 per year.

The MEI has risen an average of 8 percent per year since the index began in 1976. Had the Part B deductible been indexed to the MEI in 1976, ($60 in 1976) the current deductible would be approximately $100 per year instead of $75; a 25 percent increase!

*Delay establishing Part B premium at 25 percent of program cost until Jan. 1984, then incrementally increasing premium to 35 percent of program cost by 1988

Enactment of this proposal will result in an increase in the Part B premium from its current level of $146.46 per

year to $399.60 per year by 1988. HCFA projects the Part B premium to increase to $228.00 per year in 1988 under current law. Hence, this proposal is estimated to increase beneficiaries' out-of-pocket cost for Part B coverage by 75 percent over current law by 1988.

*Freeze Physician Reimbursements for one year

While some may regard this proposal as a cut in provider reimbursements, AARP believes it will have major impact on beneficiary out-of-pocket costs. Under the proposal, physician fee screens, i.e., reasonable, customary and prevailing charges, would not be updated in fiscal 1984 as usual. The update in 1985 would only cover the period 1984-1985. The physicians would totally lose one year of inflation protection. The effect of this proposal will be to:

a) increase Medicare beneficiaries' out-of-pocket costs for health care

Under existing law, Medicare beneficiaries have substantial responsibility for the cost of physician services. Beneficiaries must pay the annual Part B deductible of $75, plus 20 percent coinsurance on all reasonable, customary and prevailing physicians' charges. Between 1972-1982, incurred deductible charges increased by approximately 345 percent. Moreover, beneficiaries are liable for all charge reductions associated with unassigned physicians' bills. In 1980, aged beneficiary liability resulting from unassigned claims exceeded $1.3 billion, an amount representing 13 percent of total physicians' charges for the elderly for that year.

Beneficiary liability for physicians' services results, of course, not only from unassigned claims, but also from deductible and coinsurance charges. These three charge components--charge reductions associated with unassigned claims, deductible, and coinsurance--together represent "variable beneficiary liability" for physicians' services. In 1980, such variable liability for the aged amounted to nearly 35 percent of total physicians' charges due. Further, if Part B premium payments representing a form of "fixed beneficiary liability" are combined with "variable beneficiary liability" for 1980, the net Medicare contribution against total physicians' charges falls to only 45 percent, the aged beneficiary being responsible for the remaining 55 percent of charges due the physician. It is estimated that total beneficiary liability for physicians' charges due under Medicare will increase to over 60 percent in 1983. (See Attachment A).

b) erode the number of physicians willing to accept assignment

Currently, approximately 52 percent of all claims submitted to Medicare are submitted by physicians on "assignment" claims, i.e., the physician is willing to accept Medicare's allowable charge as payment in full. A freeze on Medicare physician reimbursements will have a serious negative impact on the rate of assignment, resulting in greater out-of-pocket costs to the elderly. In 1971 President Nixon froze wages

and prices under the Economic Stabilization Act (ESA). Between August 1971 and April 1974, while the ESA was in force, the physician assignment rate, i.e., the percentage of claims submitted by physicians for "assignment reimbursement", fell more than 11 percent. (See Attachment B.) And despite the freeze, physician fees rose 16 percent during the same period. (See Attachment C.)

c) increase hospital costs

For most of its effective life the ESA restricted increases in hospital costs per admission and in physicians' charges per procedure but did not restrict increases in hospital admissions or in total physician services. Since ESA had no effective limitation on the volume of services, the data indicate that hospitals and physicians responded to the ESA by allowing hospital admission rates to increase. If the Administration's proposal to freeze physician reimbursements becomes law, it is likely that both hospital admissions and total physician services will increase, resulting in even higher government expenditures for health care.

The Rand Corporation Study

With all due respect to Mr. Newhouse and his colleagues at the Rand Corporation, we are somewhat puzzled by the continual reference to his cost sharing study in the context of Medicare. Mr. Newhouse is the first to point out that the elderly were not included in the sample of the study. Any

conclusions about the applicability of the study to the Medicare population must, therefore, be regarded as mere speculation. Moreover, since the cost sharing liability for participants in the sample was limited based on income it is inappropriate to assume the same kind of results in a non means-tested program.

The Administration and others who believe that the elderly are insulated from the "true" cost of health care point to Medigap insurance as the main insulator. They believe that those having Medicap insurance are encouraged to use health care services more than the uninsured elderly. That theory has been investigated under a HCFA research grant and found not to be a correct description of the effect of private supplementary insurance on the majority of Medicare beneficiaries utilization of health care services. ("Cost Sharing, Supplementary Insurance, and Health Services Utilization Among the Medicare Elderly", Link, Long and Settle, Health Care Finance Review / Fall 1980). Simply stated, the investigators found that "among those elderly beneficiaries with one or more chronic health care problems (about 78 percent of the beneficiary population), persons with some type of supplementation have only slightly more physician visits than those with no additional coverage." (Health Care Finance Review/Fall 1980, at page 28). Thus, for over three quarters of the elderly Medicare population supplemental insurance does not significantly

influence their utilization of health care services. Hence, it is unfair and incorrect to characterize elderly Medicare beneficiaries as "insulated" from the cost of health care.

MEDICAID

In addition to $1.45 billion in Medicaid cuts already on the books for FY 1984, the Administration is seeking further Medicaid cuts of $293 million in FY 1984, for a total of almost $1.75 billion in Medicaid cuts in FY 1984. Clearly such cuts will further restrict the poor, elderly and disabled from essential medical care.

AARP firmly opposes the Administration's proposal to require states to impose copayments for all Medicaid services except nursing home care. Research sponsored by the Health Care Financing Administration (HCFA) clearly shows that the poor and near poor experience high levels of out-of-pocket costs for health care. "Out-of-pocket costs for the poor and near poor are as high or higher than for higher income groups. Almost all persons in families with out-of-pocket expenses greater than 15 percent of family income had family incomes below 200 percent of the official poverty level." (See Out-of-Pocket Health Expenses for Medicaid and Other Poor and Near Poor Persons in 1980, Howell, Corder & Dobson, January 1983.) It is a cruel hoax for the Administration to seek budget savings from this vulnerable segment of the population.

AARP also opposes the Administration's proposal to permanently reduce federal matching payments to states by 3 percent beginning in 1985. The states have already drastically cut Medicaid eligibility and services to meet the steep cuts in federal matching funds for Medicaid enacted under the Omnibus Reconciliation Act of 1981 (3% in FY 82, 3.5% in FY 83 and 4.5% in FY 84). Again targeting the most vulnerable in society, including nursing home patients, for such an unjustified, irrational cut is not only unfair, but poor public policy.

Finally, the Association strongly opposes the Administration's 17 percent reduction in funds supporting state survey and certification of nursing homes. According to the Administration's own projection, the funds budgeted will only pay for surveying less than 80 percent of Medicaid facilities in 1984. This budget proposal is a direct challenge to the Congress because of the Congressional moratorium placed on the Administration's regulations concerning the survey and certification of nursing homes. What the Administration has been unable to achieve by regulation, they are attempting through the budget. The Administration's arguments in support of reducing survey and certification were wrong last year when Congress placed the moratorium and they are wrong now. Congress must not allow the Administration to bypass the substantive objections resulting in the Congressional moratorium on survey and

certification regulations without correcting the deficiencies therein.

OTHER ALTERNATIVES TO ALLEVIATE THE PRESSURE FOR CUTS IN MEDICARE AND THAT ADDRESS THE UNDERLYING CAUSES OF HEALTH CARE INFLATION

AARP believes that changes in the Medicare program must look beyond immediate budget savings and address the serious long term health cost issues in this country. The federal government, as a major purchaser of health care services, cannot shrink from its responsibility to abate explosive inflation in the health care sector. Since approximately 75 percent of all Medicare expenditures are for hospital costs, the federal government has the market power and the financial interest to abate hospital cost inflation.

The Association has long urged the Congress to place federal limits on increases in hospital revenues per admission. Such an across-the-board approach would not single out Medicare or Medicaid beneficiaries for special restrictions. Time and again, experience has demonstrated that Medicare-Medicaid specific approaches to hospital cost containment merely lead to cost shifting to private paying patients and other 3rd party payers and thus, no reduction in the rate of increase in total hospital costs.

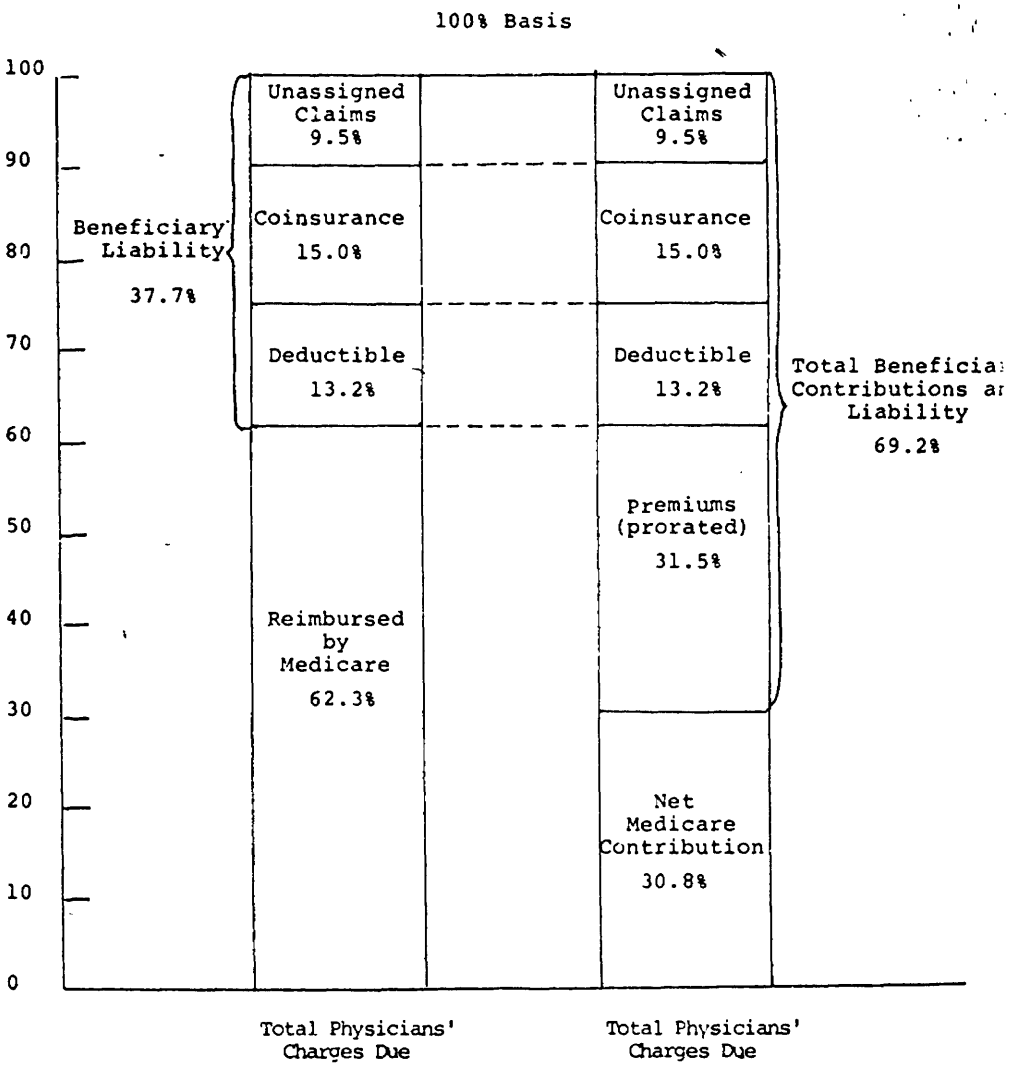
Unfortunately, Congress has rejected the imposition of uniform, across-the-board limitations on increasing hospital costs. Alternatively, the Association recommends that Congress actively encourage the states to adopt mandatory hospital rate review programs. Such programs, in the six states that have them, show great promise as they reduce both public and private sector outlays for hospital care. We urge Congress to provide financial incentives for states to initiate effective hospital rate review programs which can produce substantial savings to both government and private purchasers of hospital care services. Had all states held their increases in hospital costs to that experienced by the six states with mandatory rate review, hospital expenditures nationwide would have been $12 billion less in 1981.

ATTACHMENT A

TOTAL PHYSICIANS' CHARGES DUE:
COMPARISON OF MEDICARE REIMBURSEMENT
WITH NET MEDICARE CONTRIBUTION FOR THE AGED

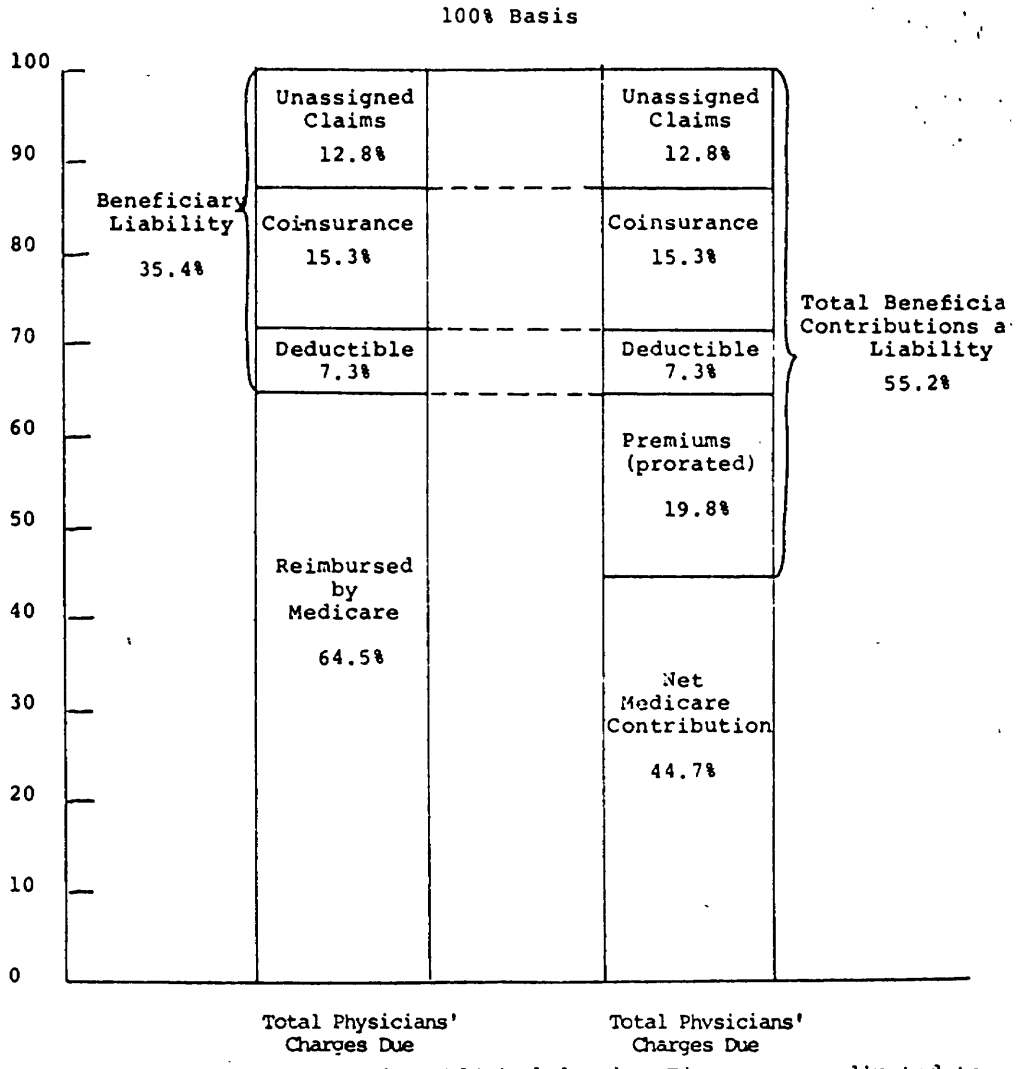
1975
1980
1983 (Estimated)

TOTAL PHYSICIANS' CHARGES DUE: COMPARISON OF MEDICARE REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED: 1975



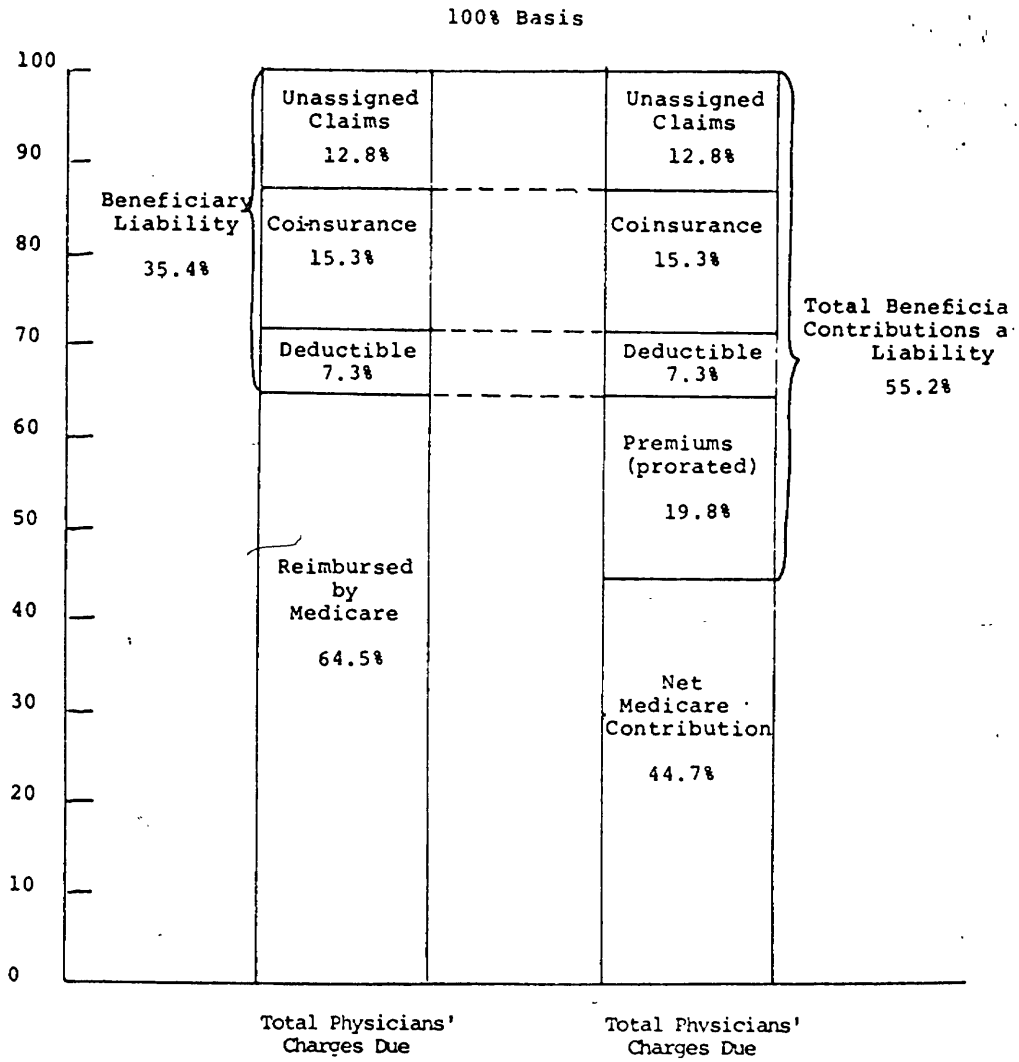

Source: Health Care Financing Review, Winter, 1980.

TOTAL PHYSICIANS' CHARGES DUE: COMPARISON OF MEDICARE REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED: 1980




Source: HCFA, April, 1983. (Unpublished data). Figures are adjusted to include estimated expenditures made toward the deductible by thos beneficiaries who used services but did not meet the deductible; 1.1% of the deductible amount shown on this table can be attribut to beneficiaries who used physicians' services but did not meet the $60.00 annual deductible limit.

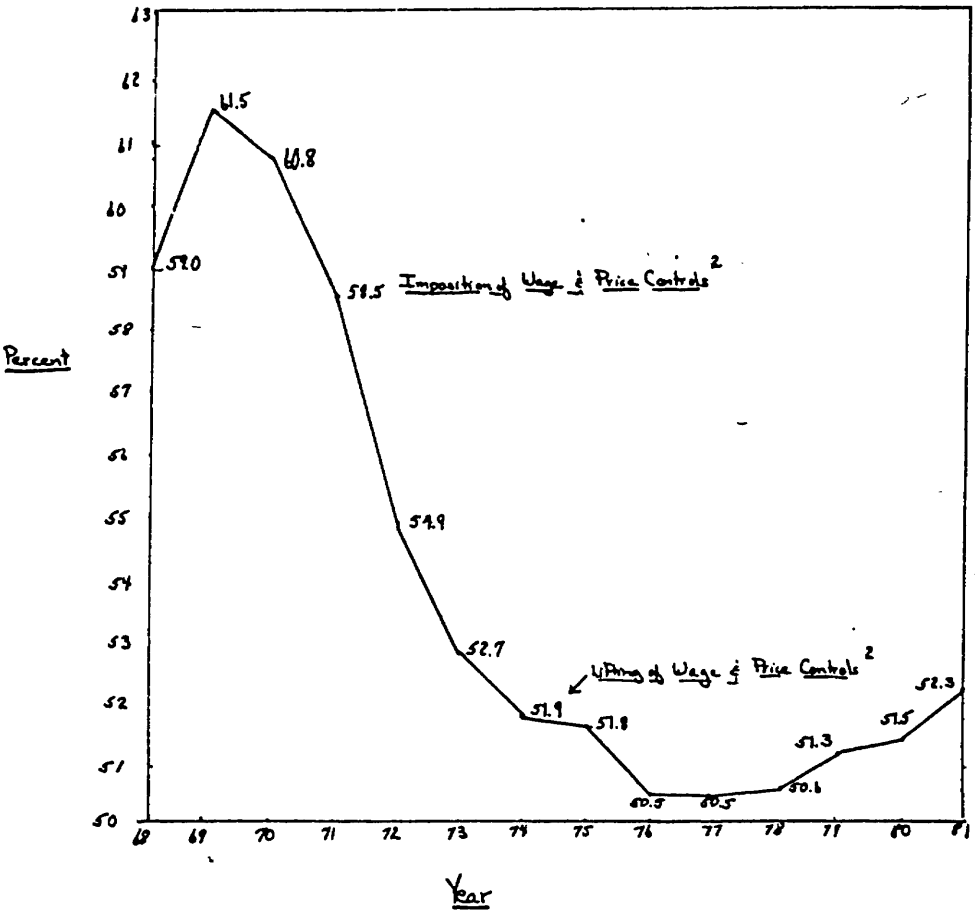
TOTAL PHYSICIANS' CHARGES DUE: COMPARISON OF MEDICARE REIMBURSEMENT WITH NET MEDICARE CONTRIBUTION FOR THE AGED: 1980




Source: HCFA, April, 1983. (Unpublished data). Figures are adjusted to include estimated expenditures made toward the deductible by thos beneficiaries who used services but did not meet the deductible; 1.1% of the deductible amount shown on this table can be attribut to beneficiaries who used physicians' services but did not meet the $60.00 annual deductible limit.

ATTACHMENT B

## Physician Assignment Rate
## (1968-1981)



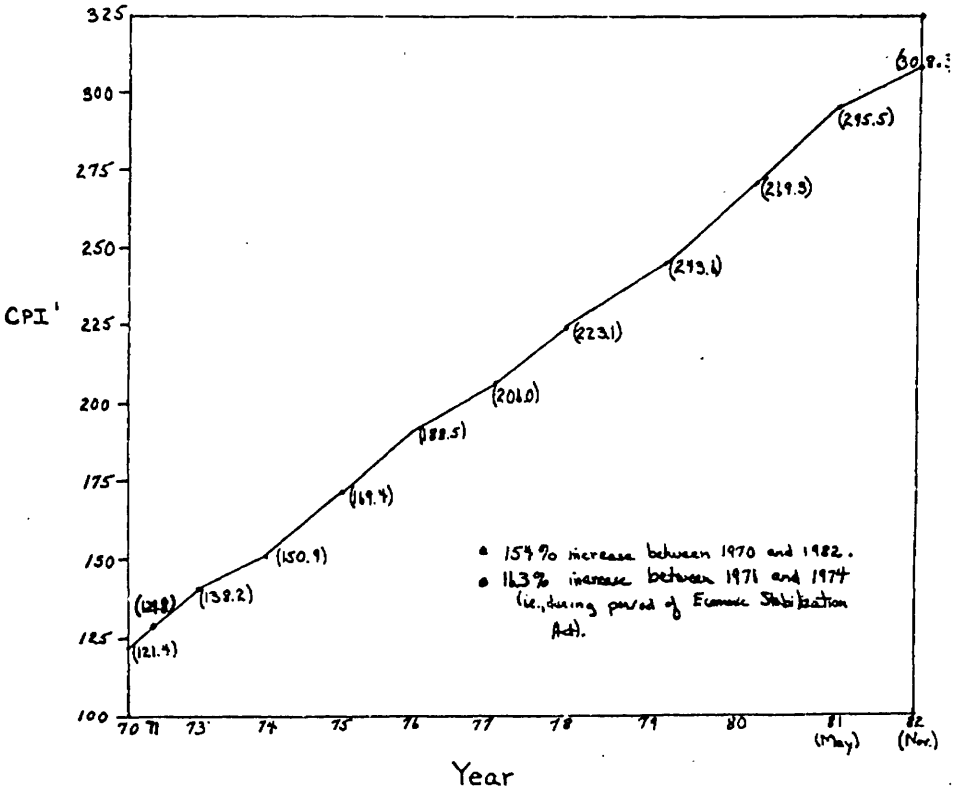

[1] Rate of acceptance of assignment based on total number of claims submitted.

[2] Decrease in assignment rate between 1971 and 1974: 11.5%

Source: HCFA

ATTACHMENT C

## Consumer Price Index: Physicians' Services (1970-1982)




[1] Annual average of monthly figures, with the exception of 1981 and 1982.

Mr. HACKING. The administration's proposal for greater beneficiary cost sharing in medicare is based on the notion that the elderly are not health care cost conscious that they are somehow insulated by medicare from the true cost of health care. Because of this insulation, so the theory goes, the elderly misuse or abuse the system and thereby increase medicare costs.

AARP rejects that theory. Medicare pays for less than half of the elderly's health care expenses. The elderly are painfully aware of the cost of paying for their health care needs. Moreover, AARP is not aware of any evidence to indicate that the elderly abuse or misuse the system. The escalating cost of medicare is a function of uncontrolled health care cost escalation, especially hospital cost escalation.

The administration's budget requests assume legislated medicare savings of roughly $2 billion. These proposed cuts in medicare increase to $4.3 billion by 1988. In addition, increases in medicare premiums that beneficiaries are required to pay will total $4.5 billion also by 1988.

Personal liability for the cost of health care provided to the elderly derives from a number of sources, such as the deductibles under parts A and B, premiums under part B, and charge reductions on unassigned claims.

All of these sources of health care costs liability to the elderly have been increasing significantly in the past several years. Persons aged 65 and over paid roughly $700 out of pocket per capita for medical expenses in 1977. But by 1981 this amount had increased by 71 percent to $1,200 per capita. That's approximately 14 percent of the elderly's annual per capita income.

In the interest of time, Mr. Chairman, I shall address specifically only two of the administration's medicare cost saving proposals. The others are treated in the statement submitted for the record.

The first is the proposal which would require part A users to pay—in addition to the deductible—8 percent of the deductible for the 2d through 15th day of hospitalization, and 5 percent for the 16th through the 60th day of hospitalization for any spell of illness, with catastrophic protection for part A services beginning after the 60th day.

For an average medicare hospital stay of 11 days, beneficiaries will pay an additional $280, plus a $46 increase in the part A deductible effective January 1 of next year, equaling a 107 percent increase in the average part A users' out-of-pocket costs for hospitalization.

The administration is selling this proposal as a good deal for beneficiaries because of the catastrophic stop loss protection feature. But the catastrophic protection is a pretense. Only 0.6 percent of enrollees, and only 2 percent of part A users ever go beyond 60 days of hospitalization.

Moreover, the stop-loss protection applies only to inpatient hospital services. It ignores the major source of catastrophic health care cost for the aged—namely, long-term nursing home care.

The second proposal I wish to address is the proposal to freeze physician reimbursements for 1 year. While some may regard this proposal as a cut in provider reimbursement, AARP believes it will have a major impact on beneficiary out-of-pocket costs. The effect

of this proposal will be to erode physicians' willingness to accept assignment.

I would point out that between August of 1971 and April of 1974, while the economic stabilization program was in effect, the physician assignment rate fell more than 11 percent.

The administration and others who believe that the elderly are insulated from the true cost of health care point to MediGap insurance as a major insulator. They believe that those having MediGap insurance are encouraged to use health care services more than the uninsured elderly.

However, a recent HCFA-sponsored study found that among those elderly beneficiaries with one or more chronic health care problem—roughly 78 percent of the beneficiary population—the ones with some type of supplementation have only slightly more physician visits than those with no additional coverage. Thus, for over three-quarters of the elderly medicare population, supplemental insurance does not seem to influence significantly the utilization of health care services.

Now with respect to the administration's medicaid proposals, AARP firmly opposed the proposal to require States to impose copayments for all medicaid services except nursing home care. HCFA research shows that out-of-pocket costs for the poor and near poor are already as high or higher than those for higher income groups.

AARP also opposes the administration's proposal to reduce permanently Federal matching payments to States by 3 percent beginning in 1985. The States have already drastically cut medicaid eligibility and services to meet the cuts in Federal matching funds for medicaid enacted under the Omnibus Budget Reconciliation Act of 1981.

Finally, the association opposes the administration's 17-percent reduction in funds supporting State survey and certification of nursing homes. This budget proposal is a direct challenge to the Congress because of the Congressional moratorium placed on the administration's regulations concerning the survey and certification of nursing homes.

That concludes my statement, Mr. Chairman.

Thank you.

Senator DURENBERGER. Thank you very much.

## STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, D.C.

Mr. CLAYMAN. Mr. Chairman, first, let me introduce Janet Myder, my associate, and also the associate research director of the National Council of Senior Citizens.

I also want to introduce for the record a statement captioned "Reagan Administration Fiscal Year 1984 Medicare Proposal."

Senator DURENBERGER. That will be made part of the record.

[The information from Mr. Clayman follows:]

## Reagan Administration FY 1984 Medicare Proposals

The President's FY 1984 budget proposals include a cut of $1.7 billion from Medicare. Unlike the provider-oriented proposals adopted by the Congress in 1982, these proposals are directed at the beneficiary and would raise cost-sharing to unprecedented levels.

The Medicare cut is being requested under a plan called "Health Care Incentives Reform."* This plan would "Provide Medicare catastrophic coverage," but only six-tenths of one percent of all beneficiaries will qualify. It would "Improve Medicare cost-sharing," but all hospitalized beneficiaries will pay a $350 deductible, plus up to $1,180 for hospital stays which now require $304 deductible and no patient co-payments.

The FY 1984 budget proposals will force the beneficiary to wait longer for Medicare eligibility, pay more for eligibility and services, and receive fewer benefits than under current law. The budget will discourage beneficiaries from receiving needed medical care and physicians from accepting Medicare assignment.

The major proposals, which include many that were made last year but rejected by the Congress, are:

° Institute New Part A Co-payment Requirements/"Catastrophic Coverage

In addition to the deductible (expected to be $350 in 1984), the hospitalized beneficiary would be required to pay $28 per day (8 percent of the deductible) for days 2 through 15 and $17.50 (5 percent of

*Department of Health and Human Services Budget Fact Sheet.

(Budget figures used in this paper were derived from the FY 1984 HHS budget document.)

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Prepared by: National Council of Senior Citizens, February 1983

the deductible) per day for days 16 through 60. No co-payment would be required after the 60th day and no more than two deductibles could be charged per year. Medicare would pay all covered hospital costs only after the 60th day. This latter provision is described by the Administration as "catastrophic protection."

- Currently, after meeting the $304 deductible, beneficiaries pay no co-payments before the 60th day of hospitalization. After the 60th day, daily co-payments of one-quarter to one-half of the deductible are required.

FY 1984 Budget Reduction: $710 million

Impact on the Beneficiary

- The FY 1984 proposal would shift beneficiary costs to the front end of hospitalization periods so that people with short stays would pay far more than under current law. For example, an 11-day hospital stay, the average for the elderly, which now costs the beneficiary $304 will cost $630 next year. Beneficiaries who require hospital stays longer than 60 days would pay less than under current law, but only two percent of those hospitalized stay longer than 60 days.

- Under this proposal, the average hospital stay will consume nearly two months' worth of a widow's average Social Security benefit of $375 or one-and-a-half month's worth of a retired worker's average benefit of $406. Since the need for hospitalization increases and income decreases with age, the older, sicker elderly will be severely penalized by this proposal.

- The Reagan Administration claims the co-payment will reduce unnecessary hospital use. However, people do not enter hospitals at will, but on doctors orders. NCSC believes the proposal will discourage many elderly people from receiving necessary medical care or impoverish them further when they need hospitalization. In addition, hospitals may turn away low-income elderly who cannot afford to pay their bills.

- While catastrophic protection is desirable for all beneficiaries, the Administration's strategy is deplorable. Only six-tenths of one percent of the 29 million Medicare beneficiaries, that is, two percent of those 7.5 million beneficiaries who are hospitalized, would ever qualify for it. In order to qualify, a beneficiary would have to be hospitalized 61 days or more and spend $1,530 out of pocket first.

- Thus the catastrophic "protection" that the Administration claims is "a psychological benefit that cannot be estimated in dollars" is hardly protection at all. It is a hoax designed to fool beneficiaries into thinking they will somehow benefit from paying more for hospital care. The reality is that all hospital stays under 60 days, and some over 60 days, will cost more.

- This proposal will assist the President in trying to balance the budget more than it will help the elderly in trying to pay for their health care.

° Raise Part B Deductible Requirement

The annual deductible for physician services (Part B) now fixed at $75 would increase annually as Medicare program costs rise.

FY 1984 Budget Reduction: ($50 million)

Impact on the Beneficiary

- Medicare does not reimburse for doctors' services until, under present law, the beneficiary spends $75 out of pocket. An increase in the required deductible will discourage some elderly from seeking medical care, particularly preventive services, due to the cost. The expected rise to $80 in 1984 and to higher levels thereafter will be greater than many elderly can afford.

- This is an example of prevailing Administration policy which, instead of controlling overall health care costs, punishes the elderly for their inordinate health care needs and for the out of control medical inflation that pushes up Medicare program costs.

° Increase Part B Premium Level

Higher percentages of program costs will be charged to the beneficiary through premium increases.

- The current $146 annual premium (deducted on a monthly basis from Social Security checks) due to increase to $162 on July 1, 1983, will increase to that amount on January 1, 1984, to coincide with the proposed Social Security COLA postponement. Thereafter, the premium, now set at 25 percent of program costs, will increase yearly until it reaches 35 percent. It is estimated that the premium could reach $379 per year by FY 1988.

FY 1984 Budget Reduction: none
($368 million cost, but the increased premium income between 1984 and 1988 is expected to be $9.3 billion)

Impact on the Beneficiary

- This is another example of punishing the beneficiary for inflation which has increased Medicare program costs.

- The options that the elderly will have under this provision are frightening to consider: Many will drop Part B coverage because they cannot afford it. If they need physician care, they will either forego that care due to lack of insurance coverage or will be burdened with unreasonable expenses. Ultimately, Medicare coverage will become a privilege for the rich.

° Delay Medicare Eligibility

- Persons reaching age 65 would not be eligible for Medicare until the first day of the month following their 65th birthday.

FY 1984 Budget Reduction: $215 million

Impact on the Beneficiary

Compared to current law, older persons would experience a 30-day delay before Medicare takes effect. The unemployed or those without adequate private insurance would be exposed to great financial risk. Some may forego needed medical care which would jeopardize their health.

° Freeze Physician Reimbursement Levels

The annual increase in physician reasonable charges reimbursable under Part B would not be granted in 1984.

FY 1984 Budget Reduction: $700 million

Impact on the Beneficiary

- Again the Administration is burdening the beneficiary for medical inflation. If physicians' fees do not increase, it is expected that few doctors will absorb the loss but will pass costs on to their patients. The elderly will find fewer doctors willing to accept Medicare B assignment and will have to pay higher fees as a result. (Only 50 percent accept assignment now).

° Offer Vouchers in Lieu of Medicare

A voucher would be granted to beneficiaries who opt for non-traditional Medicare coverage, and purchase their own health insurance in the private market. The voucher value would equal 95 percent of per capita Medicare program costs.

FY 1984 Budget Reduction: none

Impact on the Beneficiary

- The lure of a rebate may encourage some Medicare beneficiaries to take risks and purchase lower cost private insurance.

- A voluntary voucher could increase Medicare's costs as well as weaken and eventually destroy the program.

- The voucher could become mandatory and expose the elderly to deteriorated insurance coverage and unscrupulous salesmen.

° Pay Hospitals Prospectively by Diagnosis

Through a plan based on Diagnostic Related Groupings, (DRGs) Medicare would pay hospitals one fixed sum according to diagnosis of patients treated, rather than the current payment according to services used and length of hospital stay. For example, hospitals would be paid the same rate (with adjustment for local wages) for treating a patient with a broken hip requiring surgery, regardless of length of hospital stay, or number of services used. The Administration predicts that this method of prospective payment will force hospitals to operate economically efficiently.

FY 1984 Budget Reduction: Same as anticipated through the hospital reimbursement limits enacted through the 1982 Tax Equity and Fiscal Responsibility Act. ($1.5 billion)

Impact on the Beneficiary

- Prospective payment to hospitals is desirable as a cost-savings measure; it should be applied across-the-board to all insurors and all providers. If it is not, hospitals may discriminate against Medicare patients, and may shift costs to privately insured patients.

- The "DRG" plan could lead to inappropriately early discharge of Medicare patients, deteriorated quality of care, and possibly unnecessary hospitalization. Congress should alter the DRG plan to reduce these negative impacts.

Mr. CLAYMAN. Now, let me see if I can approximate to you what the ordinary senior citizen tells to his friends at his meetings with them—if I can do that, at least you will have a bit of the voice of the country.

For 2½ years I have been coming up the Hill for the National Council of Senior Citizens and other senior citizens' organizations have been doing likewise to testify on both sides of Congress' fighting a rearguard action to prevent the erosion of social security and medicare. And on both of these exceedingly important, necessary, and compassionate issues, we have failed in good part to prevent cuts to the elderly in fiscal 1982, again in fiscal 1983, and now still again battling to defend our older citizens from further blows to medicare in fiscal 1984.

What your committee and Congress generally call "cost sharing," we plainly call "cuts." I can tell you, at least out of my own experience, as I have traveled around the country to visit senior citizens, I find considerable disillusionment and frustration as well as an element of plain fear that their Government will do them in.

I am here to ask, to urge, to plead, if necessary, don't let it be done again. Enough is enough. Gnawing medicare piece by piece and inch by inch: And if we keep going at this rate, soon there will be little worthy or significant left in the medicare program.

We know, for example, that the cuts of 1982 and 1983, and as requested for 1984, will amount to a medicare budget cut of $18 billion by the end of fiscal 1988. And I don't know exactly what $18 billion is, but I know it's a good healthy bite out of that program which deals exclusively with senior citizens.

We know that medicare at best pays only 44 percent of a senior citizen's medical bills. We know that senior citizens spend about 20 percent of their income on health care; that the out-of-pocket cash expenditure on health per average senior citizen is $1,500. And ironically, they spend about the same proportion of their income on health care now as they did before medicare came on the scene. And the only thing that could mean is that medical costs have gone through the roof, and have deeply scarred and eroded the basic significance of the social role of medicare.

The essential problem is not that there are too many elderlies searching out medicare services, or that the elderly are abusing the system. The plain unvarnished truth is that too many medical providers have run unstrained and roughshod over senior citizens, Government, and, indeed, the total society.

Otherwise, how can one account for the fact that in 1982 the cost of health care rose approximately by 11 percent, while the general cost of living rose 3.9 percent? Now that's literally three times faster, higher than the general cost of living. And it seems to me this is the most serious problem that Congress has, and the problem it should focus on with great concern.

I remember, for example, just about a week or two ago an old gentleman testifying before Congressman Claude Pepper's health subcommittee and telling of lying in his hospital room, and a doctor came to him, felt his pulse, and subsequently sent him a bill for $110 for his services.

I don't know the details of the specific case. But I do know this, Senator. I know that everywhere I go—and while I don't travel as

much as I used to, I get around to a lot of senior citizens in various parts of the country—everyone virtually has the same kind of horror story. And then when I—I thought I saw a red light. Did I?

Senator DURENBERGER. Yes.

Mr. CLAYMAN. You want me to quit, don't you?

Senator DURENBERGER. Well, I can't really help it.

Mr. CLAYMAN. Let me close then.

Senator DURENBERGER. Let me say I would like to ask a question or two.

Mr. CLAYMAN. OK. Let me point out, since I am talking, as I assume I am, like a senior citizen, that I am. I told them just the other day, Monday, in Durham, N.C., about the cut in hospitalization. I told them that the average stay for an elderly citizen was 11 days; that there would be an increase in hospital costs that they would have to pay $28, from the second day to the 16th and then $17.50 each day, as I recall, for the balance of the time until the 65th day. And I said it would cost them for the 11-day stay $630 as against the current $304. The point of my story is from those 250 elderly people there, there came an audible gasp as though I had told them of some kind of a pending tragedy.

And I have a few other things to say, but I unfortunately wrote more notes than we can——

Senator DURENBERGER. We can certainly incorporate those into the record in addition to your statement.

Mr. CLAYMAN. You won't be able to read them. I will have to send them to you.

Senator DURENBERGER. That would be appropriate.

Mr. CLAYMAN. Thank you for permitting me 42 extra seconds.

[The prepared statement and additional information from Mr. Clayman follows:]

# Beneficiary Cost-Sharing Under Medicare

Statement by

Jacob Clayman
President

National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

Before the U.S. Senate Finance Committee
Subcommittee on Health

May 16, 1983

Mr. Chairman, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council represents over 4.5 million elderly persons in all 50 states through over 4,500 clubs and state councils. Since most of our members are Medicare beneficiaries, we are very concerned about proposals which would increase beneficiary "cost-sharing" responsibility under the Medicare program.

Our organization was founded during the long struggle to adopt a Federal health insurance program for the aged. Over the years we have worked toward the goals of a better life for senior citizens--one with dignity, as well as income and health security. A part of these goals, we believe, is a secure and adequate Medicare program. This goal has not yet been realized, though the achievements of Medicare have been great.

Mr. Chairman, Medicare and the Social Security law of which it is a part are two of the most significant and successful pieces of social legislation this country has adopted. These

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laws do far more than protect a financially and medically vulnerable population group. They also embody this nation's recognition that society is both responsible for and benefits from maintaining the relative financial and health security of all citizens whose risk of deterioration and dependence increases with age. Part of the value of workers' payroll taxes, therefore, is the improved condition of millions of older people who might otherwise be dependent on the uncertain support of family, Federal welfare programs, local governments, or charity.

July 30, 1983 will mark eighteen years since Medicare became law. What seems to be a relatively short time has been long enough for the elderly to benefit significantly from the program. Indeed financial access to health services and to consistent sources of care have improved the lives of millions of senior citizens. The two-year increase in life expectancy since 1965 has been attributed by some* to the Medicare program.

Unfortunately, eighteen years have been long enough for many of our lawmakers and others to forget why Medicare was adopted. They apparently have forgotten how vital it is, not only for the elderly's health, but also for the well-being of society. Those who forget or ignore these values claim that the elderly are better off today than ever before. In general this is true, but older people's improved status would not have been possible without vital programs such as Social Security and Medicare. However,

*Anne Somers, Professor of Community Medicine, New Jersey - Rutgers Medical School; statement before the 1982 Social Security Advisory Council, December 12, 1982.

in spite of these programs, poverty, dependence, and insecurity still exist for too many older persons. It is only through the strength of such programs that people who still suffer in poverty and dependence can be helped so that ultimately all can be protected.

Eighteen years have apparently been long enough to cloud people's memories in another area. They seem to think that Medicare meets the elderly's total medical needs, as we had originally hoped it would. Medicare is successfully accomplishing much of what it was designed to do, but it was not designed to do enough. The program insures against acute health care expenses, but not the chronic, long-term care expenses which can be catastrophic to older persons. It does not cover such necessary services as routine and preventive care, or the purchase of prescription drugs outside of the hospital, eyeglasses and routine eye care, hearing aids, and dentures or routine dental care. Consequently, Medicare covers, on the average, only 44 percent of the elderly's health care costs.

Medicare's benefit inadequacy and bias toward acute care, plus the mandated premiums, deductibles, and co-payments which continuously increase, have forced beneficiaries to spend more and more money out of their own pockets. Today, the Parts A and B deductibles and Part B premiums alone total $525. That is before Medicare spends one dime! Beneficiaries pay additional sums under Part B for physician service co-payments, for unassigned claims, and for hospital and nursing home co-payment requirements.

The combined effect on the elderly's incomes of current cost-sharing requirements and the cost of uncovered services is devastating. Today, senior citizens spend about 20 percent of their limited incomes on health care, nearly equal the proportion spent before Medicare was enacted. This proportion grows with every inflation point and increase in mandated cost sharing.

The Administration and the Congress are looking for ways to cut Medicare program costs. Many strategies under consideration would increase the beneficiaries' financial burden, in spite of the heavy cost-sharing burden that the Medicare beneficiaries currently bear for a program that falls far short of their needs. The National Council of Senior Citizens believes that before this Committee or any member of Congress deliberates the merits or demerits of cost-sharing, Medicare should be considered from several perspectives.

For example, we urge you to look at how Medicare helps individuals and society as a whole. To view Medicare only from a financial perspective fails to recognize its total value. Such a perspective could lead to policy which deteriorates the security of an at-risk population and which leads to increased long-term Federal expenditures and other social costs.

Indeed, the Congress needs to ask questions about Medicare spending, but members must not stop at: How much does it cost? The questioning should be broadened to include: Where does the money go? Who really benefits from the program spending? Why are costs increasing as much as eighteen to twenty percent annually? How much is enough to benefit the elderly and society?

The National Council of Senior Citizens believes that answers to these questions will provide some direction to the cost-savings, cost-sharing debate and help to formulate effective solutions.

We believe that another important perspective is a review of recent Congressional attempts to control Medicare spending. Since fiscal year 1982, cuts have been enacted that will reduce the Medicare budget by $18 billion by the end of FY 1985. This amount includes cuts of $4.1 billion in FY 1982 and FY 1983 which affect the Medicare beneficiary. For example:

- The Part A deductible was 27 percent higher in 1982 than 1981 ($204 to $260), more than double the historical increase. (It is now $304 per benefit period.)
- The Part B deductible for 1982 rose 25 percent over the 1981 level ($60 to $75).
- Part A co-payment levels for both hospital and skilled nursing facility care were increased.
- Part B open enrollment and deductible carry-over provisions were repealed.
- Reimbursement for services in certain free-standing detoxification facilities was repealed.
- Reimbursement levels to radiologists and pathologists were reduced from 100 percent to 80 percent requiring the beneficiary to pay new cost-sharing levels of 20 percent.

These cuts were made in an attempt to slow the growth of Medicare program costs and of the Federal deficit. We cannot see that either cause has been served very well. Health care inflation continues to soar (the rate for March of this year was 10.5 percent versus a CPI of 3.6 percent; for all of 1982 it was 11 percent versus a CPI of 3.9 percent). Medicare program costs continue to rise at 18 percent yearly. The beneficiaries' cost-sharing burden has grown (average annual out-of-pocket costs are

now estimated to exceed $1,500 per year). Medicare costs have been shifted to other health care payers (estimated by the Health Insurance Association of America to have been $6 billion last year and to exceed $7 billion this year). The Hospital Insurance Trust Fund is running low (CBO predicts deficits by 1988 or 1989). The Federal deficit is growing.

The point is, critical problems exist, and they must be solved. The Medicare program grows more expensive yearly, but provides an eroding, inadequate benefits package. The beneficiary's financial burden for health care is increasing, but beneficiary income is not. (Many of our members have asked if Congress will stop health inflation for the period during which their Social Security benefits are frozen.) The health care system is devouring resources without a proportionate return on investment for people of any age. The CPI is dropping, but medical inflation soars and shows no sign of abating.

The problem is that, in spite of three fiscal years of budget cuts, the health care system is still not economically efficient. Federal costs have merely been shifted to others. The needed control over health care costs across-the-board has not occurred, and, as the nation nears a health care crisis, the President and the Congress continue to push for further cuts in the Medicare program.

Unless Congress directs its cost-saving strategies toward the entire health system, it will not begin to solve Medicare's problems, which are a function of that system. For example, consider that 75 percent of Medicare dollars are spent on hospital

care. In 1982, the hospital inflation rate was 12.6 percent, and so far in 1983 it has been 12.5 percent. Yet, during this period the CPI has been dropping to levels one-third or less than the rates of general medical and hospital inflation.

It is estimated that over one-half of hospital inflation in the last few years resulted from price increases. Only a small fraction is due to increased admissions and intensity of services used or the aging of the population. This pattern is reflected in Medicare program costs. How can tinkering with the Medicare budget effect any real or long-term savings while the health system remains the most highly inflated sector of our economy? It cannot.

The National Council of Senior Citizens urges you to recognize that adjustments to the Medicare budget will have only a minimal impact, if any, on the health system. As the Congress settles for short-term budget strategies, without tackling the major financing and delivery components which contribute to medical inflation, rising costs will continue to ravage the economy and the health care budgets of the young, the old, and the Federal government.

In this context, the prospect of changing beneficiary cost-sharing under Medicare raises many questions and issues. I would like to submit for the record NCSC's detailed analysis of the President's Medicare proposals. Now I will bring some important points to your attention.

- <u>What is cost "sharing"? Who "shares"? What is "shared" and why?</u>

  As we see it, cost "sharing" is just a euphemism for cost shifting, burden bearing, and solution evading. Proposals to increase beneficiary cost-sharing would

mandate that the elderly and disabled share the Federal government's costs while the contributors to rising costs are left alone.

- What are the goals of cost-sharing?

The Administration and other advocates of increased deductibles, premiums, and co-payments claim that cost-sharing will produce a cost-conscious consumer who will demand fewer allegedly unneeded services and somehow pressure doctors and hospitals into cost-efficient behavior.

Cost-sharing, then, would be the Medicare beneficiaries' contribution to "cost containment". The beneficiaries would share not only part of the Federal government's Medicare costs, but also a large portion of its responsibility for cost control.

- Will cost-sharing work? Is it an effective and equitable solution to Medicare's rising cost problem?

No. The National Council of Senior Citizens believes that, in addition to the fact that beneficiaries already carry a heavy cost-sharing burden, any proposal to increase cost-sharing would be an entirely inappropriate method of trying to solve serious Medicare financing problems. Many variables preclude its effectiveness as a cost-containment tool. Moreover, serious consequences for the beneficiary as well as the Federal budget can result. Here are some examples:

° The assumption that the consumer of health care controls usage or influences spending is false.

Physicians make 70 percent of the decisions. It is the physician's judgment not that of the patient which determines hospital admission and use of diagnostic technology, prescription drugs, laboratory and radiological tests, ancillary services, institutional vs. out-patient care, etc.

The health consumer is rarely, if ever, a participant in the decision-making process which leads to hospital construction and expansion or equipment purchases, leading causes of rising medical costs.

If demand for services were to decrease for any reason, physicians could still generate demand and maintain a desired income level. In testimony on April 23, 1983 before the Social Security Advisory Council studying

Medicare, several physicians' groups voiced opposition to mandatory assignment in part due to the income loss to the physician. I am not commenting on what an appropriate reimbursement level is, but I will read several quotes from physicians to illustrate what physicians can do if they perceive that their income or the demand for their services is threatened.

"I would be forced to increase my fees and collect more from non-Medicare patients, since I would experience a considerable loss since I have a large geriatric practice."

"...there is an incentive to order more tests, increase the frequency of visits, etc., to increase the total bill in an effort to maintain income to the physician."

"May increase visit frequency or length of stay to recover money lost by reduced payment on assignment."

(All of the above quotes are included in written testimony submitted to the Social Security Advisory Council on April 6, 1983 by N. Thomas Connally, M.D., on behalf of the American Society of Internal Medicine.)

° Increases in cost-sharing can lead to undesirable consequences for the beneficiary, the Federal budget, and the taxpayer.

Since cost-sharing is not cost-containment or cost-control, it will not lead to the delivery or financing changes needed to render the health care system more efficient. The cost of health care for all people will therefore continue to rise.

The elderly or disabled beneficiary will be placed at risk medically and financially. The patient who is unable to pay or fears the unpredictable out-of-pocket costs of health care may make decisions in one of the few areas where he/she has control: the initial decision to seek needed care. Early medical intervention is critical in heart disease, stroke, and cancer which account for 75 percent of all deaths in the population age 65 and over. We cannot even begin to calculate the risk to beneficiaries who might have early symptoms of these diseases but postpone or forego medical care because of cost-sharing. We believe that such behavior also could increase Part A costs.

The cost-sharing proposed under Part A by the Administration would penalize the sick elderly by placing the burden of Federal savings on those who need hospital care. In general, this group is comprised of older beneficiaries with lower income, but higher medical expenses. Income decreases with age but medical need increases. Supplemental "medigap" insurance would be of deteriorating value because rising out-of-pocket costs increase premiums beyond the reach of many elderly persons. (Our detailed analysis of this proposal is being submitted separately for the record.)

Access to medical care for people with low income and/or high medical needs will be impeded. Since the elderly's health needs and morbidity rates are great, income level is not necessarily an indication of an older person's ability to pay for care. However, no citizen should be prevented from receiving appropriate and timely services because of a misdirected "cost-savings" policy.

Hospitals' bad debts problems could grow under new cost-sharing policies. If beneficiaries cannot pay their bills, these debts become costs to other payers such as private insurors and Medicaid or other public programs. To avoid such problems, hospitals might turn away Medicare beneficiaries they perceive as bad financial risks. (The new DRG plan may encourage hospitals to do so.)

Cost-sharing can also erode the capacity of Medicare to fulfill its mandate to protect a high risk population and reduce their dependency levels. The less that Medicare can protect, the greater will be the dependency of a growing elderly population on others for financial, medical, and physical assistance.

This eroding protection risks workers' confidence in the program. If they feel that their payroll taxes go to a program that cannot adequately protect today's elderly, how can they feel confident that when they grow old they too will benefit?

There are many other reasons why cost-sharing would be a misdirected policy. Some studies (Roemer) have shown that cost-sharing can <u>increase</u> government expenditures when lower cost, more timely services are forgone. Others (Rand) have not included elderly people in their studies, nor have they identified the short- or long-term health status consequences of cost-sharing.

We believe that estimates of the administrative costs to providers should be made, and that the long-term health and cost effects of increased cost-sharing should be identified.

Is it sound public policy to risk the elderly and disabled citizen's future health and the Federal government's future expenditures for short-term "savings" which have certain short-term costs? The National Council of Senior Citizens considers this approach to be very poor public health and budget policy. There <u>are</u> better ways to save Medicare dollars. Cost-saving plans must begin with the larger health care system.

Unless and until the costs of our health care system are brought under control, no amount of cost-sharing or other budgetary devices will help Medicare. Furthermore, the cost to the beneficiary of such ineffective strategies would be too high. The threat of Hospital Insurance Trust Fund insolvency has surfaced with enough advance warning for Congress to adopt carefully developed and equitable methods <u>outside</u> of the budget process to assure Medicare's future protection. We also believe that the opportunity exists for Medicare program improvements to be made in such a way that the beneficiary and the trust funds will be better off.

We believe that Congress has the obligation to control the rising cost of health care for the benefit of <u>all</u> citizens, and that this can be accomplished through a sensible approach. Many plans are under consideration and others are being developed.

The plans that can succeed are those which instill economic efficiency into our health system. They are targeted to the causes of rising costs and to the real decision-makers in the

system. With a firm Federal commitment, these plans call for prospective payment to assure that the providers take the financial risk for their actions. The plans include all payers and all providers to avoid cost-shifting. Such plans also require the states to participate in cost-control programs. Finally, the plans that can succeed also assure quality of care and preserve access to services, without increasing the financial burden of the beneficiary.

Are such plans possible? The NCSC believes they are, but not as long as the Congress seeks short-term budget savings regardless of the cost to people. Therefore, we urge you to take a broader approach to Medicare financing. We stand ready to work with you and your staff in developing a sensible approach. We firmly believe that the solutions which Congress ultimately adopts must not fail the elderly or any other citizen who needs health care.

Senator DURENBERGER. Let me go to North Carolina, then, for purposes of asking my first question. Suppose you had presented to this group of senior citizens this proposal: Did you know that despite all the horrible things they have done in the last couple of years, the Reagan administration is proposing a plan to provide catastrophic health care coverage so that people who are hospitalized more than 60 days per year will not be required to pay the huge sums of money that are now required? I suppose there would be a gasp that anything like that could come out of this administration. Would there be that gasp? Or would they be pleased to hear that kind of information?

Mr. CLAYMAN. Incidentally, we have written to them and they have the full story. But I did not use it in my speech. Answering your question, honestly, obviously, if they had the choice of would it be one or the other, I have no doubt that they would accept the present situation as against the totality of the new recommendation.

Senator DURENBERGER. All right. I find it hard to believe that most medicare qualified persons would turn down an opportunity to get catastrophic coverage. The question is whether we pay for it through a premium or we pay for it by other people who get sick for less periods of time, or is there some other alternative.

Mr. CLAYMAN. Let me quickly add my final note to that point. They would like that in addition. But they would rather not pay the price that is being asked. That's the point.

Senator DURENBERGER. All right.

Mr. CLAYMAN. Because the greatest number of them are susceptible to the first item rather than the last.

Senator DURENBERGER. All right. I understand.

Jim?

Mr. HACKING. Mr. Chairman, I certainly agree with what Mr. Clayman has said here. The administration has proposed a catastrophic protection feature but not in isolation. There is a tradeoff. And the tradeoff is increased cost sharing up front with a net gain to the medicare system. That's not the kind of catastrophic protection feature that we want to see introduced.

I would also point out that the catastrophic feature they are talking about applies only to inpatient hospital services. It does not cover the major cause of financial catastrophe for the elderly the cost of nursing home care.

Senator DURENBERGER. So that if we could find another means of financing it, even though it is coming from medicare eligible persons, it might be more acceptable.

You wouldn't argue with the point that one of the things that is right now missing from this medicare system is that sense of preventing the cost of the catastrophic illness, would you?

Mr. HACKING. I wouldn't disagree with that.

Mr. CLAYMAN. I would not disagree with that, but I would not have a tradeoff that is being suggested. I think it does violence to the future of senior citizens.

Senator DURENBERGER. I think you got at this in your testimony, Jim. On the issue of the physicians, I certainly can understand your concern about the impact that a freeze on physician fees, as recommended, could have on beneficiaries. Do you have for us a

recommendation as to how we might hold down the rate of growth in part B of this program while at the same time encouraging physicians to take assignment?

Mr. HACKING. Well, Mr. Chairman, some years ago we urged that consideration be given to an across-the-board limit on the rate of escalation in physician fees, not just in medicare, but across the board. There might be some considerable merit in that.

However, given the current situation where the physician is free to accept assignment or refuse it, to do something that is going to make the physician less likely to accept assignment will merely result in a shift of additional costs onto the beneficiaries themselves. There has been quite a bit of that going on. I did cite the evidence from the economic stabilization period that indicated that physicians were significantly less willing to accept assignment when their medicare fees were frozen.

Senator DURENBERGER. Have you looked at the prospect of our requiring publication of lists of physicians that will accept assignment?

Mr. HACKING. We've always been advocates of that. And we still are. That would be very helpful. However, we see no progress being made in that direction.

Let me ask my colleague, Mr. Christy, if he has anything to add on this point.

Mr. CHRISTY. I think bringing physicians under the DRG's would be a valuable and positive step. I think that when the doctors realize that there are going to be limitations on the amount of services they can provide patients in the hospital, they will start thinking more directly about the cost of those services and their requirement of hospitalization. So I think that should be the next step.

Senator DURENBERGER. Jacob, do you disagree with that general direction in terms of what we do about the part B side of medicare? I think the last suggestion was that we should have a DRG system for part B as we have for part A.

Ms. MYDER. I would agree with what has been said. I think the point is that short of mandatory assignment some method has to be pursued to either have doctors willing to take assignment or another provision, whether that be a prospective payment or something that would control the increase.

Senator DURENBERGER. I appreciate your testimony. And if there is any desire to elaborate on your testimony here today, the record will be open for that purpose. So thank you very much for your testimony.

Senator DURENBERGER. I understand we have an agreement that our next witnesses be Mr. Alex McMahon and Jack Owen, president and the executive vice president respectively of the American Hospital Association of Chicago, Illinois. We thank you for your patience. And thank you for your expertise. You may proceed. Your printed statement will be made part of the record.

## STATEMENT OF J. ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. MCMAHON. Thank you, Mr. Chairman. In that case I will summarize it just briefly.

Mr. Chairman, we put cost sharing in the same category as the prospective payment proposal that we discussed with you and the committee before. We worked with you on the prospective payment, and look forward to doing so on the cost sharing issue because we don't agree with some of the witnesses that say it is only a transfer of funds. We think it can, properly implemented, effect demand.

On pages 2 to 4 of my testimony we mention the fact that we view cost sharing from two perspectives. First, properly done it can promote cost consciousness by the patient. We recognize that the current system of minimal cost sharing encourages demand. And minimal cost sharing can induce the demand, with inappropriate consequences.

Second, minimal cost sharing can't protect the solvency of the health insurance trust fund, as discussed on pages 4 through 7.

The situation is getting worse because of the growing elderly population and increased utilization. Something must be done.

Beginning on page 7 we set forth some options for dealing with the problem of the solvency and the demand issue; raising revenue, which is difficult; reducing payments has even more difficulty. If we were going to do anything substantial, it would mean horrendous reductions in payments to hospitals and doctors. They would be cut in half with obvious implications for the willingness to provide services to the beneficiaries.

We didn't mention the voucher system directly, but we do support the voucher system because our benchmark is the changing of incentives. Unfortunately, the voucher system doesn't seem to be gaining a great deal of support. But our faith in it, our belief in it, our support of it is unwaivering.

On page 1 we set forth some guidelines because we think that cost sharing can promote cost consciousness on the part of the beneficiaries, but it must be predictable, equitable, and understandable.

We dealt with the specific proposals from pages 12 to 19, giving first attention to the administration's proposal. The administration's proposal, Mr. Chairman, isn't tailored to the new prospective pricing system. It is still appraised in terms of per diem costs. It doesn't vary depending upon the selection of the hospital. We think that's unfortunate. We believe there ought to be some interest on the part of the beneficiary to look at hospital costs and go to the lesser cost hospitals when those hospitals can, indeed, provide adequate care.

We don't think we have to worry about promoting early discharging on the part of the individuals anymore because the hospital under the DRG system is obviously motivated to do that. We do think that cost sharing could be tied to income.

In addition, we do support the catastrophic limits.

From pages 16 to 19 we come to the key part of our testimony: the urging of a careful look at the assignment, nonassignment option. We urged this, as you may recall, in our original prospective price proposal announced earlier this year. We think it can help both cost consciousness on the part of beneficiaries and, indeed, can help with the solvency question of the hospital insurance trust fund.

Medicare would make its payment in full to a hospital taking assignment with whatever cost sharing that might be required with hospitals taking assignment. If a hospital didn't want to take assignment because it couldn't bring its costs down to what will be the prospective price system, then obviously the beneficiary would pay more.

That choice can avoid cost shifting to other patients by those hospitals that cannot bring their costs down to a DRG limit. But we think most hospitals would accept assignment for two reasons.

In the first place, most of them are community institutions with substantial community pressure; particularly, from the elderly. You just heard testimony as to how strongly the elderly feel. They are going to get involved in the act of encouraging hospitals to take assignment. Second, a hospital with a substantial medicare case load is going to do everything it can to make sure that it remains in a competitive position in order to keep those patients. We think the assignment and nonassignment option does, deal with the incentives on both the part of the beneficiaries and on the part of the institutions.

In summary, Mr. Chairman, we know there is a difficult problem facing the health insurance trust fund. We know that prospective pricing can help. We think the voucher would help as well, but it can't do everything. I think we are going to need some kind of cost sharing, but it ought to be tailored to this new payment system. We don't think the administration's proposal as it has been designed does that.

Cost sharing should encourage cost consciousness. It should also encourage the use of the lower cost institutions. That's why, again, we come back to the assignment, nonassignment option because it ties in with some of the other approaches that you are thinking about. It's similar to a voucher. Assignment/nonassignment requires some advance planning by the beneficiary. To that extent it deals better with the individual faced with cost sharing at the time of illness. We think it well deserves your consideration.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. McMahon follows:]

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Cable Address: Amerhosp

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE COMMITTEE ON FINANCE
ON
MEDICARE AND MEDICAID COST SHARING

May 16, 1983

Mr. Chairman and members of the Subcommittee, I am John Alexander McMahon, president of the American Hospital Association (AHA). With me is Jack W. Owen, executive vice president and director of its Washington office. The AHA is the principal national organization of hospitals, representing 6,300 institutions and 35,000 personal members.

Thank you for giving me the opportunity to present the AHA's views on cost-sharing requirements under the Medicare and Medicaid programs. I want to commend you and your colleagues for your efforts to gain control over the rapid increase in health care spending by changing the incentives to achieve more cost-conscious behavior.

The AHA views beneficiary cost-sharing proposals from a dual perspective: one of promoting greater cost consciousness on the part of the consumer to moderate demand and the utilization of health services; the other as a necessary element to ensure the continued viability of the Medicare Hospital

Insurance (HI) trust fund, while protecting the ability of hospitals to meet the needs of their communities for hospital care and ensuring access for Medicare beneficiaries.

Promotion of Consumer Cost Consciousness

Health care expenditures, particularly for Medicare and Medicaid, have risen dramatically since the mid-1960s. National health expenditures increased from $41.7 billion [6 percent of the gross national product (GNP)] in 1965 to $286.6 billion (9.8 percent of the GNP) in 1981. For Medicare, program costs have increased since Fiscal Year 1967 from $4.5 billion to $46.6 billion in 1982 and are projected to reach $59.8 billion in FY 1984. In the Medicaid program, federal outlays have increased from $1.5 billion in 1967 to $17.4 billion in 1982, with $21.0 billion estimated in FY 1984.

There are many reasons for this rapid increase in program outlays. But it is important to keep in mind that the increase in expenditures was a necessary and appropriate response to the incentives originally built into the Medicare program. The pressing need in 1965 was to expand access--which means the use--of hospital care. The program incorporated expansionist incentives to achieve this goal: cost-based payment of hospitals, fee-for-service payment of physicians, and limited consumer cost sharing. The response to these incentives should have surprised no one: increased availability of services by hospitals and increased use of services by beneficiaries.

Just as the system of cost-based reimbursement discouraged efforts by hospitals to improve productivity or to limit the acquisition of specialized technologies or services to those that could be economically supported by existing patient loads, so the cost-sharing provisions originally built into Medicare discouraged the use of less costly alternatives to inpatient hospital care by the patient. The adoption of prospective pricing as the basis of hospital payment will require hospitals to develop lower cost ways of providing hospital care, without compromising quality. The adoption of rational, carefully constructed beneficiary cost sharing provisions would lead consumers to consider the use of less costly alternatives to inpatient treatment.

It is generally accepted that extensive coverage of health care costs by third-party payers (insurance companies, Blue Cross/Blue Shield, Medicare and Medicaid) have exacerbated the rapid increase in health care costs. Third-party coverage, by insulating consumers and beneficiaries against the full cost of health services, tends to encourage patients to utilize services without significant consideration of the cost. The goal, then, of increased cost sharing is to encourage patients and providers to use more economical health services, to increase price competition among providers, and to encourage providers to hold down prices in response to the threat of losing patients.

The theory that increased cost sharing would affect the demand for health services by lowering the use of such services is now firmly established. For

example, preliminary results of the Rand Health Insurance Study indicate that price affects both the number of people using medical services and the number of ambulatory visits per user. Although the study does not include the elderly population, if persons 65 and over respond in the same manner as younger persons, increased cost sharing under Medicare would result in a lower use of services and, as a result, reduce health expenditures.

Many are concerned about the effect on health status of reduced services associated with cost sharing. Unfortunately, information on health status impacts is not available. Many fear that increased cost sharing would cause patients to forego early treatment and diagnostic procedures or preventive care which could result in lower health status and, eventually, higher health costs. Moreover, low-income patients may not have the funds to pay for services. Although these issues deserve serious consideration, cost-sharing strategies can be constructed in such a way as to avoid negative consequences to health status.

Hospital Insurance Trust Fund Insolvency

Perhaps the most difficult and alarming issue facing the Congress is the projected insolvency of the Hospital Insurance (HI) trust fund. The HI trust fund covers inpatient hospital care, post-hospital care in skilled nursing facilities, and home health services for persons confined to their homes who need skilled nursing or medical care. It is financed primarily from a portion of the Social Security payroll tax. Employers and employees covered by Social

Security each contribute 1.30 percent of earnings up to a maximum of $35,700; the HI tax rate is scheduled to rise to 1.35 percent in 1986.

The HI fund is in a dilemma similar to that facing the Social Security retirement program this year. It is confronted with the same kinds of problems such as demographic changes, increasing benefit expectations, advances in medicine, and slow economic growth. According to recent estimates by the Congressional Budget Office (CBO) and Social Security actuaries, the HI fund is expected to be depleted between 1988-1990.

Perhaps one of the more significant of these factors is that the elderly represent the fastest growing segment of our population. Consider these projections:

- The number of persons covered by Medicare grew from 19 million in 1967 to 25 million in 1982 and is expected to reach 32 million by the turn of the century;

- The total population age 65 and over stood at 24.9 million persons in 1980 and will increase to 31.8 million by the end of the century--an increase of 27 percent;

- The growth of the elderly population will begin to rise dramatically about 2015 and continue to increase, peaking in 2030, when the effect of the "baby boom" will be fully realized and the elderly will comprise approximately 18 percent of the total population;

- Another significant factor is the "graying" of the population age 65 and over. Between 1980 and 1999, the population aged 75 to 84 will increase by nearly 50 percent. During the same period, the population aged 85 and over is projected to increase 61 percent; and

- Average male life expectancy increased from 66.8 years in 1965 to 69.9 in 1979. For females, it increased from 73.7 to 77.8 years.

The aging of the population already has increased utilization of health care at higher levels of intensity, a trend that is expected to continue. Persons aged 65 and over account for nearly 30 percent of all personal health care expenditures and 43 percent of all hospital expenditures.

AHA utilization projections indicate that hospital use by the elderly will account for approximately 35.2 million more days of hospital care in 1989 than in 1980. Fifty-two percent, or 18.4 million days, will be due to population growth, and 48 percent, or 16.8 million days, will be due to increases in the inpatient day use rate.

Hospital expenditures per capita per year also increase with age. For those over age 65, expenditures are $869 per capita, compared with $370 per capita for those between 19 and 64. Moreover, the percentage of the population suffering from chronic conditions increases from 8.9 percent in the 17-to-44 age group, to 24.1 percent in the 45-to-64 age group, to 46.4 percent for those over 65.

In addition to demographics and utilization, hospital costs are a key factor in the HI financing problem. According to CBO, Medicare payments to hospitals are projected to increase at an average annual rate of 13.2 percent, of which 10.8 percent will be attributable to rising hospital costs. But 6 percent of this 10.8 percent annual increase is due to hospital input price increases, such as labor, capital goods, and supplies, over which hospitals have little control.

Finally, earnings on which the HI tax is applied are growing at a much slower rate than HI expenditures. Over the 1982-1995 period, covered earnings are projected to grow at an annual rate of only 6.8 percent, compared to 13.2 percent for expenditures. This results in a difference (deficit) of 6 percentage points.

## OPTIONS FOR HI SOLVENCY

A variety of options are under discussion to reduce Medicare expenditures and to solve the long-term financing problems of the HI trust fund. The options tend to fall into the broad categories of raising revenues, restraining the rate of increase of Medicare payments to providers, and increasing beneficiary cost sharing. I will briefly discuss these three categories.

Raising Revenues

One way to increase revenues is to raise the payroll tax rate. As mentioned previously, the tax currently paid by employers and employees is 1.30 percent of covered earnings and is scheduled to rise to 1.35 percent in 1985 and 1.45 percent in 1986. According to CBO, maintaining solvency through payroll tax increases alone would require increasing the tax rate steadily to 2.54 percent by 1995 and continuing to increase it thereafter.

Likewise, utilizing general revenues may be an option. However, given the size of the amount of revenues that would be needed--$73.8 billion per year by 1995--taxes would have to be increased considerably.

Restraining Payments to Providers

Because 70 percent of HI trust fund expenditures are paid to hospitals, much attention has been focused on restraining the rate of increase in hospital Medicare payments. As you know, this past March the Congress enacted the most fundamental change in the way Medicare pays hospitals since the enactment of the program. The new prospective payment system for inpatient hospital services is intended to change the incentives for hospitals by rewarding cost-conscious management.

The AHA strongly supported the adoption of a prospective payment system and, during last year's hearings on the FY 1983 budget, called for an end to

short-term, narrowly focused "tinkering" with the Medicare reimbursement system, and made a commitment to work with the Congress on long-range structural reforms. Over the past year, the AHA fulfilled its commitment and worked closely with you, Mr. Chairman, towards the enactment of just such a system. We believe that hospitals have accepted the responsibility of reforming the structure of health care financing and therefore have taken an important first step in containing costs and in helping to stabilize the HI trust fund.

Prospective pricing will not bring more money into the health care system for hospital payment. It will, however, reward hospitals which change behavior appropriately. Shorter lengths of stay, cost-conscious use of ancillary services, and greater attention to productivity, wages, and prices are the keys to changing hospital incentives and ultimately will benefit the trust fund. Although long-term projections of the impact of prospective payment on the HI trust fund are not available, we believe that the behavior change which will result from the new incentive payment system will make an important contribution to the trust fund's continued financial viability.

Unfortunately, some believe that sharp reductions in Medicare payments to hospitals should be the primary focus of attempts to stabilize the HI trust fund. If this were to occur, according to CBO, maintaining solvency by payment reductions alone would require hospital payments to average 42 percent less by 1995 than they would have been under cost reimbursement. This translates into an annual rate of increase per hospital admission of hospital

input prices minus 1.6 percentage points, creating a large gap between the price of hospital services and the amount hospitals would be paid. Such a large discrepancy between price and payment could lead to reduced access to services for Medicare beneficiaries. Therefore, we caution the Congress to consider seriously the negative consequences of tying HI trust fund solvency to prospective pricing alone.

Increasing Cost Sharing

Changing the structure of Medicare benefits to increase cost sharing by beneficiaries represents another option to reduce Medicare expenditures and stabilize the HI trust fund. Greater cost sharing could achieve savings in two ways: directly, as a result of increasing the financial responsibility of beneficiaries for medical costs; and indirectly, by discouraging the use of health care services.

None of the cost-sharing options of which we are aware would generate enough savings to more than postpone the onset of insolvency for a few years. Indeed, to eliminate the trust fund deficit through greater cost sharing would require a very large increase in costs to beneficiaries, an increase that would be unacceptable to most people. What is becoming increasingly clear through the examination of various options--raising revenues, payment reductions to providers, increased beneficiary cost sharing--is that no one option alone would be effective and acceptable in solving the problems of the HI fund. What will be necessary is an appropriate mix and design of health care reforms, including beneficiary cost sharing.

## GUIDELINES FOR COST SHARING

When options for beneficiary cost-sharing are being considered, we believe a set of guidelines must be followed. The benefit structure should:

(1) Establish consumer incentives consistent with the changing priorities and resources of the Medicare program and the new provider incentives created by the adoption of prospective pricing. Specifically, consumer cost-sharing should promote cost consciousness:

   a. in the decision to use inpatient hospital care or to choose a less costly alternative such as outpatient treatment;

   b. in the choice of a hospital provider.

(2) Be predictable, so that patients are aware of their potential out-of-pocket financial liability at the time they decide to use a service or choose a provider.

(3) Be equitable, so that patients would not be denied access or experience undue financial burdens on patients who are seriously ill and require intensive medical/hospital care.

(4) Be simple, easy to understand and administer, to avoid an increase in the costs of program administration and to avoid confusion on the part of beneficiaries.

## COMMENTS ON SPECIFIC PROPOSALS

### Part A Restructuring

Medicare currently covers only 90 days of inpatient hospital care per spell of illness, with a special lifetime reserve of an additional 60 days. There is no cost sharing for the first 60 days of any spell of illness, after the first day deductible of $304 ($350 in 1984). Coinsurance of $76 per day is required for days 61-90 and increases to $152 for 60 lifetime reserve days. Medicare also covers up to 100 days of care in a skilled nursing facility per spell of illness. After the 20th day, coinsurance equal to 12.5 percent of the hospital deductible ($36 in 1983; $43.75 in 1984) is charged per day.

The Administration proposes to restructure the Medicare Part A benefit to provide coverage for unlimited hospital days. The existing deductible applicable to the first day of hospital care would remain in place. Cost-sharing requirements would be revised by imposing coinsurance equal to 8 percent of the deductible (about $28 in 1984) on days 2 through 15 of a spell of illness. After day 15, the coinsurance amount would drop to 5 percent ($17.50). After the 60th day, no beneficiary would be required to pay either a coinsurance or a deductible (catastrophic cap). The coinsurance rate for days 21 through 100 of care in a skilled nursing facility would be reduced from 12.5 percent to 5 percent of the hospital deductible.

The AHA supports the intent of the Administration's Part A restructuring. We view this as an important first step in approaching the demand side of the health care equation by injecting more cost consciousness on the part of the beneficiary. Moreover, by providing catastrophic protection, the proposal would remove the financial burden--and the fear of devastating costs--from the most seriously ill beneficiaries.

However, we would like to bring to your attention several issues regarding the Administration's cost sharing proposal which we believe deserve serious consideration.

The prospective payment legislation recently enacted through the Social Security Amendments of 1983 (P.L.98-21) moved away from retrospective cost-based reimbursement as the basis of hospital payment for the Medicare program. The approach to prospective payment adopted by the Congress sets prices according to diagnostic-related groups (DRGs), severs the traditional relationship between Medicare payment and costs, and puts the the hospital "at risk" for differences between its costs and the DRG prices. We believe that any restructuring of the Part A benefit must consider the design of prospective payment as the basis for that restructuring.

First, the existing cost-sharing benefit and the Administration's proposed cost sharing continues to be based on the per-diem cost of a hospital room. This results in a two-track system: a cost-based beneficiary cost sharing system and a prospective hospital pricing system. Since we are moving to a

pricing structure for Medicare through the prospective payment system, we believe it would be more appropriate to relate cost sharing to the price.

Second, under the Administration's cost sharing proposal, all beneficiaries would pay the same amount of out-of-pocket expenses. Because of the equal payment, beneficiaries would be, at best, financially indifferent to choosing a less costly hospital. Such a benefit design therefore, would offer the beneficiary no financial incentive to utilize a lower-priced hospital. We beleive that in order to inject true cost consciousness on the part of the beneficiary, any cost-sharing proposal should be so designed that the amount of cost sharing would depend upon the hospital selected by the beneficiary. In fact, if the prospective price is set at an adequate level to cover the hospitals financial requirements, it may be possible for the hospital to deliver the needed service without the necessity of beneficiary cost-sharing.

Also, under some circumstances such as short lengths-of-stay, the amount of cost sharing under the Administration's proposal could be more than the hospital's price for the service. This would result in a beneficiary's out-of-pocket expense being higher than the hospital's price. We believe such a situation would be inequitable to beneficiaries and recommend that provisions be included in any cost sharing proposal to prevent this occurence.

Third, designing cost sharing to encourage beneficiaries to seek early discharge may be unnecessary. The prospective payment legislation itself provides strong incentives to hospitals to discharge patients as early as

medically feasible. Failure to do so places the hospital at financial risk, since the cost of additional days of care beyond the DRG price will not be paid. Therefore, hospitals and attending physicians will have the incentive to shorten lengths-of-stay.

Fourth, the Administration would remove the limit on the number of days of hospitalization covered by Medicare during a spell of illness. In addition, the proposal would require no more than two inpatient deductibles during any calendar year, even if there were three or more spells of illness in that year. We agree with the Administration's intent to separate cost sharing from the spell-of-illness criteria. Cost sharing applied to spells of illness has proven to be an administrative burden to the beneficiary, the hospital, and the federal government because each time a beneficiary is admitted to a hospital, eligibility needs to be verified.

We now would like to bring to your attention another issue which should be considered when designing beneficiary cost sharing: the need to protect against catastrophic financial losses.

Perhaps the greatest fear among beneficiaries is the possibility of incurring large financial obligations due to severe and prolonged illnesses. According to a recent CBO study, about 11 percent of elderly Medicare enrollees had reimbursements in 1978 of $5,000 or more (in 1984 dollars). Enrollees using extensive Medicare-covered services are more likely to be older, have at least one period of hospitalization, and die during the year than are elderly

enrollees in general. Although income data are not available for these large users, according to CBO, the average income of those aged 80 and above is only 81 percent of incomes of persons aged 65 through 69, indicating that a disproportionate share of these high users of services also have limited incomes.

Since cost sharing for such persons could increase their liability substantially, a liability they may not be able to afford, we believe that options to expand cost sharing should be designed with a financial limit. Moreover, a maximum total liability, in addition to protecting against large financial losses, would help ensure that beneficiaries would not forego needed health services because of inability to pay.

Assignment/Non-Assignment Option

Since 1972, the federal government has reduced the rate of growth in Medicare payments to hospitals. This reduction began with the 1972 Social Security Amendments' (P.L.92-603) schedule of cost limits--the so-called Section 223 cost limits--which classified hospitals according to groups based on bed size and location and placed a limit on the amount Medicare program would pay for hospitals' daily inpatient operating costs. Since 1972, the federal government has continued to "ratchet-down" on the level of the cost limits, and in 1982, under P.L.97-248, the Tax Equity and Fiscal Responsibility Act, it expanded the Section 223 limits to cover Medicare payments for ancillary and special-care unit costs as well as routine operating costs, and applied

the limits on a per-case basis. In addition, a rate-of-increase target rate was established which created incentives for hospitals to hold their costs below the target rate by providing them with a "bonus," and imposed a penalty for costs exceeding the target.

The prospective payment legislation recently enacted moves further in holding down Medicare payments by paying hospitals on the basis of average prices within diagnosis-related groups (DRGs) and moving from hospital-specific rates to regional and national rates. And given the projections of insolvency of the HI fund by the end of this decade, the Medicare program, of necessity, is becoming a program with tighter financial limits. These trends make it inevitable that Medicare beneficiaries must accept more of the payment burdens for services that are more costly than the government is willing to finance.

It is on this basis that we believe hospitals must be given an option of "nonassignment," that is, to be able to charge beneficiaries amounts beyond the Medicare payment. The nonassignment option is not intended as a substitute for other forms of cost sharing but is necessary to prevent some hospitals from incurring financial losses resulting from their participation in Medicare, and to continue to provide services to Medicare beneficiaries who desire to ultilize a particular facility.

We view the assignment/nonassignment option as similar to the concept of preferred provider organizations. In this case, the Medicare program would pay for all costs (less the usual cost-sharing) in assigned hospitals. But if

the patient wishes to use more costly providers or levels of services than can be supported by the Medicare payment, the beneficiary would incur additional out-of-pocket expense.

Currently, hospitals serving communities or patients that demand a more costly level of service than can be supported by Medicare payments are unable to recover these higher costs from the program. In the past, hospitals have, of necessity, shifted their Medicare payment shortfalls to other third-party payers and private-pay patients. But increasingly, other payers are resisting such shifts, thereby removing the traditional method of absorbing financial losses due to Medicare payment limits. The assignment/nonassignment option would provide a potential safety valve, thus helping to assure the continued availability of some health care services, even if they cost patients additional dollars.

Some hospitals would choose the nonassignment option, but others would choose to accept assignment. In fact, I believe that the majority of hospitals would choose to accept the assignment option for several reasons. First, through their boards of trustees, hospitals are accountable to the community and are heavily influenced by community attitudes. Trustees would closely examine the exercise of the option, and would approve nonassignment status when no other alternative means of meeting the hospital's financial requirements could be found. The decision to refuse Medicare assignment generally would be made only when acceptance would require such extensive subsidization of Medicare patients that it would jeopardize the ability of a hospital to meet its overall community service obligations.

Second, competitive pressures would prevent hospitals from increasing any additional charge to beneficiaries beyond "acceptable" community limits. In this regard, I believe nonassignment would be an important stimulus to competition, because it would give individual beneficiaries an incentive to "shop" among assignment and nonassignment hospitals. Beneficiaries would become more cost conscious by examining the "value" in terms of additional out-of-pocket expenses between assignment and nonassignment hospitals, and between the differing charges of two nonassignment hospitals. In this way, beneficiaries could choose between hospitals on the basis of price as well as service and amenities.

Medicaid Copayments

The Administration would require states to impose nominal copayments on Medicaid beneficiaries. The categorically needy would be required to pay $1 per day for hospital services and $1 per visit for physician, clinic, and hospital outpatient services. The medically needy would be required to pay $2 per day for hospital services and $1.50 per day for physician, clinic, and hospital outpatient services. In addition, states would be allowed to impose nominal copayments on all eligibility groups for all services.

Although the AHA supports the use of mechanisms that encourage patients to make appropriate and responsible use of health services, we question whether requiring copayments from Medicaid recipients would achieve the desired goal. Medicaid recipients have limited financial resources and might be unable to

meet even the nominal copayment provisions contained in the Administration's proposals. As a result, some Medicaid patients might forego needed care, particularly when extended periods of service are needed. In addition, collection of small fees, set at different levels for different types of patients, could be extremely difficult for hospitals.

## SUMMARY

Mr. Chairman, we believe the time has come for all to recognize that Medicare is a program with financial limits. The projected insolvency of the HI trust fund by the end of this decade means that you will be faced with difficult decisions over the next few years to ensure its viability.

We believe an important first step was taken with enactment of Medicare prospective payment for hospitals, which changes the incentives for hospitals to make them more cost conscious and to change their behavior. But if the federal government is to moderate the growth in Medicare spending, it must also establish incentives for beneficiaries. We believe that all parties participating in Medicare must share responsibility for ensuring its viability.

The administrations proposals recognize the need to change beneficiary incentives, but would not, in their current form, meet all of the objectives identified earlier in my testimony. Specifically, the proposed cost sharing provisions would not give beneficiaries an incentive to "shop" for hospital services on the basis of price as the beneficiaries out-of-pocket

liability would be the same regardless of the hospital used. Second, the proposed provisions would not enable a beneficiary to select a provider that offers a different level of amenities than can be supported by the "average price" paid by the Medicare program under the prospective pricing system.

The administration's proposals do provide an opportunity to begin a much needed discussion of the beneficiaries role in ensuring the long term financial solvency of the Medicare program. We urge you to give serious consideration to the need for and objectives of beneficiary cost sharing. A well constructed set of cost sharing policies can substantially improve the effectiveness with which the increasingly limited funds are used.

We thank you for this opportunity to share our views. The Association and its staff will gladly assist you and members of the Subcommittee in any way possible as you work toward resolution of these critical issues.

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Senator DURENBERGER. You have been here long enough this morning—and I appreciate that—to hear the drift of some of the questions. Obviously, one of the concerns here is at what point cost sharing is most effective. The large question is still how much do you put up up front when people are buying their protection, and how much do you save for the time they actually use services. And in that latter category, you have the deductible. The only rationale that I've heard this morning for the hospital deductible is that it's a red flag that gets you to ask the question about the need for hospitalization.

I think Bob Rubin indicated that he thought the more people you have in the act, the better.

But if you like vouchers then I would presume that you would also like the notion that we should be putting as much of our emphasis up front at the premium end as possible. Is that a correct statement?

Mr. MCMAHON. Yes. I think as far as the incentive toward cost conscious behavior that the premium, as you say—whatever is up front makes more sense because then there is the thoughtful consideration as to what institution, what physician, what system we should use. The deductible itself, as you heard, has some kind of a modest impact. Cost sharing on a per diem basis will have some modest impact, which can, in effect, support the hospital and the physician in encouraging the briefest length of stay possible because there is an advantage.

But the cost sharing ought to be related to the price at the hospital, and not a flat per diem so that it varies according to the hospital chosen. For example, a medical center may not be called for but it's the place you are used to, it's the place you like to go. You will make that determination that this is where I want to go and that's where I am going to go regardless. In addition, there ought to be some additional cost conscious—nonassignment hospitals—that will cost me more but I am willing to pay for it.

Mr. OWEN. Could I just comment, Mr. Chairman?

Senator DURENBERGER. Yes.

Mr. OWEN. I think there is one other thing, too, that was not brought up. There's an educational value in the deductible or the up-front dollars. We have a big job trying to convince all the people who have been using hospitals these many years as to what is the most appropriate system to use. Cost sharing and assignment gives us an opportunity to educate people who are going to use health care to choose wisely. You can't underestimate education. Although it's an indirect effect as far as costs are concerned, in the long run it will pay off.

Senator DURENBERGER. We've got about 75 percent of those people who have insulated themselves in advance to the cost of copayments, which I take it is another argument for not putting all of our eggs into a copay basket. Is that correct?

Mr. MCMAHON. Yes.

Senator DURENBERGER. On the flip side of that, let me just test your testimony against the entire population. When we address the issue of the need for cost sharing, and the need to zero in a part of that cost sharing up front, does that generally apply, in your view, to the entire population; particularly, as we look at the employer-

employee relationship? Or are you just saying this is something good for retired people?

Mr. McMAHON. We think the statement you've heard is that it isn't all that different on the impact on the increase in health care costs for the elderly versus the rest of the population. We are consistent in saying that we like the voucher for medicare. We also like the tax cap for the employed population.

We are very pleased with the activity that is going on in the employment related health insurance sector. There is a movement in two directions, one is toward some variations in premiums based on what the individual wants. We are doing that with our own 800 employees in the American Hospital Association. But there is also a movement toward more cost sharing. Business is coming around to the view that the incentives must be changed, the individual must become more cost conscious; both through more involvement on the premium side and in some cases more involvement on the cost sharing basis as well.

But business is looking in terms of relating cost sharing to the kind of choice that the individual makes as to provider system or hospital or physician.

Senator DURENBERGER. And did I hear you correctly that you have a position in favor of the tax cap proposal?

Mr. McMAHON. Yes.

Senator DURENBERGER. Do you feel strongly about that or is it sort of a mushy position?

Mr. McMAHON. Not mushy whatsoever. If I felt mushy, I wouldn't have raised it. We feel very strongly about the tax cap. I have had lots of conversations with business leaders. Unfortunately, I'm making no progress with labor. But I have lots of conversations with business leaders to explain to them the great advantages which offset the administrative concerns that they have. I am practicing what I preach with my own 800 employees. We have moved in that kind of direction even without the enactment of the tax cap. I understand there are people who say we don't need any more incentives; we are moving a different way. The incentive of the tax cap will only aid in that direction.

Senator DURENBERGER. I appreciate that a lot.

On behalf of Senator Baucus I'd like to ask you the following question by way of clarification. Under the administration's proposal, who is responsible for collecting the coinsurance amounts? If it's the hospital, how would medicare treat the uncollectibles, the bad debts?

Mr. McMAHON. At the present time, of course, it is the hospital that is responsible for doing it. At the present time the uncollectible cost sharing is turned around and billed at the end of the fiscal year to the medicare program. We think that makes good sense because the medicare program then relieves the pressure on the hospital to over force the collection process. If it could be left that way, it would be good sense.

But it's the hospital's collection. If the hospital can't collect it, if it knows that it is not collectible, then it should be billed back to the program.

As you know, we are only talking again about 20 to 25 percent of the collectibles because medicaid and medigap pick up the rest.

The small amount of flexibility that it gives to the hospital not to over force collections in the cost sharing would make good sense. I think by the time you get to that, you are probably dealing with a portion of the population that is nearly not so economically motivated as the other sectors are.

Senator DURENBERGER. All right. Thank you both very much. We appreciate you being here, and appreciate the thoroughness of your testimony.

Senator DURENBERGER. Our next witness will be Mr. James Isbister. You will correct me if I mispronounced that. He is senior vice president, Federal programs, Blue Cross/Blue Shield, Chicago, Ill.

What did I do to your name?

Mr. ISBISTER. Very close. Closer than usual, Mr. Chairman.

**STATEMENT OF JAMES ISBISTER, SENIOR VICE PRESIDENT, FEDERAL PROGRAMS, BLUE CROSS/BLUE SHIELD ASSOCIATION, CHICAGO, ILL.**

Mr. ISBISTER. I have with me Paul Boulis who is our expert on medigap.

Senator DURENBERGER. Very good. Your statement will be made part of the record, and you may proceed with your testimony.

Mr. ISBISTER. Thank you.

[The prepared statement of Mr. Isbister follows:]

# TESTIMONY
# OF THE
# BLUE CROSS AND BLUE SHIELD ASSOCIATION

## FY 1984 BUDGET PROPOSALS
## RELATED TO MEDICARE AND MEDICAID
## COST SHARING REQUIREMENTS

BEFORE THE
SENATE COMMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

PRESENTED BY:
JAMES D. ISBISTER
SENIOR VICE PRESIDENT

MAY 16, 1983

Mr. Chairman and Members of the Subcommittee, I am James D. Isbister, Senior Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for 99 Blue Cross and Blue Shield Plans.

Thank you for this opportunity to comment on the Administration's proposals (in S. 642 and S. 643) for revising beneficiary cost-sharing requirements. Our comments are based on our experience both as Medicare intermediaries and carriers, and as a source of private supplementary coverage for 9½ million Medicare beneficiaries. Although S. 643 also contains proposals to revise cost-sharing under Medicaid, our comments will focus only on the Medicare program because of our extensive involvement with Medicare beneficiaries.

We all face a very significant problem — how to deal with the rapidly escalating costs of providing Medicare benefits and the lack of adequate financing capacity under current law to pay those costs through the 1990s. The Congressional Budget Office estimates a Trust Fund deficit of $300 billion by 1995.

There are a range of options to solve the long-term Medicare financing problem. Some involve raising taxes. Some involve reducing benefits. Still others would radically restructure the program. All of the options pose problems, and the choice will be difficult.

The purpose of this hearing is to address the Administration's proposals for raising beneficiary cost-sharing and what the impact would be on "program costs, access to care, utilization of services, and the financial status of beneficiaries." While these specific proposals are not a long-term solution to the Medicare financing problem, and are not offered as such, we believe such major changes should be considered when the Subcommittee considers the broader issue of options available for long-term solutions.

The proposals before you will save money for the government. However, the burden of the savings clearly falls primarily on the Medicare beneficiaries. The greatest effect will be on the poorest and medically neediest among them.

Let me explain how we believe this will happen.

**Impact on Medicare Beneficiaries**

The proposed restructuring of Part A and revised cost-sharing for Part B is designed to produce a substantial reduction in Medicare expenditures while offering increased catastrophic protection for beneficiaries. While increased patient cost-sharing may achieve some savings through reduced utilization, we are concerned that most of the savings achieved through these approaches will be passed on to Medicare beneficiaries. Beneficiaries will absorb these new costs either in the form of increased out-of-pocket expenditures or increased premiums for supplementary health insurance coverage.

The most far-reaching of the proposed changes involves restructuring Part A of Medicare by moving the coinsurance to the early stages of an illness. The proposal also assures, for the first time, that beneficiaries have catastrophic protection. The Administration's proposal would involve copayments of about $28.00 per day in 1984 for the 2nd through 15th day of inpatient hospital care and copayments of $17.50 per day from the 16th to the 60th day. As before, Medicare beneficiaries would be required to pay the first day deductible. This amount is projected to be $350.00 in 1984. After two deductibles and 58 days of copayments were applied in a year, a new catastrophic provision would take effect and there would be no additional out-of-pocket costs for inpatient hospital services. As you know, currently there is no copayment feature for the first 60 days.

At present, a Medicare beneficiary could be responsible for $13,475.00 if he or she remained in the hospital for 150 consecutive days. Under the proposal, the individual's total out-of-pocket expense for the same 150 days would total only $1,529.50. However — and this is a critical point — the average length of stay for beneficiaries is only about 11 days. In addition, only one out of two hundred Medicare beneficiaries remains in the hospital more than 60 consecutive days. The sizeable program savings would be realized because Medicare would apply copayments to the early days of hospitalization

and full coverage for those days that are rarely utilized. For the 199 out of 200 beneficiaries who remain in the hospital for 60 days or less, there would be a considerable increase in expenditures.

We question whether all beneficiaries are in a position to absorb such major increases in cost-sharing. Medicare beneficiaries, for the most part, are on fixed incomes that have been eroded by inflation in recent years. And, as the Subcommittee is well aware, inflation in health care costs has been substantially higher than the overall inflation rate.

The Administration has also proposed a revision to the current copayment requirements for skilled nursing facility benefits. We are pleased by this reduction in the Medicare beneficiary's share of the skilled nursing facility expense — 12.5 percent of the Part A inpatient hospital deductible to 5 percent. We believe it is more cost effective if patients, no longer in need of inpatient hospitalization, are encouraged to transfer to less costly skilled nursing facilities. About 72 Blue Cross and Blue Shield Plan Medicare supplementary programs have been providing coverage for the current skilled nursing facility copayment expense as a means of encouraging the use of cost effective settings.

For Part B, the Administration has proposed an increase in the premium so that by 1988 premium payments will account for 35 percent of the annual program costs. Assuming an annual increase of 3.2 percent in the number of Part B enrollees and an 18 percent increase in program costs, there will be over 35.5 million enrollees resulting in over $31 billion in program costs in 1988. The enrollees' share at 35 percent would be close to $11 billion in premiums in 1988. On a per person basis, this would amount to approximately $306 or an increase of $160 over the $146 they now pay annually.

In contrast to proposals that involve increasing the deductibles or copayments, this approach would spread the impact among all persons enrolled under Part B, not

just those who use medical services. We are concerned, however, that some beneficiaries may have difficulty meeting this increased cost.

Indexing the Part B deductible to the Medicare Economic Index is also proposed. The original Part B deductible in 1966 was $50.00. The Congress increased it in 1973 to $60 and to $75 in 1982. This proposal to adjust the deductible at the same rate as the economic index represents added cost to those beneficiaries using Part B services. The economic index has increased about 8 percent annually over the last six years, and at that rate, this deductible would reach $110 by 1988. Standing alone this does not appear to be an inordinate amount; coupled with other increases in out-of-pocket spending for services or in premiums for supplementary coverage, it may adversely impact beneficiaries.

In addition, the Administration is proposing a one-year freeze at 1983 rates for the Part B reasonable charge allowances. In addressing this specific proposal, an important factor to consider is physician acceptance of assignment. Freezing the Medicare reasonable charge may encourage more doctors to refuse to accept assignment. If that is the case, more beneficiaries will be required to pay increased difference between the Medicare reimbursement and the physician's charge.

**Administrative Considerations**

In reviewing the Administration's proposal to restructure the Part A cost-sharing features of Medicare and to provide catastrophic hospital benefits, we believe there are factors to consider in addition to the financial consequences on beneficiaries — though none are as important. These factors include program complexity and whether the new cost-sharing arrangement would be compatible with the new DRG payment system.

Although the Administration's proposal would provide catastrophic hospital benefits, it would retain the "spell of illness" concept in order to apply the deductible and revised

coinsurance. This concept is very confusing to beneficiaries and complicates program administration. The "spell of illness" refers to the period that generally begins with the first day a beneficiary receives inpatient hospital care and ends when the beneficiary has been out of a hospital or skilled nursing facility for sixty consecutive days. We would urge the Subcommittee to consider whether any simplification of this benefit rule is feasible should major changes in the program cost-sharing features be pursued.

We would also urge the Subcommittee to take this opportunity to review other approaches to patient cost-sharing for hospital services that may be more compatible with the design and incentives of the DRG system as well as easier for beneficiaries to understand. Under the new DRG system, Medicare, except in extraordinary situations called "outlier" cases, will pay the same rate to a hospital for a particular case, regardless of the patient's actual length of stay. Since the new payment system already has strong incentives built into it for hospitals to reduce length of stay, increasing the program emphasis on a per diem hospital coinsurance would not seem to be appropriate. The savings to the Medicare program would come from the increased beneficiary payments for days of care actually received. This leads to an anomolous situation in which providers and patients save money only if length of stay is reduced but the Medicare program saves money only if length of stay is increased.

**Impact on Medicare Supplementary Coverage**

We would hope that the Congress, in reviewing the effect of these proposals, would not assume that private Medicare supplementary — Medigap — insurance will provide adequate protection against these new expenditures. While Medigap will do a great deal to spread the risk and help make any new cost-sharing features more affordable for the aged, Medigap premiums must necessarily increase to absorb the new costs. Many beneficiaries are now at the point that they cannot afford the Medigap premiums.

The beneficiaries who will not be able to afford the Medigap premiums are the ones least able to afford any major increases in cost-sharing.

Our actuaries sought to calculate the average increase in a Plan's premium if it were to cover these new proposed copayments for inpatient hospital services. They have factored out the previous costs of the 61st-90th day copayments, the 91st-150th day lifetime reserve copayment, and the 365 day lifetime expansion, because none of these apply if the proposed catastrophic program is implemented. As a result, the average Plan would need to add $4.06 per month of pure premium increase for this part of the proposal.

Regarding the proposed limit on the number of times the inpatient deductible would be imposed, our actuaries felt that it would have a negligible impact on Medigap premiums because very few beneficiaries are now charged for three or more inpatient deductibles in one year. With respect to some of the other proposals, we estimate a savings of about $1.05 a month in premium cost for Plans that provide the skilled nursing facility copayment expense benefit in their Medigap policies. The effect of the Part B proposals is less significant. The proposed indexing of the Part B deductible would increase Medigap premiums by a small amount. The effect of the proposed freeze in Part B reasonable charge allowances is difficult to estimate because our Plans differ in their calculation of the Part B coinsurance liability. For Plans that calculate their liability for the Part B 20 percent coinsurance using Medicare allowances, there would likely be savings which could be passed on to supplementary coverage policyholders. If Plans use their own UCR profiles to calculate their liability, premiums would increase.

Another related problem has longer term consequences for beneficiary access to private supplementary insurance. A significant number of Blue Cross and Blue Shield Plans are already experiencing losses on their Medigap coverage. These losses arise from the difficulty Plans have in securing adequate rates from state insurance

commissioners when Medicare cost-sharing requirements increase. With implementation of the proposed changes, the situation would likely become even more serious for those Plans that are unable to secure adequate rates.

**Long Term Effects**

Finally, in addition to our concerns regarding the probable impact of increased cost-sharing on the Medicare beneficiary, we have some concerns about the long-term effect of providing catastrophic benefits under Part A. The implications of virtually unlimited hospital benefits may be more far-reaching than that anticipated by advocates of this approach. Over the next few decades, this benefit change, interacting with the rapid growth of sophisticated life-sustaining technology and service intensity, and the aging of the population, may have a significant impact on the long-term financial health of the Medicare program and raise serious public policy and ethical question for future generations.

**Conclusion**

In closing, I would again like to commend the Subcommittee for examining the effect of the proposed changes on beneficiaries. We share your concern about the rapidly rising costs of the Medicare program and recognize that this persistent problem will threaten the solvency of the Medicare trust fund in the next several years unless action is taken. The Administration's proposals, however, represent only a piecemeal approach to addressing the trust fund's solvency problem and focus primarily on approaches which pass the cost savings onto beneficiaries who have a need for health care services. We urge you to consider the proposals in the broader context of how to assure the solvency of the Medicare program. We will be happy to work with you as you begin addressing this very difficult problem, for which there clearly are no easy solutions.

Mr. ISBISTER. It has been a long morning, and I have very few new thoughts. Some opinions though, Mr. Chairman, and I will be brief.

I think overarching the discussion here is a very significant and thorny problem which is how to deal with the rapidly escalating cost of medicare in the face of the fact that the revenues that will be generated under existing law will not be sufficient to meet the bill.

As you well know, there are a lot of options for dealing with this problem. The selection of the combination is going to be difficult, and implementation painful.

The thing you asked us to focus on specifically in this morning's hearing was the effect of cost sharing; specifically, the administration's proposals. I'd like to summarize very briefly the main points from our statement, which has been submitted for the record. And observe that I think in the course of the deliberation this morning that major tradeoffs were well presented. The issue of equities involved and so forth.

Our own conclusions are, first, that these cost sharing proposals will, indeed, deal a substantial savings in medicare expenditures. Estimated by the administration at $1.4 billion for 1984.

Second, though, increased patient cost sharing may reduce utilization somewhat and thereby reduce health care costs for society as a whole. But the amount of the utilization reduction will be small in comparison to the expected Federal expenditure reduction. And we believe almost all of the savings to the Government will have to be made up by medicare beneficiaries either through out-of-pocket payments or through increased premiums for supplemental health insurance coverage.

Third, we believe the impact will be felt unevenly. The brunt will be borne by those, as pointed out on several occasions this morning, who are either not eligible for medicare or find it difficult to pay medigap coverage or simply cannot afford it.

Fourth, as large as the projected savings from the cost-sharing proposals are, they are small in relationship to the looming long-term medicare deficit of $300 billion by 1995.

For these reasons we recommend that you consider the beneficiary cost-sharing proposals as part of your deliberation of the overall options for long-term solutions to the funding problem. Viewed in that context, the short-term proposals or alternatives could be developed as part of the first steps of a longer term strategy, and could be refined in ways which are consistent with that strategy. And especially, again, to pick up a refrain from at least two of the presentations this morning that they be consistent with the DRG payment system as it evolves.

Our own association has been looking at some of the long-term strategic options. Our board will be deliberating them over the summer. While we may not reach a consensus about a precise set of recommendations to you, we would welcome the opportunity to share our thoughts and analyses.

Finally, let me just make one comment about catastrophic coverage. We suggest a little bit of caution in its consideration, and lots of deliberation about its long-term consequences. We are for such coverage. We operate it in our private business. But I think we

must all keep our eyes wide open to the possibility that a catastrophic coverage entitlement interacting with the rapid growth of new life-sustaining technologies and the aging of the population will have a very considerable impact on the long-term financial health of the medicare program, and raise possibly serious public policy and ethical questions for future generations.

Those are the highlights from our prepared statement. Mr. Chairman, I would be pleased to try to respond to any questions.

Senator DURENBERGER. Thank you.

I take it you haven't yet come to a conclusion on the point that Gail Wilensky made. And that is that there is no way to control the cost of high technology through the reimbursement system. I think her judgment was the cost of high technology would have to be controlled in some other way because people do need some form of catastrophic assurance and protection. I think her advice to us was that we might get more good out of the system if we recognize the need for catastrophic, find the best way to finance it, and do it. Then recognize that you will still have to tackle the high-technology issue.

Mr. ISBISTER. I think our conclusion would be the same as hers, Mr. Chairman. The point being that I think personally that this issue, if you look out from now to the end of the century—look at the demographic projections, the kinds of technologies which are obviously going to come on line. It is a very profound one and we are going to have to develop as a society our techniques for dealing with it, techniques that are perhaps wholly new, which we have never considered or had to employ in the past.

It's just that I think it is useful to reflect as we embark on this venture as to what some of those long-term consequences are going to be.

Senator DURENBERGER. Since you are the biggest part of the business out there, can you give us some advice on the direction we ought to be going with cost sharing in terms of sharing at the premium end versus at the utilization end? I think your paper does a good job on the relationship between per diems and a DRG system.

Could you just generally cover that area that I have raised a number of times?

Mr. ISBISTER. Sure. Well, taking it first at the outset, providing incentives of various kinds for people to be more selective as they make their initial purchase either of health insurance or prepaid care, our major concern with the kinds of incentives that have been developed to date to provide a stimulus for that kind of choice is the concern with the problem of adverse selection and the segmentation of the market. Not by relative cost efficiency, but by the risks who accrue in each of the insurance or prepaid pools. That's the one that we have all been trying to break—broken ourselves on trying to solve. Because what you really want to do in that kind of price competition which you are seeking is you want to market the differences in price that result from relative efficiency of operation. You don't want to mask them based on the characteristics, the healthiness or unhealthiness, the age, and so forth, of the people who select each of the options.

And that's been our major concern with many of the proposals. Now the competition proposal is designed to promote those kinds of

choices. I see the savings ultimately coming from one of three ways, which I alluded to earlier. Either through a competition amongst insurers so that people will select on the relative efficiency and effectiveness of insurers both from the standpoint of their administrative operations and their ability to affect overall costs, or through providing alternatives, as you had suggested earlier this morning—HMO's, preferred provider organizations and so on and so forth. Or through increased cost sharing.

Our concern with the latter approach, central to the debate this morning, is that in any set of incentives that are provided for increased cost sharing or others that we try to devise means so that the competition, as I say, occurs on the basis of price and not the characteristics of the individuals who select each of the options. We believe that the maintenance of the insurance principle is terribly important.

Senator DURENBERGER. It occurs to me as I sit here listening to all this testimony—there are various ways to look at cost sharing. I have been looking at cost sharing in terms of how do you get the consumer involved in the utilization decisions and all that sort of thing. How do you get the consumer involved in getting out of the hospital more quickly or not going into the hospital at all.

But it seems to me that one of our problems as we go around this cost sharing thing is that we start on the presumption that you want people to pay part of the bill so that they will use services more appropriately.

As we try to reach a conclusion here about the role of cost sharing, it's quite obvious that we have got to determine when it is we want a price-sensitive consumer helping us leverage the system. And that may tell us whether or not we want it up front in a premium or we want it someplace so people are more sensitive at the time of use.

Is that a sort of logical way to try and grapple with the whole issue of cost sharing?

Mr. ISBISTER. I think it's an appropriate way to think about it. And to think, as your original question to me suggested, that there is a form of cost sharing which is up front at the time of the purchase and then there is the cost sharing at the point of care.

With respect to the latter—and I didn't address that from your earlier question—our own opinions and knowledge would lead us to the same sort of conclusion that you heard this morning. That deductibles, if they are high enough, do have an impact. That there are other forms of cost sharing in copayments that can have an effect if they are high enough.

But the question that is not known yet—presumably the Rand study will shed some light on it—is what the effect of that was on health status. And whether the care which was foregone was whether it was needed care or unnecessary care.

Senator DURENBERGER. Can you think of any really powerful reason why we shouldn't get rid of the distinction between part A and part B of medicare? Why we shouldn't have just one medicare program where people do what they did when they were employed? They bought a health plan, and it covered the hospital and the doctor and the medicine and so forth. What's the rationale for keeping part B separate?

This is my Blue Shield/Blue Cross question. Right? [Laughter]

Mr. ISBISTER. There is that reason that you are dealing with providers which are of different sorts. I think the fact of the matter is if we had a historian here the answer would be that the separation evolved for a whole variety of historical and legislative reasons. And certainly the possibility of a merger is something which probably should and could be considered as part of your deliberations.

Senator DURENBERGER. Rather than having history going for it, you can't think of any other good reason why we should keep it separate?

Mr. ISBISTER. I think I could underscore one point I made earlier. I think you are dealing with two different provider entities—the doctors and the hospitals. And one has to sort out what the advantages are in terms of the separate form of administration as it relates to those two different entities.

Senator DURENBERGER. All right. I think I have taken my alloted amount of time; taken you past the lunch time. And I have certainly taken Dr. Thomas Connally past his lunch time.

Mr. ISBISTER. Thank you for this opportunity.

Senator DURENBERGER. Thank you very much for being here.

Dr. Connally, come on up. You act as coordinating chairman of the governmental activities, American Society of Internal Medicine. Tell us what you think of cost sharing. And I apologize for the time, but I guess neither of us has ever adopted the notion that these hearings are only supposed to last 2 hours and everybody should just come and rattle off their testimony, and we should sit here like idiots. So it has been very helpful to ask questions of people.

Dr. CONNALLY. I think your questions are far more helpful than the testimonies, or the answers to the questions anyway.

## STATEMENT OF DR. N. THOMAS CONNALLY, COORDINATING CHAIRMAN, GOVERNMENTAL ACTIVITIES, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, D.C.

Dr. CONNALLY. I'm Thomas Connally, and I am a practicing physician here in Washington and a member of the board of trustees of the American Society of Internal Medicine.

With me is Robert Doherty who is director of medical services and governmental affairs on our staff.

The American Society of Internal Medicine's House of Delegates consisting of internist leaders from all 50 States has been on record since 1977 as favoring improved patient cost sharing in all private and public health insurance plans. And since 1975 it has favored national health insurance to cover medical costs for catastrophic illness.

We believe that the administration proposal to require increased coinsurance for in-hospital services and to provide medicare coverage for the cost of catastrophic illness is a significant and welcome step toward the goal of improved health insurance protection, and more cost effective benefit design.

The CBO has reported that the long-term solvency of the medicare health insurance trust fund will require either substantial revenue increases or reductions in outlays or both far greater than

under the program changes being considered today or both. Given this economic reality, there is little question that any plan to rescue the medicare program must include increased patient cost sharing. In our view, the question is not if there will be increased medicare cost sharing but rather when it will take place. It is our sincere hope that Congress will act now to introduce more cost sharing into the medicare system.

Our support for improved medicare cost sharing is based on our strong belief that if patients share the cost of their medical care, they and their physicians will be more cost effective in the use of services. Under current law, medicare beneficiaries and physicians have little or no economic incentive to carefully consider the necessity of each day of hospitalization once the $350 deductible is satisfied. In my own practice, it is not uncommon for the families of hospitalized elderly patients to ask me to keep the patient in the hospital 1 more day simply because it is inconvenient for them to take the patient home.

As a result, I'm often under subtle pressure to keep the patient there longer than is absolutely necessary often because there is no place for the patient to go or the family is not ready for them to go. Other internists report similar experiences.

I have no doubt that this would be less likely to occur if the patient or the patient's family is required to pay out of pocket some of the cost of the extra day.

I will depart from the testimony a little bit here and give you an expansion of this feeling because much of our testimony is duplicative of what some other more knowledgeable people have already told you—people from the CBO and the Rand Corp.

I think the doctor's role is a dual one. Our first and ancient, traditional responsibility is to the patient. To get him well, to comfort him. But also in this day of insurance, it's to be his broker. And we are to help him get his benefits from the system.

We know and we have an increasing feeling also that we have a societal obligation. We've got to look out for the medicare trust fund which is going broke. We've got to look out for the Blue Cross and Blue Shield plans running into financial trouble.

But there comes a point when I think every doctor shifts his role from being the patient's broker to saying, well, you have got to go home; you are really too great a drain on the system. But I think if the patient has to share in that cost it's a lot easier for the physician to make that shift. And I think that's really the crux of the situation. This decision on when the patient leaves the hospital and how much care is delivered. It's a subtle one. And each physician handles it in a different way and physicians handle it in different ways with different patients. The doctor-patient relationship is extremely complicated.

I think if there is this incentive on the part of the patient to get out it makes it easier on everybody. I think it makes it easier on the system. It makes it easier on the doctor. And I think in the long-run it is going to make things work better for a more efficient system.

One of the points that you have raised and Senator Baucus raised earlier is whether increased Part A cost sharing will be nec-

essary under the DRG program now that we have diagnosis related groups coming in.

First, I think we are not at all sure that diagnosis related groups are going to work. Our experience is limited to a short period of time in New Jersey, which really hasn't been measured yet. The medicare population may be just the wrong population to try this sort of thing on since they often have multiple and shifting diagnoses and since there are often social reasons for them not leaving the hospital.

So I think if your DRG's are going to work, the cost sharing would be complimentary. It would make it much easier and more workable. I think the point of view of the people who design the DRG's—and I understand their problem—is to make the hospitals force the doctors to be more cost effective.

Well, I think you may have a built-in problem of the administrative staff of a hospital and the medical staff getting at loggerheads here. But I think if the patient is brought into this and he himself or she herself and their families become more cost conscious, it may make the whole thing work better. So rather than saying that patient cost sharing during the hospitalization is superfluous now that we have DRG's, I think it is even more important and even more necessary. And it makes the DRG system more likely to work. Even with it the system may not work and we could point out lots of problems you might run into.

I think that in listening to the testimony of the elderly people there are lots of concerns about the increased cost to them, and that is understandable. I think there are some other alternatives that you could look at such as a slight reduction in the deductible. I would not want to do away with the deductible by any means, but a slight reduction might be appropriate. Also you could increase copayment based on their income. Or medicare could have, as the Congressional Budget Office has suggested, several different plans which people could buy into with different deductibles and cost sharing amounts.

You could, if you would have maybe a combination of some deductible, but some variance in that up-front payment, which you have been talking about.

Senator DURENBERGER. We will put your whole statement in the record.

Dr. CONNALLY. Sure.

Senator DURENBERGER. Do you have an answer for us on catastrophic coverage and its effect on prolonging life and high technology?

Dr. CONNALLY. Well, I think I would agree with Dr. Wilensky. There comes a point when I think all of us begin to ask what insurance is for. It's really for the catastrophy, the disaster. I think everyone wants to have insurance in place for that. And I think that your economic incentives at that stage are not going to be the answer. I think we've got to begin to look a lot deeper into the more troublesome aspects of the physician-patient, physician-societal and patient-societal relationship. What's it worth? What are those few extra days of life worth? These are the kind of things we have got to look into. I think we need to maybe augment or change

a whole lot of our medical education, continuing medical education and public awareness.

I have an extremely large elderly population. And one of the things that I am told literally daily is "Don't keep me alive too long, Doctor." And I think often we are keeping people alive beyond what is reasonable and beyond what they want or beyond what their family wants. And this is the thing we have got to learn—to ease out the plug in a gentle, humane fashion.

I think that's a point where economic incentives are not going to help us. So I don't think you are moving backward by putting in a catastrophic program.

Senator DURENBERGER. Let me ask you about the question that was asked at the end of the Blue Cross testimony. Your statement covers part A. Let me move over to the part B side. Why, other than for historical reasons, don't we have just one medicare system? Charge a premium for it, have some cost sharing as appropriate, but remove the distinction between part A and part B that exists. I would ask you to comment on that.

And then if you suggest that we perpetuate the dual system, tell me what we can do about the unwillingness of physicians to accept assignment.

Dr. CONNALLY. Well, that's a complicated question, the moving into one system. I think you have got to think of it as the doctors and the hospitals being sort of different economic entities in most circumstances. To try to move the system into one system would be difficult.

I think one way to ease into that would probably be through preferred provider organizations. I think that may be the way to make the doctors more cost conscious about the care they are delivering to outpatients, what they are charging. Encouraging people to go into PPO's would also make the whole system more efficient.

One way to do that, of course, would be with the tax incentives which you have proposed and which we, as an organization, are very much in favor of with certain caveats.

I think another way to do that would be maybe to move into the PPO arena.

Senator DURENBERGER. Even without going to that point or going beyond that to some kind of a limited group or competitive medical plan process, we could have a DRG but put the doctor in charge of it. I suppose that would be one way. And let the doctor make the decisions about hospitalization or not. That would eliminate some of the concerns that were reflected at the time we were doing hospital DRG's. We haven't got any incentives in there for doctors not to hospitalize. We have all kinds of pressure to come in with a higher DRG. We've got all kinds of pressure to get people out of the hospital as quickly as possible, and that those pressures are coming, as you indicated, to the docs through the hospitals.

Dr. CONNALLY. I think before trying to expand the DRG program into physician payment—I know this past legislation called for a study of what it would be like if it happened—I think we really need to look at those DRG's carefully as we go along. I think that the potential for an awful lot of game playing on the part of physicians, hospitals and others is there.

I know that with many, many of my older patients the main reason they are in the hospital changes every few days. They come in with pneumonia, and then they have congestive heart failure, then arrhythmia, then renal failure. And there are probably far more than just the 6 percent outliers the plan calls for.

I think you have the potential for some games playing and diagnosis creep and all sorts of problems that could end up costing the system more than we ever realized. I think we are going to have to be very, very cautious in monitoring and watching what goes on before moving headlong into expanding it.

Senator DURENBERGER. I have one last question. Do you have an opinion on the impact of the administration's proposal to freeze physician fees and its impact on the willingness of physicians to participate in the program?

Dr. CONNALLY. Well, again, we were the only medical organization who was in favor of that for year only. I think 1 year——

Senator DURENBERGER. Sort of like the PIK program.

Dr. CONNALLY. We were calling on everybody. The generals, the old people, the hospitals everybody to cut last year when the economic problems were so great. We felt we could not say cut everybody but us.

I think, however, if you continue to have the overhead costs for physicians escalating and you have an indefinite hold on how much medicare allows, you are asking physicians to assume an untold burden by asking them to accept assignment plus hold the prevailing charges where they are. So I think one of the reasons physicians are so reluctant to accept assignment is that over its history, medicare has not kept up reimbursement in most things particulary with cognitive skills. Reimbursement for some of the surgical skills, some of the procedural skills has gone way ahead of the overhead cost or way ahead of what is reasonable. But with cognitive skills the day to day seeing and examining of patients, it has not kept up with the physician cost.

Senator DURENBERGER. Thank you very much for your testimony. We appreciate it a lot.

The hearing is adjourned.

[Whereupon, at 12:51 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Senate Finance Committee
United States Senate

RE: FY84 Budget Proposals to Revise Beneficiary Cost Sharing Requirements under the Medicare and Medicaid Programs

May 31, 1983

The American Medical Association takes this opportunity to present its views on the Administration's proposals on beneficiary cost sharing in the Medicare and Medicaid programs.

We recognize that Congress and this Committee must confront the need to strike a balance between national expenditures and national income. Unfortunately this does not necessarily mean a "balanced budget" will result. Like the Congress, the AMA is concerned about the growing federal deficit. However, in considering reductions in federal spending, it must not be forgotten that programs like Medicare and Medicaid are designed to provide essential health care benefits to people, and that individuals should not be made inadvertent victims of the budget process.

The American Medical Association cautions against establishing unrealistic targets for savings in health programs that would result in limiting access to and availability of health care for those individuals

for whom the federal government has assumed a primary financial responsibility. In creating the Medicare and Medicaid programs in 1965, Congress committed itself and the nation to providing access to high quality care for the elderly and the needy. That promise, to a large extent, has been met. The seventeen years since enactment of those programs have seen a tremendous improvement in the health status of the targeted populations. This is a result of which Congress, the health care community and all Americans can be proud.

Nevertheless, the Medicare and Medicaid programs have been the targets of a seemingly unending stream of recent program cuts that have had federal budgetary considerations as their primary genesis. It must be remembered that the increased costs and strains on the budget that have resulted from the growth of the Medicare and Medicaid programs are not attributable solely to problems with these programs. The elderly represent an increasing percentage of our population, and the recession has added many individuals to the indigent rolls. In addition, the quality of care has increased with dramatic new technologies and improved access and services.

The AMA does recognize that changes should be made in governmental health programs in order to improve their efficiency and operation. No program should remain sacred from scrutiny, review or constructive criticism. The Medicare and Medicaid programs, however, have already been the subject of major reductions during the fiscal 1981, 1982 and 1983 budget cycles. While there are further changes in those programs that we would support, we do not believe that the Medicare and Medicaid programs should

continue to be targeted for major cost cuts or major program restructuring unless adequate assurances are provided to make certain that access to appropriate high quality care will be available to beneficiaries of the programs.

If major cuts are to be made again in the Medicare program, the Congress must recognize and tell the American people that it is now necessary to abandon the earlier promises of the Medicare program. Nor can heavy reductions in federal aid to the states under Medicaid avoid the return to a two-tiered system of health care for the needy. The idealistic goal of the mid-sixties, i.e., to place the elderly and the needy of this country in the mainstream of our health care system, is, as we approach the mid-80's, becoming a myth. Medicare and Medicaid cuts cannot be made without hurting patients by either denying care or by forcing them to shoulder an increased share of the cost of their care.

The American Medical Association realizes that Congress needs assistance from the public in making any substantive determinations on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future "health policy agenda" for the American people. This activity involves approximately 150 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, the public, and health care insurors. This project is designed to develop a philosophical and conceptual framework as the basis for specific action plans and proposals that are to be responsive to the particular social, economic, scientific, educational and political circumstances involved in health care decisions.

PROPOSED MEDICARE AND MEDICAID REVISIONS: COST SHARING REQUIREMENTS

The Administration's budget package includes three bills, S. 641, S. 642 and S. 643, that contain a number of changes in the Medicare and Medicaid programs that could result in substantial shifts in cost sharing requirements under the programs. While some of these proposals may be appropriate, they must all be closely examined prior to enactment into law.

Medicare

Catastrophic Coverage/Increased Copayments (S. 642)

The Administration proposes a new catastrophic hospital benefit with new copayment requirements for Medicare beneficiaries. All covered hospital costs would be paid by Medicare after 60 days' hospitalization each year. At present, Medicare hospital coverage expires after 150 days of hospitalization during a "spell of illness," with escalating patient copayments between the 60th and 150th days. However, the proposal would alter the current formula for beneficiary cost-sharing by providing for patient cost-sharing from the second through the sixtieth day. The current first-day deductible would remain, but would be incurred no more than twice yearly.

The American Medical Association supports catastrophic coverage for Medicare beneficiaries, with appropriate copayment during early stages of hospitalization. We are concerned, however, with the amounts of copayments proposed and the timing of their implementation. We believe that it would be more equitable for copayments to be imposed later than the second day of hospitalization. We also note that the Administration's

specific proposal requires co-payments significantly higher than necessary to fund the costs of the additional catastrophic coverage. This would in fact transfer costs from Medicare to the beneficiaries either directly or through increased premium costs for supplemental coverage. A co-insurance adjustment that is not substantially greater than the cost of the catastrophic benefit would be more equitable. We urge the Committee to consider these concerns in reviewing the Administration's proposal.

Freeze on Physician Reimbursement (S. 643)

The Administration proposes that physicians' reimbursement under the Medicare "reasonable charge" system be frozen for one year. The customary and prevailing charge screens to be used for year 1984 would not be updated but would be kept at the levels used in fee screen year 1983.

The American Medical Association opposes this proposal. Since the passage of PL 92-603 in 1972, annual increases in allowable charges under Medicare have been restrained by several arbitrary factors. Specifically, payment was fixed at a "prevailing charge" ceiling defined at the 75th percentile of the customary charges; and any growth in the recognized "prevailing rate" was restricted by an "economic index" factor related to 1972 prevailing charges (which by virtue of a statutory lag time reflected 1971 actual charges). Furthermore, "economic index" allowances were based on data that never really reflected actual increases in the costs of providing medical services.

A freeze is especially unfair in light of continued cost increases that physicians must face in their practice and for which Medicare reimbursement will be denied. Is the federal government now going to pay

1983 prices that are already deflated to all suppliers in 1984? The answer is obviously no. We believe that it is unfair to freeze the costs of one sector of the economy while not asking attorneys, architects and other professionals to accept a similar freeze and while allowing prices paid other suppliers to rise.

Physicians are not unaware of the financial circumstances of their patients. As an example due to the current recession, more and more patients without any insurance coverage are seeing physicians. Physicians all over the country are treating these patients free or for greatly reduced fees. Over 40 medical societies have organized programs to assure care to those in need.

At the present time, approximately 87% of all physicians (including pediatricians and psychiatrists) treated Medicare patients in 1982, with approximately 80% of these physicians submitting some claims on an assigned basis; beneficiaries thus enjoy a wide range of choice in determining who will be their attending physician. In addition, over half of all Medicare claims are on an assigned basis and over half of the total charges are assigned. The primary reasons why claims are not accepted on assignment are administrative deterrents, paperwork and inadequate reimbursement levels. The result of the further reductions proposed by freezing any reimbursement increase would be a further disincentive to acceptance of Medicare assignments. This could lead to increased costs to be borne by beneficiaries as the federal government further reduces its responsibility and the value of the program to the beneficiaries.

We urge the Committee to reject this proposal.

Part B Premiums and Deductibles (S. 643)

The Administration proposes to increase the premium for Medicare Part B to cover 35% of the costs of the program and to index the Part B deductible. (A six-month freeze of the Part B premium was enacted in P.L. 98-21, the Social Security Act Amendments of 1983.)

The American Medical Association supports this proposal. It is in keeping with the original intent of the Medicare program in that originally the program was to be funded one-half by general revenues. Medicare, like insurance programs, should have appropriate front-end copayments and deductibles. We would recommend, however, that rather than tying the index of the Part B deductible to the overall consumer price index (CPI), the index should be tied to the medical care component of the CPI to reflect more accurately changes in the cost of medical services.

Medicare Eligibility (S. 643)

Under existing law a person is ordinarily covered by Medicare on the first day of the month in which he or she reaches the age of 65. The Administration proposes that eligibility for Medicare be deferred to the first day of the month following an individual's 65th birthday.

The AMA does not support this proposed change. It would be an inappropriate cost shift to the private sector and individual beneficiaries. This proposal would not create incentives to reduce health care costs.

Elimination of Deductible for Certain Laboratory Services (S. 643)

This provision provides that the Part B deductible would not apply to diagnostic services that are performed in a laboratory for which the Secretary has established a negotiated payment rate.

The American Medical Association is concerned that this provision would have the effect of singling out one group of beneficiaries for different benefit levels. It could create situations where beneficiaries who do not have access to a laboratory with a negotiated rate would be forced to bear an increased cost in care. In our view, this provision would prove to be inequitable, and we recommend against its adoption.

## Medicaid

### Medicaid Copayments (S. 643)

This proposal would mandate a nominal Medicaid copayment of $1.00 per physician, clinic or outpatient visit and $1.00 per hospital inpatient day for the categorically needy, with a similar copayment at $1.50 for the medically needy.

The American Medical Association opposes this proposal. We supported provisions in 1982 which gave to states the options of imposing nominal co-payments. We believe that the present system under which states have the flexibility of requiring nominal copayments is preferable.

### Medicaid Matching Payments (S. 643)

Under the 1981 Reconciliation Act, federal payments to states for Medicaid were reduced by 3%, 4% and 4.5% in FY82, FY83 and FY84 respectively. A state may qualify for offsets to these reductions if it has a qualified hospital cost review program, an unemployment rate which exceeds 150% of the national average, or fraud and abuse recoveries greater than 1% of federal expenditures. In addition, states may earn back all or part of the reductions if expenditures remain below specific target amounts. The Administration proposes to extend the Reconciliation Act reductions, including the offsets, at 3% in FY85 and beyond.

The AMA recognizes the budgetary problems facing the federal government. However, the net effect of this proposal simply is to shift an increased burden on the states, many of which are also facing severe budget difficulties. Most states, in fact, have already made deep cuts in their Medicaid programs, and many states are facing the need for further cuts even without further reductions in federal aid. These reductions in Medicaid benefits hit hardest those states suffering the greatest financial problems. The needy in our society--those most affected by economic hard times and who can least afford to pay for their medical care--will be hurt the most. In order to avoid additional cutbacks, we believe Congress should not extend the reduction in federal Medicaid payments to the states beyond fiscal year 1984.

## CONCLUSION

The American Medical Association realizes the complex and difficult task facing this Committeee in reviewing the FY84 budget and the Administration's proposals concerning the Medicare and Medicaid programs. We are sympathetic with the need to reduce federal expenditures, but we are deeply concerned that inappropriate changes will result in individuals having to bear inappropriate increases in costs and possibly forego necessary care.

In this statement we have offered support for some provisions of the Administration's proposals that will have the effect of increasing cost consciousness in Medicare and Medicaid beneficiaries without causing serious impairment in the programs' ability to meet their intended purposes. However, we believe enactment of all cuts recommended by the Administration could seriously lessen the effectiveness of the Medicare and Medicaid programs. They would deprive people of needed medical care, and break faith with those people who were promised that Medicare and Medicaid would provide appropriate care.

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May 23, 1983

The Honorable Robert Dole
Chairman
Senate Finance Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, I would like to provide our comments and concerns regarding the Administration's proposal to alter current cost-sharing arrangements under the Federal Medicare and Medicaid programs, and request that this statement be included in the Health Subcommittee's May 16, 1983 hearing record.

The proposed restructuring of Part A (hospitalization) and revised cost-sharing for Part B (physician and outpatient services) is designed to produce a substantial reduction in overall Medicare expenditures while offering increased catastrophic protection for beneficiaries.

While increased patient cost-sharing may achieve some cost savings through reduced utilization of physician and hospital services, the very same revisions in cost-sharing may have a perverse effect upon early intervention and prompt diagnosis of illness. If, as the Rand study has indicated, utilization of outpatient Part B services has been tempered as the result of existing co-payments and deductibles, is it not possible that the burden of care has simply been shifted to hospital-based treatment where co-payments and deductibles are substantially reduced or non-existent? The APA has argued in the past that the Medicare system is structured in such a way as to discourage early outpatient interventive care in favor of hospitalization. If Part A co-payments and deductibles are restructured as the Administration proposes, it seems likely that patients would simply delay their physician encounter for entering the hospital -- becoming more ill, and therefore in need of more intensive, longer-term care (and possibly "triggering" the new catastrophic coverage envisioned by the Administration). This seems to us to be a false economy. Worse, the Administration proposes further increases in the outpatient Part B premium, and indexing the Part B deductible to the consumer price index. It is thus discouraging both early interventive outpatient care as well as earlier entry into the hospital for necessary hospital-based treatment.

There is yet another perverse impact such changes in Medicare co-payments and deductibles could engender: delayed hospital admission and thus more severe illness could increase the cost of what would otherwise be the usual course of the hospital-based treatment for the Medicare patient, now fixed under the prospective payment law. If patients enter the hospital sicker, their care will necessarily be more complex, more expensive, and potentially could skew the DRG payment system upward. Thus, the higher patient co-payment and deductible cost-sharing will actually be phantom savings.

Both the Part A and Part B changes will affect the mentally ill elderly and disabled in a continuing discriminatory and negative manner. Under current Medicare law, inpatient treatment in a psychiatric facility is limited to 190 days in a beneficiary's lifetime. As this Committee understands, up to 150 of those lifetime days can be lost if the beneficiary is in the hospital on the day he or she "turns" 65. We have not seen any indication in the Administration's proposal regarding Part A changes which would eliminate the arbitrary 190 day lifetime limitation for these patients. Rather, they apparently would be subject to increased co-payments and deductibles on the "front end" of their hospitalization in a psychiatric facility, but would not have the ostensible benefit of "catastrophic" coverage due to the continuing imposition of the 190 day lifetime limitation. In fact is is not clear whether a 60-day hospitalization in a psychiatric facility would be able to "trigger" the catastrophic benefit in the first place.

Thus, the mentally ill could be burdened three different ways: once by increased co-payments and deductibles for their hospitalization up to 60 days; once by never triggering into the catastrophic coverage beyond those first 60 days; and last, by not having access to the same proposed catastrophic coverage (if they can "trigger" into the system) as the Administration proposes for all other medically ill Medicare beneficiaries.

We have argued before this Committee that the 190 day lifetime limitation is an inappropriate and arbitrary form of discrimination against the mentally ill and disabled in the past. The Administration's proposal, unless amended by the Committee as we have suggested, would make catastrophic coverage of necessary medical care and treatment to this population under such Medicare program unattainable.

The alternative to such inpatient treatment has always been the promise of outpatient care. Historically, here too, the mentally ill have been singled out for disparate, unnecessarily restrictive treatment under Medicare, notwithstanding repeated recommendations by the APA, AMA and more recently a Task Force of the American Hospital Association to the contrary. Regrettably, as this Committee knows, under Medicare today, the mentally ill are subjected to an unprecedented 50 percent patient-borne co-payment coupled with a ceiling of $250 Federal expenditures in any single year. We have argued before this Committee in each year since 1977 for equitable coverage of psychiatric disorders under Medicare Part B -- both in terms of the human needs of the mentally ill elderly, and, perhaps

more important today, in terms of the cost efficiencies of appropriate psychiatric intervention in reduced physical health care expenditures.

The continuation of these discriminatory ceilings and co-payments will cause yet another undue hardship for the mentally ill Medicare beneficiary when coupled with the new proposed premium increases and indexing of Part B deductibles to the CPI. The mentally ill, in fact, will be purchasing fewer services for a greater amount of personal expense. In the private sector, increased premiums often buy better coverage. Under the Administration's proposed Medicare changes, the mentally ill gain no effective coverage and have increased out-of-pocket expenditures.

The Administration's proosals, then, place the mentally ill Medicare beneficiary in a no-win situation. First, he or she does not receive better outpatient coverage, notwithstanding greater patient-borne costs. And, at the same time, prompt, needed hospitalization is similarly discouraged with the imposition of unprecedented hospital-based deductibles and co-payments. Moreover, the severely mentally ill Medicare beneficiary may never be able to reach the Part A catastrophic "trigger."

If the Committee determines there are to be changes made in the Medicare patient co-payments and deductibles under Parts A and B, coupled with the introduction of a catastrophic health insurance plan for those requiring hospitalization beyond 60 days, we urge the Committee at the same time to delete existing discriminatory Medicare limitations. Otherwise, the Administration's proposal will serve only to exacerbate further the discrimination against those Medicare beneficiaries suffering from mental illness.

Sincerely,

Melvin Sabshin MD

Melvin Sabshin, M.D.
Medical Director

Testimony

of the

American Society of Internal Medicine

to the

Senate Finance Committee

Subcommittee on Health

on

Proposals to Improve Medicare Cost Sharing

May 16,1983

My name is N. Thomas Connally, MD, and I am a physician in private practice here in Washington, DC and a member of the Board of Trustees of the American Society of Internal Medicine (ASIM). I am pleased to present the views of practicing internists throughout this country on proposals to improve Medicare cost sharing.

ASIM strongly believes that Congress should enact legislation to increase beneficary cost sharing for inhospital services. ASIM's House of Delegates, consisting of internist-leaders from all 50 states, Washington, D.C. and Puerto Rico, has been on record since 1977 as favoring improved patient cost sharing in all private and public health insurance plans. The Society has also been on record since 1975 as favoring national health insurance to cover the medical costs of catastrophic illness. We have also taken the lead in promoting positive incentive-based reforms to make the medical care system more cost-effective. ASIM believes that the administration's

proposal to require increased coinsurance for inhospital services, and to provide Medicare coverage for the costs of catastrophic illness, is a significant and welcome step toward the goal of improved health insurance protection and more cost effective benefit design.

The Congressional Budget Office (CBO) has reported that "The long term solvency of the (Medicare) health insurance trust fund will require either substantial revenue increases or reductions in outlays far greater than under the program changes being considered today--or both" (Reducing the Deficit: Spending and Revenue Options, February, 1983). Given this economic reality, there is little question that any plan to rescue the Medicare program must include increased patient cost sharing. Other programs and proposals--such as prospective payment for hospitals, reforms in physician reimbursement, and improved competition in the health care system--may also be needed. But without improved Medicare cost sharing, it is unlikely that those other measures, by themselves, can be sufficient to restore solvency to the health insurance trust fund. Therefore, in ASIM's view, the question is not if there will be improved Medicare cost sharing, but rather when it will take place. It is our sincere hope that Congress will act now to introduce more cost sharing into the Medicare system. Inaction and delay can only exacerbate the solvency problem.

ASIM's support for improved Medicare cost sharing is based on our strong belief that if patients share in the cost of their medical care, they and their physicians will be more cost effective in the use of medical services. This belief is supported by both the experiences of practicing internists, and the growing body of research literature that supports the

efficacy of cost sharing as a cost containment strategy. Under current law, Medicare beneficiaries and physicians have little or no economic incentive to carefully consider the necessity of each day of hospitalization, once the $350 deductible is satisfied. Practicing internists are aware of many instances where patients could be discharged from the hospital a day earlier, or could be treated in the physician's office or at home rather than in the more expensive hospital setting. However, often these patients remain in the hospital for reasons of convenience--or because it costs the patient more out-of-pocket for the physician to treat him or her on an outpatient basis. Improved Medicare cost sharing in the form of coinsurance for the first 60 days of hospitalization would create a clear incentive for patients and physicians to determine the need for each day of hospitalization solely on the basis of medical factors. In my own practice, it is not uncommon for the families of hospitalized elderly patients to ask me to keep the patient in the hospital "one more day," simply because it is inconvenient for them to take the patient home. As a result, I am sometimes compelled to keep the patient in the hospital longer than is absolutely necessary, simply because there is no place for the patient to go. I have no doubt that this would be less likely to occur if the patient or the patient's family is required to pay out-of-pocket some of the cost of that extra day. In the long run, considerable cost savings for the Medicare program would result.

This conclusion is supported by numerous research and demonstration projects. A 1980 HCFA-funded study estimated that the current levels of Medicare Part A cost sharing have resulted in 4.4 million to 6.2 million fewer days of hospital care for the elderly, and an estimated total reduc-

tion in hospital expenditures by the elderly of between 700 million and 1 billion dollars, compared to the projected utilization if cost sharing provisions did not exist (C. R. Link, S. H. Long, R. F. Settle. Cost Sharing, Supplementary Insurance, and Health Services Utilization Among the Elderly). The CBO has projected that by expanding hospital coinsurance to require beneficiaries to pay 10% of the deductible amount for each of the next 29 days of a hospital stay in each calendar year (about $35 per day in 1984) in addition to the first day deductible, approximately $16.5 billion in federal outlays would be saved over the next 5 years (Reducing the Deficit: Spending and Revenue Options). A recent Rand Corporation study also found that total expenditures per capita (inpatient plus ambulatory, excluding dental services and outpatient mental-health services) rises steadily as coinsurance falls (Rand Corporation; Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance, December, 1981). Similar results have been reported in other studies on cost sharing. Most recently, Blue Cross/Blue Shield officials credited increased patient cost sharing and other measures (such as improved coverage for services in physicians' offices) with cutting their hospital admissions by 9.5 percent from 1970 to 1981, while admission rates for the general population increased 11 percent ("Blue Cross Plans Cut Admission Rates", Washington Post, May 12, 1983). Taken together, these studies provide conclusive evidence that increased cost sharing is an effective means for reducing utilization of hospital services.

ASIM recognizes that the primary objection to improved Medicare cost sharing is that it may impose an unreasonable burden on beneficiaries. Although we do not necessarily agree that the administration's proposal for

most beneficiares is excessively burdensome, ASIM urges Congress to consider modifications in the plan to broaden its appeal and spread the cost burden more equitably, rather than rejecting it out of hand. Three options merit particular consideration:

1. Eliminate or reduce the $350 Part A deductible, but increase the amount of per diem coinsurance required during the first 60 days of hospitalization. This option would result in improved Medicare protection for the first day of hospitalization, which is now paid entirely by the beneficiary. Many beneficiaries with short hospital stays, could be expected to be better off under this proposal than under current law, despite the increased per diem coinsurance requirements, while at the same time it would encourage physicians and patients to consider cost benefit factors at the early days of hospitalization.

2. Base the amount of increased coinsurance on beneficiaries' income. This would ensure that economically disadvantaged individuals are not unduly penalized by coinsurance requirements. The CBO has reported that this option is administratively feasible (Containing Medical Care Costs Through Market Forces, May, 1982).

3. Offer a series of options under Medicare with different benefit structures, as suggested by the CBO in the May, 1982 report cited previously. Under this proposal, Medicare would offer several plans with different levels of cost sharing. Persons choosing an option less comprehensive than the current Medicare benefit

structure would get a cash payment reflecting Medicare's claims experience with the option. Those selecting a more comprehensive option would pay an additional premium. The CBO believes that such a choice would probably increase the average degree of cost sharing, since those seeking more cost sharing, who have no opportunity to do so today, would be more likely to change plans.

ASIM is aware that the widespread availability of supplemental insurance plans that cover Medicare's deductible and co-insurance amounts is counterproductive to the goal of increased cost-sharing. Although we have no specific recommendations at this time for addressing this problem, we believe that it requires study by Congress.

In conclusion, ASIM urges Congress to enact legislation to require increased Medicare Part A coinsurance. Such action would be an important step toward introducting incentives into the medical care system to encourage more cost-effective behavior. If Congress chooses not to enact the administration's proposal, we would urge consideration of the other options identified above to increase beneficary cost sharing. ASIM believes that increased cost sharing--along with additional measures to introduce positive incentives into the health care system--will make a major contribution to restoring the fiscal stability of the Medicare program and reducing the overall rate of increase in medical care expenditures.



BD/tlw
G1-3427

# CALIFORNIA ASSOCIATION OF CHILDREN'S HOSPITALS

Submitted by

Jane Hurd
President
California Association of Children's Hospitals

Before the

SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
David Durenberger, Chairman

RE: FY 1984 BUDGET REQUEST
FOR THE MEDICAID PROGRAM

Introduction

The California Association of Children's Hospitals (CACH) is a nonprofit organization founded to promote adequate recognition of the special needs and circumstances of children's hospitals in the formulation of public health care policy. The Association is composed of seven member institutions providing the vast majority of all tertiary and many of the secondary health care services to children in the State of California.

As documented in the Study to Quantify the Uniqueness of Children's Hospitals, these institutions operate at a higher cost than general hospitals because of the type and intensity of care required for their patient population. For example, children's hospitals maintain more specialized services, such as neonatal care, treatment for developmental disabilities and family counseling, and devote a greater percentage of beds and days of hospitalization to intensive care than general hospitals. Also, quite simply, children require substantially more attention by health professionals than other patient populations.

In addition to the specialized, intensive care provided to their patients, children's hospitals serve a proportionately greater number of indigent children. On the average, children's hospitals deliver a significantly higher percentage of free care -- averaging about 17 percent of total gross charges --

than general hospitals. Moreover, within each of our children's hospitals, Medicaid beneficiaries represent from one-third to over one-half of all patients served. Clearly, children's hospitals are heavily dependent on public revenues to support their health care facilities.

From this unique perspective, CACH would like to take this opportunity to comment on the Administration's Fiscal Year (FY) 1984 budget proposal.

## MEDICAID
## (Title XIX of the Social Security Act)

### Copayments

Prior to the passage of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), states were allowed to impose cost-sharing requirements on the categorically eligible (i.e., individuals receiving cash assistance) only for optional services and on the medically needy (i.e., individuals with incomes above cash assistance standards) for all medical services. In contrast, TEFRA allowed states to impose copayments on both categorically eligible and medically needy individuals for all health care services. However, children and pregnant women as well as individuals in long-term care facilities were exempted from these copayment requirements.

For FY 1984, the Administration would require states to extend cost-sharing requirements for all inpatient and outpatient services, including services rendered to children. For the categorically eligible, a $1.00 per visit copayment would be charged for physician, clinic and hospital outpatient services and a $1.00 per day copayment would be assessed for inpatient hospital services. For the medically needy, a $1.50 per visit copayment would be charged for physician, clinic and hospital outpatient services and a $2.00 copayment would be assessed for inpatient hospital services. In an attempt to reduce the unnecessary utilization of health care services, this proposal allegedly would result in $249 million in savings for 1984.

First and foremost, the greater percentage of children are hospitalized, not out of choice or election, but because they are extremely sick. In fact, the major costs associated with the hospitalization of children arise from treatment intensity, including extensive nursing care. Once a child has been hospitalized, copayments will not contain the cost of providing specialized services and intensive care.

Second, children cost the Medicaid program substantially less than any other age group. Although they comprise almost half of the recipient population, children account for only 19 percent of Medicaid expenditures. To the extent that these children are subjected to cost-sharing requirements, the savings generated will be minimal.

Finally, children's hospitals will be forced to attempt collection and, where families are unable to pay the cost-sharing fee, absorb the additional cost of providing this health care at no charge. Given the proportionately high percentage of nonpaying patients and Medicaid beneficiaries served by our children's hospitals, coupled with the budget cutbacks in the Medicaid program already sustained over the past years, we simply cannot afford this additional reduction in revenues.

Of course, the real impact of these copayment requirements will be seen in their effect on the health of this nation's children. Out of financial necessity, hospitals increasingly will be forced to terminate crucial health care services and to undercut the quality of these services. Ultimately, the ten million children whose sole means of financing medical treatment and hospitalization is Medicaid will suffer from the added financial burdens of these copayment requirements as well as the inability to obtain necessary health care services.

For these reasons, we urge this Subcommittee to reject the Administration's FY 1984 proposal to extend cost-sharing requirements under the Medicaid program to children.

Federal Matching Payments

The 1981 Omnibus Budget Reconciliation Act reduced federal payments to states for Medicaid by three percent, four percent

and 4.5 percent in 1982, 1983 and 1984, respectively. As a part of its FY 1984 budget request, the Administration is proposing to extend the authority for these reductions in federal matching payments, including the offsets, at three percent in 1985 and beyond. The cost to the State of California would be approximately $100 million annually.

As you undoubtedly are aware, the $3.1 billion in Medicaid cuts in FY 1982, FY 1983 and FY 1984 under the 1981 Budget Act have forced states to cut back on preventive and supportive health services for low income families and children. In a national survey conducted by the Children's Defense Fund on the impact of federal budget reductions on state programs during 1982, every state reported cutbacks in their Medicaid programs as a result of stricter eligibility requirements and/or limitations on health care services. In addition, most of an estimated 1.5 million children, recorded as losing AFDC status since October, 1981, have lost their Medicaid eligibility.

In the State of California, stricter financial criteria have been imposed on the "medically needy" to limit eligibility in the Medicaid program. In addition, copayments have been established for Medicaid beneficiaries, including children over twelve years of age, to receive health care services. (Because these copayments are "experimental," they have been excluded from the 1982 law prohibiting the imposition of copayments on

children under the age of 18 years.) Moreover, certain drugs have been eliminated from the list of prescribed drugs covered under the Medicaid program.

For organizations like children's hospitals, these cutbacks have posed severe financial problems. In several of our member institutions, the inpatient rates for private patients already have been marked up to cover revenue losses from outpatient services, inpatient services for indigent patients, shortfalls in the State's Medi-Cal program and bad debts. Further cost shifting to offset the proposed reductions in Medicaid payments only will encourage private patients to go to other hospitals and clinics for treatment. This shrinking of the private patient base, in turn, will exacerbate the problem by forcing our children's hospitals to become even more dependent upon the Medi-Cal program. Quite simply, very little opportunity exists for the hospitals to shift costs to other sources.

The results of these proposed reductions will be to force our member institutions to provide even higher levels of free care and/or cut back on previously provided services. Ultimately, the communities served by our hospitals will suffer from the added financial burdens of receiving this health care as well as the inability, in some instances, to obtain necessary services.

For these reasons, we urge this Subcommittee to reject the Administration's FY 1984 proposal to reduce federal matching payments by three percent in 1985 and beyond.

Healthcare Financial Management Association

Ronald R. Kovener, FHFMA, CAE, Vice President

Statement of the
Healthcare Financial Management Association
to the
Subcommittee on Health
Senate Committee on Finance
on
Medicare Cost Sharing

May 23, 1983
(hearing held May 9, 1983)

Summary of principal points:

HFMA supports Medicare beneficiary financial participation through cost sharing and believes cost sharing should achieve the following objectives:

1. influence demand, while not discouraging access to essential services

2. influence choice of service (for example, encourage lower cost ambulatory or home service in preference to inpatient service)

3. improve the patient's understanding of services provided and their value

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4. permit patients to express their preferences and priorities

5. contribute to accurate reporting to the patient of services provided

6. provide essential financial resources when other priorities dictate limitations on funding by the Medicare program

7. permit discretion and flexibility for providers of services and the patient

The Healthcare Financial Management Association (HFMA) has more than 22,000 individual members who are financial managers of healthcare providers or who are closely associated with the financial management activities of healthcare providers. These members are involved in evaluating and implementing the Medicare payment system and are, therefore, very interested in the Medicare cost sharing requirements and proposals to restructure and modify these requirements. We appreciate the opportunity to present HFMA views on cost sharing by the Medicare beneficiary.

HFMA believes that the concept of Medicare beneficiary cost sharing is especially important in view of congressional action adopting prospective payment for Medicare inpatient hospital services. Prospective payment will provide increased financial incentives to hospitals to control the cost of services through

the more efficient use of healthcare system resources by patients and physicians. The Medicare beneficiary should have similar financial incentives if the goals of prospective payment are to be realized. This reassessment is also timely in view of recent research evidence that patient payment influences use of services, but does not adversely affect health status.

HFMA supports the objective of the Administration's effort to restructure Medicare beneficiary cost sharing for hospital services under Part A. We agree with the Administration proposal that restructuring of hospital coinsurance charges for the second through the 60th day of hospitalization is an important step toward needed reform of the present Medicare cost sharing requirements. However, additional changes in beneficiary cost sharing will be required to fulfill the above listed objectives.

Beneficiary Cost Awareness

Beneficiary cost sharing should promote cost awareness and thereby discourage unnecessary utilization of health services and encourage the use of less expensive alternatives for health care. Present requirements for hospital cost sharing do not achieve this objective. After the payment of an initial deductible ($304 in 1983), the first 60 days of hospitalization for a spell of illness are covered in full. After 60 days, a coinsurance payment of 25% of the initial deductible is charged

for each day. After 90 days, beneficiaries may use their one-time reserve of 60 days with a required payment of 50% of the initial deductible per day.

This approach does not provide appropriate incentives for the beneficiary to consider the financial implications of an extended stay in the hospital until the number of patient days during a spell of illness reaches 60 days. Thus, there is little financial incentive for the patient to use the healthcare system more efficiently by actively cooperating in the search for alternatives to inpatient care such as home health care.

The Administration's proposal to require cost sharing for each patient day will provide the necessary financial incentive to beneficiaries to avoid unnecessary days of care in the hospital. We believe this will promote greater beneficiary understanding of the cost of services and the availability of effective and less expensive alternatives.

Current cost sharing provisions (and the Administration's proposal) are the same for all institutions regardless of the costliness of service provided. Cost sharing can be structured in a way that financially benefits patients for low cost choices, while also reducing Medicare outlays for services. Conversely,

cost sharing can be structured to permit a patient to choose a higher cost alternative which is consistent with the patient's preferences and priorities, but does not result in higher Medicare expenditures.

Beneficiary Access to Essential Services

Cost sharing should not be so burdensome as to impede access to essential health services. While many beneficiaries have adequate financial resources available for increased cost sharing, others do not and may be adversely affected. Limits on beneficiary cost sharing are appropriate and should be designed to ensure access to needed services even when financial resources are limited.

Several alternatives are available and should be considered. The Administration's "catastrophic coverage" proposal would remove the limit on covered days of hospital care during a spell of illness and eliminate coinsurance after the 60th day. This will benefit the relatively few beneficiaries who face very large coinsurance requirements.

Another alternative might be to condition cost sharing requirements on beneficary income. In this way cost sharing could be designed to take into account the special circumstances of individual beneficiaries by imposing variable cost sharing

based on income levels. The practical and philosophical problems in implementing this alternative are substantial and should be carefully studied to determine feasibility.

Use of Cost Sharing to Promote Price Competition

HFMA believes increased provider discretion in assessing cost sharing amounts is essential and consistent with the goals of the recently enacted hospital prospective payment system. Cost sharing requirements should be structured so that providers have the option of either reducing or eliminating beneficiary financial liability. This would encourage price competition among providers and would also encourage the beneficary to evaluate alternative providers. For example, some providers may wish to forego or reduce hospital coinsurance charges for selected services in order to attract beneficiaries and thereby achieve operating economies.

Use of Cost Sharing to Match Services to Beneficiary Priorities and Preferences

Restructuring Medicare cost sharing holds the potential, not only for cutting federal spending, but also for providing additional financial resources to providers. The current cost sharing requirements and the Administration's proposed modifications reduce federal spending by shifting the liability for covered

services to the beneficiary. This is done in an arbitrary manner which does not permit beneficiaries to express their preferences or for the government to receive any indication of whether its spending priority is consistent with the public's priorities. Beneficiary willingness to pay additional amounts for covered services would provide a measure of any disparity between government and beneficiary healthcare priorities. Quality, variety, innovation and development of healthcare services should not be limited exclusively by government funding priorities. It should not be necessary for hospitals to withdraw from the Medicare program in order to be responsive to the needs and preferences of their patients.

Medicare cost sharing requirements need to be modified so that beneficiaries can choose additional services if they wish to pay additional amounts. The hospital prospective payment system prohibits additional charges to beneficiaries for covered services in excess of the coinsurance and deductible amounts required by the Social Security Act. HFMA urges Congress to reconsider this position. Beneficiaries should be able to express their preferences and priorities with respect to choice of hospitals and services, similar to their ability to choose physicians who charge more for services than Medicare will pay. Charges to patients in excess of required cost sharing amounts should be permitted if there is adequate notice and agreement by the beneficiary.

Administration Should be Simplified

The current combination of deductibles, coinsurance, "spell of illnes" and "life-time reserves" provisions are an administrative nightmare. Patients and providers alike are unable to quickly and accurately determine who is responsible for what. The Administration's proposal will simplify the administration of the coinsurance provisions of existing law somewhat because all days of care after 60 days of hospitalization each year would be covered without regard to the spell of illness criteria. Other changes are needed to reduce administrative complexity which is costly for the government and providers. Beneficiaries also suffer from uncertainty and retroactive determinations. A system of eligibility determination and decisive, prompt decisions should be as practical for Medicare as it is for VISA or MasterCard.

In summary, we would like to reiterate HFMA's recognition of the need for prompt action to reform the current cost sharing requirements of the Medicare program. The Administration's proposal is a limited, but important, first step toward this objective. Beneficiary cost sharing should be modified to achieve the objectives enumerated through such steps as:

- encouraging cost awareness and thereby discouraging unnecessary utilization and encouraging the use of less expensive alternatives;

- assuring access to needed services which may require limits on cost sharing amounts;

- allowing providers discretion in assessing cost sharing amounts to encourage price competition;

- allowing beneficiaries to pay additional amounts for services if they choose; and

- simplifying the administration of these provisions.

We appreciate the opportunity to present HFMA views on cost sharing. HFMA staff are available to further discuss this issue.

TESTIMONY

Submitted To

The Subcommittee on Health
U.S. Senate Finance Committee

On

FY '84 Budget Proposals Related To
Medicare & Medicaid Cost Sharing Requirements

On Behalf of

THE JOINT PUBLIC AFFAIRS COMMITTEE FOR OLDER ADULTS (JPAC)

May 16, 1983

Contact: Judith Duhl, Director
Caryn Resnick, Program Associate
JPAC, 40 W. 68 Street, NYC 10023
(212) 724-3200

Mr. Chairman and members of the Finance Subcommittee on Health. I write to you on behalf of the thousands of elderly who are affiliated with the Joint Public Affairs Committee for Older Adults (JPAC). JPAC is a citizen action coalition of older adults with representatives of more than 100 senior centers throughout metropolitan New York. Health care, especially Medicare, has been of special concern to JPAC. We therefore appreciate this opportunity to present our views on the future financing of the Medicare program.

The majority of our members are Medicare beneficiaries, and depend heavily on Medicare to cover a portion of their costly medical care. We are extremely alarmed by the Administration's recent budget proposals for FY '84 to control escalating health care costs by penalizing beneficiaries. We believe that Congress must explore cost control strategies that apply to the entire health care system. Shifting costs to the elderly beneficiary who is unable to accept additional financial burdens is inequitable and irresponsible. Alternative strategies which would resolve the inflationary costs of the Medicare program are available and must be pursued so that elderly beneficiaries will not continue to be victimized because they are old and they are sick. They simply cannot afford it.

Medicare as it exists today covers only about 44% of the older persons total health care costs. The remainder comes out of the pockets of the 26 million elderly Medicare beneficiaries, the majority of whom are living on fixed incomes.

The elderly over all, remain one of the lower income groups in the United States. The Bureau of Census reports that in 1981 the mean income for the elderly was $14,246 per household; $8,202 per person. The number of poor persons over 65 was 3.9 million, with a poverty rate of 15.3 percent. In 1981, the percent of the elderly over 65 whose income was below 125 percent of the poverty level was 43.3 percent.

The elderly are forced to spend large amounts of their limited resources on health care costs not covered by Medicare. The elderly, more than any age group are vulnerable to the harsh impact of illness and the frightening cost of health care which takes a disproportionate amount of their income. The fear and anxiety which accompanies serious illness, the specter of being reduced to poverty was allayed with the advent of Medicare. Now once again, the proposed increases in Medicare costs to the elderly person cast a dark shadow.

Medicare coverage is limited and costly to the beneficiary. In addition to paying ever increasing deductibles for Part A and for Part B, the Medicare beneficiary pays annual premiums and daily co-payments for hospital stays beyond 60 days. The

beneficiary must pay co-payments for a skilled nursing facility after the 20th day. S/he is also responsible for the total cost of extended care facilities if s/he does not need skilled care, and is not Medicaid-eligible. Other uncovered costs include most eye, dental, ear, and foot care and related prosthetic devices. Beneficiaries are also responsible for the full cost of prescription drugs outside the hospital. Older persons pay for all doctors' charges in excess of the Medicare Reasonable Fees in addition to the required 20%. Only one-half of all doctors accept the current Medicare assignment.

The need to control Medicare costs is understood by us all - but not by overburdening its beneficiaries - the sick, old, and disabled. In the face of projections of bankruptcy of the Part A trust funds, the Medicare system has already experienced a series of short-term reductions, all of which weigh heavily on the elderly beneficiary - none of which control health care costs across the board nor reduce the nation's total health bill.

In the first 2 years of our present Administration, we have seen cuts in the Medicare program that by 1986 will total $22 billion, by cutting Medicare coverage and increasing the costs to recipients.

- The Part A deductible was increased from $204 to $260 and, as of January 1, 1983, to $304. The deductible will be $350 in 1984.

- The Part B deductible was increased from $60 to $75.

- The Part B premium rates have increased from $11.00 to $12.20 and are scheduled to increase to $13.70 by January 1, 1984. Furthermore, premiums will be fixed at 25% of program costs and will increase as program costs continue to rise.

- Reimbursement to radiologists and pathologists were reduced to 80% from 100%.

The Administration's proposals for the FY '84 Medicare budget continue to shift costs to the elderly:

Current Administration Proposals For Medicare include the following:

. Increase Part B deductible to $85;
. Increase Part B premiums to $32.00 by 1988;
. Require the elderly to pay a share of hospital costs.

Currently, seniors pay a $304 deductible for the first day of hospitalization. Medicare pays the full cost for days 2 through 60. Beneficiaries pay $76/day for days 61 through 90, and pay $152/day for days 91-150.

The Administration proposes:

. Part A deductible, plus
. $28.00/day for days 2 - 15;
. $17.50/day for the next 45 days;
. no cost after 60 days.

The Administration says this proposal would reduce out-of-pocket expenses for seniors with long stays in the hospital. However, of the 7 million Medicare beneficiaries hospitalized each year, only 200,000 stay in the hospital more than two months. Under the new proposals, a person in the hospital for two weeks would be forced to pay twice as much as it costs now - $714 instead of $304. Most Medicare patients stand to lose under this proposal.

OTHER PROPOSALS still under consideration include:

. voucher system - the elderly would be given a lump sum in order to purchase a private health insurance plan;

. introduce a "means test", whereby only lower-income elderly would be eligible for Medicare benefits.

. impose a freeze on physicians' fees. This proposal would not freeze the doctor's bill to recipients, but would instead increase the difference between Medicare-reimbursed "reasonable charge" and the ultimate cost to the patient.

The Administration's proposals are an assault on the poorest of the sick. We adamantly urge solutions to the Medicare budget deficit by containing hospital costs and restructuring the health care system. The elderly cannot and will not be penalized because of illness.

The elderly simply cannot absorb any further out-of-pocket costs for their health care, nor can they afford to lose any benefits. It is time for public policy makers to stop blaming the victims of high health care costs and include the providers into the responsibility of health care.

Alternative strategies which would not impose additional financial burdens on the elderly, but which could efficiently reduce Medicare costs are possible and should be sought.

In conclusion, we urge that you evaluate your recommendations realistically, keeping in mind that older people need a very broad spectrum of health care services ranging from preventive care to acute hospital care to chronic or long-term care, including home health care. The elderly also need a health care insurance system that realistically matches their financial needs.

Thank you for this opportunity to present our views.

# Written Testimony
# of the
# American Health Care Association

## Presented for Hearings of the
## Senate Finance Committee Subcommittee on Health
## on
## FY84 Budget Proposals Related to Medicare
## and Medicaid Cost Sharing Requirements

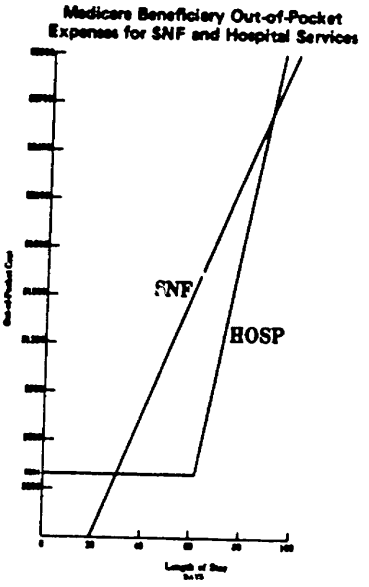
May 9, 1983

The American Health Care Association, representing nearly 8,000 long term care facilities who provide care for over 750,000 elderly, chronically ill, and convalescent people, appreciates the opportunity to comment on budget proposals related to Medicare cost sharing requirements. The Medicare coinsurance for skilled nursing facility services ($38 in 1983) is currently fixed at 12.5 percent of the hospital deductible and is payable for the 21st through 100th day of SNF care. As part of its budget package, the Administration has proposed that the rate be reduced to 5 percent of the hospital deductible ($15.24 in 1983).

AHCA supports the Administration's proposal to reduce the SNF patient's cost sharing under Medicare. The present cost sharing for SNF patients is excessive, especially relative to other Medicare services. Currently a SNF patient, after already have paid the hospital deductible and possibly coinsurance, must pay $38 per day from the 21st day to the maximus 100th day. In many areas of the country, a $38 fee approaches 100 percent of the facility's reimbursement. In contrast, home health recipients pay nothing and hospital patients pay nothing beyond the deductible until the 61st day. An erosion of the SNF benefit has occurred because it is linked to the faster rising hospital costs.

According to current practices, a Medicare patient spending 60 days in a hospital in 1983 will pay a deductible of $304, but if in a SNF for the same number of days would be faced with

5 times that amount in copayments: $1,520. The chart below shows the cumulative impact of patient cost sharing for SNF vs. hospital care.




As a result, patients needing nursing home care for an extended period of time cannot utilize the full 100-day Medicare benefit without severely depleting or completely liquidating financial resources. Consequently, many individuals are faced with the choice of refusing care or joining the thousands of impoverished Americans on the Medicaid rolls - for the Medicaid program does cover extended stays in SNFs as well as intermediate care facilities (ICFs).

We believe the present requirement is unfair and therefore support efforts to reduce the SNF patients' cost sharing. However, when a SNF prospective payment is implemented, the SNF coinsurance should be set at a percentage of the SNF's payment rate, rather than perpetuate the artificial linkage to inflationary hospital costs.

# STATEMENT FOR THE RECORD

ON HEARINGS ON

THE IMPACT OF THE ADMINISTRATION'S FY 1984 BUDGET

FOR BENEFICIARY COST SHARING UNDER MEDICARE

SUBMITTED BY

JAMES A. COX, JR.
EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

May 16, 1983

Mr. Chairman:

This statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF). NARF is the national voluntary membership association of community based rehabilitation facilities. Our membership includes freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities and vocationally oriented facilities including sheltered workshops, work activity centers and developmental centers. Of our medical membership, most if not all are Medicare providers and are nonprofit in nature. They serve Medicare beneficiaries suffering from stroke, heart attack, chronic disease and other illnesses common to the elderly and disabled.

In its FY 1984 budget, the Administration has proposed a four part program to decrease rapidly escalating costs associated with the Medicare program. One facet of this program is what the Administration has termed Medicare catastrophic coverage and beneficiary cost sharing. We believe that the Administration's proposal is a misuse of the term catastrophic coverage as it has been used traditionally over the last 15 years and would create a true catastrophy for Medicare beneficiaries if implmented as proposed.

Under current law, on the first day of hospitalization a beneficiary pays a deductible which will be $350 in 1984 under Part A of Medicare. The beneficiary does not pay any additional costs until the 60th day. At that time, the beneficiary pays one fourth of the deductible for days 61 through 90 and if

hospitalization continues to be required, pays one half of the deductible for days 90 through 150. If the beneficiary exhausts these lifetime reserve days, then he or she is reponsible for the full cost of hospitalization until that spell of illness is finished.

The Administration's proposal would restructure payment of the deductible. It proposes that a beneficiary pay the first day's deductible, and then be required to pay an amount equal to 8 percent of the deductible for days 2 through 15 in a spell of illness. For days 16 through 60, the deductible will be reduced to 5 percent. After 60 days the beneficiary will not be required to make any further payments for hospitals costs. Currently under Medicare, the maximum a beneficiary hospitalized for 150 consecutive days in 1984 would pay is $13,475 out of his or her own resources. The Administration notes that under the new plan a beneficiary's expenses would be $1,530 with no additional coinsurance after 60 days. The Administration has also noted that some 170,000 Medicare beneficiaries each year experience a spell of illness involving more than 60 days in a hospital. This means that less than 1% of the approximately 30 million beneficiaries would benefit from this change.

The average inpatient hospital stay is 7 to 11 days. Under the Administration's proposal, the average hospitalized Medicare beneficiary's total cost per hospital stay in 1984 would range from $510 to $630 vs. $350. However, the picture is quite different for a typical beneficiary in a rehabilitation setting where the length of stay is longer because of the nature and severity of the illness. Depending on the patient's condition, the length of stay generally for freestanding hospitals and units averages about 25 days. Hence, the cost of an average stay for a beneficiary in a rehabilitation setting would go from $350 for the first day with no cost sharing, for days 2 through 25, to $917 ($350 plus $28.00 times 14 days plus $17.50 times 10 days). Therefore, the

average Medicare beneficiary in a short term acute care setting would increase his or her out of pocket expenses by a factor of two while a typical rehabiitation patient's out of pocket expenses would increase by a factor of almost three.

Shifting such costs to the beneficiaries in this manner is unwise and other considerations should be made in attempting to restrain costs under Medicare. A beneficiary's greatest fear is of exorbitant financial obligations due to a long illness. Shifting costs to the rehabilitation beneficiary ignores that many of these people will be discharged out of the hospital and need additional care either at home, in a nursing home, or on an outpatient basis. They are required to pay for this care through Part B premiums and existing coinsurance. If the individual needs extensive skilled nursing services and certain home health services - these must be paid out of the person's pocket. The Administration and others have stated that shifting costs to beneficiaries will make people more conscious of costs and thereby reduce use. While possibly true if beneficiaries must pay more they may delay seeking medical advice and then seek it when they are considerably sicker and require more resources. Studies by the Rand Corporation and others using various levels of cost sharing show that use is reduced. However, these studies use younger, working people as a control group. They do not study the effect on Medicare beneficiaries who tend to have greater medical needs. Also, these studies and others have noted that no long term followup has been done. No one knows the impact on people's health status.

In addition, facilities may face some administrative problems and potentially higher debts if enacted. If beneficiaries are responsible for direct payment, the question then becomes who is responsible for collecting it. If the provider is responsible, it must consider what effect increased finacial responsibility

of Medicare beneficiares will have on its billing and collection procedures and on its bad debt load. Additionally, a hospital may consider whether or not they will continue to admit a Medicare beneficiary if it is already in considerable financial difficulty.

Therrefore, we recommend that your committee, in examining ways in which to control health care costs under the Medicare program, reject the Administration's proposal as it examines ways to control health care costs under Medicare. It will have an adverse effect on specialty rehabilitation providers and may result, in the long run, in decreased access for Medicare beneficiaries, increased program costs as facilities consider the increased costs of collection and administration and an adverse effect on the financial status of the elderly Medicare beneficiary. People will be served in acute care settings not familiar with rehabilitation requirements and other people will not be served at all. We recognize the urgent need to consider a way to finance the Medicare program and that beneficiary cost sharing is one option. If any cost sharing is to be imposed it should be considered only in conjunction with improved true catastrophic protection so that the more ill beneficiary does not face great financial expense.

NATIONAL COUNCIL OF STATE
PUBLIC WELFARE ADMINISTRATORS
OF THE AMERICAN PUBLIC WELFARE ASSOCIATION
1125 FIFTEENTH STREET, N.W. WASHINGTON, D.C. 20005

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TESTIMONY

OF THE

NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

OF THE

AMERICAN PUBLIC WELFARE ASSOCIATION

FOR THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

U.S. SENATE

HEARINGS ON MEDICARE AND MEDICAID COST SHARING

May 16, 1983

23-270 O—83——18

The National Council of State Public Welfare Administrators, consisting of the chief executives and managers of the state human service agencies responsible for administering Medicaid, is concerned about the administration's FY 84 proposals to require increased cost sharing by Medicaid and Medicare recipients. We believe the proposal for mandatory Medicaid copayments would impose inappropriate financial burdens on both recipients and state governments and would significantly complicate the administration of Medicaid in all states. As for the recommendation to increase Medicare hospital coinsurance, states are in no position financially to cover this cost for low-income Medicare beneficiaries who qualify for Medicaid.

In 1981, Congress passed the Omnibus Budget Reconciliation Act, which provides states with greater flexibility and control in administering a more economical Medicaid program. As a result, states have successfully acted to reduce the growth in Medicaid costs. From a historic growth rate of 15 percent, Medicaid's growth fell to less than 10 percent last year. With continued revenue shortfalls in most states during the recession, reforms have been needed to maintain a Medicaid program that continues to provide adequate care.

The key to these reforms is that they have given states the latitude to adjust Medicaid to state-specific circumstances. Rather than cut back essential program benefits and eligibility, states have mainly used the new flexibility in program administration to save funds while maintaining services. The National Council of State Public Welfare Administrators

has supported congressional initiatives to give states needed discretion and will continue to support proposals of this nature to the extent they allow states to maintain a viable program within fiscal constraints.

Viewed against this background, we cannot support the administration's proposal to implement mandatory copayments in Medicaid. Our position is that, while copayments may be a worthwhile policy to pursue, states should be given the flexibility to decide which services copayments apply to, at what levels they are to be set, and which groups of recipients are to be affected by them. Copayments can be a way to reduce inappropriate utilization. But requiring, for example, the same copayment for outpatient hospital services as for visits to clinics' or doctors' offices--as the administration proposes--provides no incentive to make the desired shift from costly outpatient hospital services to less expensive physician services. An equal copayment on each of these services simply serves as an additional revenue source or way to avoid costs. The states believe that such a policy would neither improve program efficiency nor be fair to Medicaid recipients.

Some states do not anticipate any benefits from copayments--others see them as a way to reduce inappropriate utilization and save money. But if they are to serve as a method of improving utilization patterns, a state must be given the authority to set them according to its own characteristics. Factors such as the composition of the state's Medicaid population, its degree of urbanization and the availability of alternative service delivery have an impact on the way in which copayments

should be used.

The service for which states most often express a need for copayments is primary care delivered in emergency rooms. A visit to an emergency room for such care often costs the Medicaid program several times the amount the service would have cost if it had been delivered in a physician's office. This is program money lost, which could have provided benefits to other recipients who need care. If states were allowed to use copayments in situations such as this, without exemptions, and without placing any or the same copayment on alternatives, such as visits to a physician's office, they would retain money that could be better used to provide more care in other settings. Mandatory copayments under the administration's plan simply do not promote the efficient use of program resources.

For similar reasons, the provision in the Tax Equity and Fiscal Responsibility Act (TEFRA) exempting certain groups and services from copayments also causes less efficient and equitable administration of program funds. First, the populations exempted from copayments under TEFRA comprise a very large portion of each state's overall Medicaid population, meaning that the effectiveness of copayments in controlling utilization is severely limited. Second, the administration of these exemptions, particularly the one pertaining to services for pregnant women, has proved so difficult that some states which previously imposed copayments on optional services have eliminated them altogether. Determination of whether a woman is pregnant or not, or of which services relate to pregnancy, creates more administrative

inefficiencies and costs than states believe justify continuation of any copayments. Finally, the states find that it is simply inequitable to exempt some groups and not others. Copayments should be imposed to discourage inappropriate utilization, regardless of the Medicaid groups involved. The states hope that the subcommittee will seriously consider repealing some, if not all, of the copayment exemptions enacted last year.

The subcommittee should also be aware of the impact changes in Medicare cost sharing would have on Medicaid. Though Medicaid is hardly a small program, the influence of Medicare policy upon Medicaid is often viewed as an incidental matter. Yet, nothing could be further from the truth. The administration has proposed to restructure Part A of the Medicare program so that recipients would pay a larger portion of their first 60 days in the hospital in any year, and bear no costs for stays exceeding that time. While the National Council of State Puhlic Welfare Administrators has not taken a position on this proposal per se, we believe it would cost states more money at a time when they cannot even finance their own programs adequately. This is because Medicaid would apparently have to pay for the new coinsurance for recipients who are eligible in both the Medicaid and Medicare programs. Because approximately half of this new money would come from the states, the net effect would be a shift in Medicare program costs from the federal government to the state and local governments, many of whom have worse financial situations than does the federal government.

In conclusion, the National Council of State Public Welfare Administrators believes that copayments in the Medicaid program can be useful to states in controlling inappropriate utilization, but neither the administration's proposal nor current federal law allows states the latitude to implement such a policy in an effective manner. Modifications in the Medicaid statute are needed to allow states to implement copayments so that unnecessary care is reduced, regardless of the recipient group involved. We also want to strongly encourage the Senate Finance Committee to take into consideration the impact on Medicaid and state treasuries of the administration's Medicare cost sharing proposals.

STATEMENT OF

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS (NAMES)

BEFORE THE

SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

ON

HEALTH CARE FINANCING ADMINISTRATION BUDGET
PROPOSALS and PROGRAMS
RELATED TO COST SHARING

May 16, 1983

This statement is submitted for the record on behalf of the National Association of Medical Equipment Suppliers (NAMES). NAMES is a national trade association representing suppliers of durable medical equipment (DME) for use in the home. In 1982, we estimated that NAMES 1000 members supplied medical equipment to over two million patients in their homes in every state.

Most NAMES members are small businesses serving local communities or small geographic areas. They work closely with physicians, hospital discharge planners, therapists, nurses and the patient's family to provide quality medical products and services at reasonable and competitive prices. The DME industry is heavily oriented toward service. NAMES estimates that the typical DME supplier spends less than 35% of their total cost of doing business on the purchase of equipment and approximately 50% of the cost of doing business on service related expenses.

For example, most NAMES members who deliver and maintain respiratory equipment provide monthly house calls by a respiratory therapist or other trained employee. This individual checks the equipment, sees if the patient is following the doctor's orders and answers any questions the patient may have. Patients often develop a very close relationship with the supplier.

Purpose of Statement

Mr. Chairman, our purpose in testifying today is twofold. First, we wish to express our support for Section 104 of S.643 which would mandate siuilar reimbursement for DME whether such equipment is furnished as a "medical or other health service"

under Part B of the Medicare program, or as a "medical appliance" under the home health service benefits of the Medicare program. Second, we think it is important for the Committee to understand that the coinsurance proposal only partially addresses the issue of the hospital industry's entry into and potential control over allied health fields such as durable medical equipment purchased or rented through hospital based home health agencies.

The 80 Percent Reimbursement

Adoption of Section 104 would ensure uniform reimbursement for DME furnished to a beneficiary in his home regardless of whether the equipment was supplied by a hospital based or free-standing home health agency or DME supplier. Currently home health agencies have an unfair competitive advantage because the Medicare beneficiary is not currently required to pay the $75 deductible and 20% coinsurance which the DME supplier must collect from the beneficiary for the same equipment. Thus, the most important component of a free market, price, is not a factor in the beneficiary's selection of an equipment supplier.

Without passage of Section 104 NAMES sees a growing issue with hospital based and other home health agencies entering the durable medical equipment business and receiving 100% Medicare reimbursement. These new market entries are very likely to be accelerated with the advent of prospective reimbursement for hospitals and the earlier discharge of patients into home health. If this proposal is accepted HCFA estimates cost savings to the Medicare program of $15 million for 1984 and 1985; $20 million

for 1986 and 1987 and $25 million for 1988. We believe the Committee should adopt section 104 and institute equality in reimbursement and increase competition with lower costs to the Medicare program.

NAMES is as concerned as the critics of Section 104 are with the possibility of Medicare beneficiaries being unable to obtain necessary equipment without 100% reimbursement. The durable medical equipment industry and many Medicare beneficiaries have lived with 80 percent reimbursement under Part B for over 15 years. While some beneficiaries have been unable to obtain equipment we have found, on the whole, that the overwhelming majority of beneficiaries are able to obtain necessary equipment and handle the 20 percent they owe through co-insurance, Medicaid, state aid or family support. In short, it is not as severe a problem as perceived by the critics of Section 104.

Competition

Another problem of unfair competition is not addressed by S.643. Many hospitals and some independent home health agencies are expanding their operations into all facets of home health, including DME under Part B. The DME industry welcomes competition provided it is fair and based on the traditional concepts of reasonable price and quality of service and care. Competition is being short circuited as hospitals refer their home care patients directly to hospital owned DME companies. This control over the patient is both unfair and improper. It impedes competition by not providing the opportunity

for patients, their family or physician to determine if medical equipment can be found which is lower priced or of a better quality from an equipment supplier which provides better service, more professional expertise and longer ties to the community.

NAMES therefore proposes that where a hospital and/or home health agency is related to the durable medical equipment company by way of common ownership or control Medicare will not reimburse the hospital, home health agency or equipment supplier unless there is a full disclosure of all available medical equipment suppliers in the area, the services they offer, the relationship between the hospital or home health agency and the commonly owned or controlled DME supplier and any other information competing suppliers wish to furnish the patient, their family or physician for consideration in making an equipment purchasing decision. If the patient, family and/or physician, wishes to meet with an individual supplier they should be allowed to do so without the consent of the hospital.

This would save the Medicare program revenues by increasing competition and eliminating potential overutilization of home health services through a hospital owned DME supplier. It would be similar to the related organization principal embodied under Part A regulations with a "reverse twist" designed to promote competition is to provide more competition in the home health care field with an eye to reducing costs while providing more patient services.

Definition of Durable Medical Equipment

NAMES supports the Administration's effort to bring a consistent use of the term "durable medical equipment" to the Medicare program. NAMES recommends however that the definition proposed in section 104 be revised to reflect the current state of the art technology. For example, oxygen tents and iron lungs are not commonly used. A more up-to-date description is necessary. We would be pleased to work with your staff on this and other issues raised in this testimony.

Conclusion

Mr. Chairman, NAMES supports the Administration's proposal to require cost sharing for DME furnished as a home health benefit and urges the committee to provide greater competition and beneficiary freedom of choice where hospitals are related to DME companies. Thank you for the opportunity to present our comments.

STATEMENT SUBMITTED BY
NATIONAL ASSOCIATION OF MANUFACTURERS
TO THE INTERNAL REVENUE SERVICE
ON PROPOSED REGULATIONS UNDER SECTION 6661
OF THE INTERNAL REVENUE CODE RELATING TO THE
ADDITION TO TAX FOR THE SUBSTANTIAL UNDERSTATEMENT OF LIABILITY
May 16, 1983

The National Association of Manufacturers (NAM) is an organization comprised of nearly 12,000 member firms which account for nearly 80 percent of the nation's industrial output and 85 percent of the nation's industrial work force. While some of our member companies are large multi-divisional and multi-national organizations, more than three-fourths are generally classified as small businesses.

NAM is greatly concerned that the proposed regulations do not reflect the avowed Congressional intent of penalizing those who play the "audit lottery"--those who take highly questionable positions on tax returns "in the hope that they will not be audited." (Report of the Committee on Finance, United States Senate, on H.R. 4961, 97th Congress, 2nd Session at p. 272 (1982), hereinafter referred to as the "Finance Committee Report", and General Explanation of the Revenue Provisions Proposed by the Joint Committee on Taxation at p. 216 (1982), hereinafter referred to as the "Joint Committee Report.") We also find the proposed regulations inconsistent with the stated Congressional intent of creating "a more flexible standard under which the courts may assure that taxpayers... who endeavor in good faith to fairly self-assess are not penalized." (Joint Committee Report, pp. 217-218).

In lieu of following these Congressional guidelines, the proposed regulations give no assurance of penalty waiver to taxpayers who possess legal reasoning power equal to that of a member of the federal judiciary. Apparently well reasoned legal opinions, which contain citations of supporting legal authority and even conclude that the entire body of law (statutory, administrative, and judicial) supports the position of the taxpayer, cannot, under the proposed regulations, provide a taxpayer assurance that his tax adviser might not be in error and the taxpayer subject to the penalty. In addition, the proposed regulations purport to apply this new standard to all items contained in returns for all years prior to 1982 (contrary to the clear legislative intent) if losses or excessive tax credits from those years carry forward into 1982 or subsequent years. They also appear to disavow specific statutory authority permitting an avoidance of the penalty "if there is or was substantial authority" to support the taxpayer's position. (Our emphasis.)

Such is clearly an anathema to our American tradition of fair play and a challenge to the general success of our self-assessment tax system. In our complex tax system, where IRS errors are well documented and numerous technical questions cannot be answered with certainty, the proposed burden is just too great.

The following is a detailed analysis of the proposed regulations as well as our suggestions as to the content of final regulations.

CARRYOVERS ATTRIBUTABLE TO PRE-SECTION 6661 YEARS

Proposed Regulations Section 1.6661-2(d)(5)(i) provides that a net operating loss carryover, tax credit carryover or capital loss carryover is to be treated as a credit or deduction in the year in which taken into account. To the extent such item arises during a year with respect to which Section 6661 applies (a year with respect to which the return is due after December 31, 1982), we believe this view to be appropriate. To the extent, however, such carryovers are attributable to years prior to those to which Section 6661 applies, we believe the proposed regulations exceed both the scope of the statute and the underlying legislative intent.

Taxpayers should not be required to perform a tax audit of these earlier years to determine the existence of substantial authority for each and all of the items on such returns, the treatment of which contributed to the existence of a carryforward. For a 1982 calendar year taxpayer, this could mean the auditing of tax returns for the six years prior to 1982. This would be necessary to determine whether an adequate disclosure must be made on the 1982 tax return for items which met the "reasonable cause" test in the earlier returns--but might not come within the yet to be clarified definition of "substantial authority."

The intent of the Congress appears quite clear. Each item claimed on a return is to be analyzed to determine whether the treatment of such item is (1) supported by substantial authority or (2) facts affecting such item's tax treatment were adequately disclosed in the return. This burden is very substantial with respect to many taxpayers--particularly those taxpayers having a multitude of U.S. operating units as well as non-U.S. operating units. To believe that Congress intended this careful analysis to occur for pre-1982 federal income tax returns extends beyond a reasonable interpretation of Congressional intent. While individual items on the 1982 tax return may lend themselves to analysis within the time constraints given to file such return (provided certain suggested changes contained herein are adopted), it is submitted that the Congress did not intend that such item-by-item analysis be done with respect to all prior years' returns that result in a net carryforward item appearing on a 1982 tax return. Also, while we understand the IRS may view a carryforward "item" as the same as any other "item" appearing on a 1982 tax return, such composite or net carryforward "item" does not lend itself to an analysis as to support by substantial authority or adequate disclosure. Certain corporate taxpayers have already notified local IRS offices that tax audits must be postponed if the taxpayer's resources must be devoted to auditing pre-1982 tax returns and related financial records for potential disclosure requirements.

To be consistent with the legislative intent as well as not to subject taxpayers to an unconscionable if not impossible burden, Proposed Regulations Section 1.6661-2(d)(5)(i) should be amended to read as follows:

> "A net operating loss carryover, tax credit carryover or capital loss carryover shall be treated for purposes of this section as a credit or deduction in the year in which taken into account--except that as to a carryforward arising from a year for which a return was filed as to which Section 6661 does not apply, such credit or deduction shall be treated for the purposes of this section as a credit or deduction in such earlier year."

SUBSTANTIAL AUTHORITY FOR ISSUES OF FACT

Code Regulations Section 1.6661-3(b)(2) should be amended to include within the listing of authorities permitted to be considered in determining the existence of "substantial authority", the financial books and records of a corporation having a class of securities registered pursuant to Section 12 or required to file reports pursuant to Section 15(d) of the Securities Exchange Act of 1934, 15 U.S.C. Sections 78, et seq. Although the proposed regulations indicate that substantial authority is required for issues of fact as well as for issues of law, there are no examples of what constitutes authority for an issue of fact. Furthermore, the proposed regulations' listing of the types of authorities does not include any which would serve as authority for an issue of fact.

The Foreign Corrupt Practices Act requires every issuer of a class of securities, indicated above, to make and keep books, records, and accounts that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the issuer. We submit that this legal requirement to maintain accurate records, subject to criminal sanctions, should give those records the status of authority for the facts contained therein, at least for the purpose of avoiding a potential Section 6661 penalty.

As we understand the principal concern of Congress in adopting this statutory provision was to curb the use of "abusive tax shelters," we believe an inclusion of the financial books and records of a company, subjected to SEC criminal sanctions, within the listing of authorities is not inconsistent with this purpose. We believe "tax shelters" are not usually sold by companies subjected to these SEC requirements. The suggested treatment would also be consistent with the Federal Shop Book Rule which provides that books and records, kept in the due course of the regular conduct of a taxpayer's business, are competent evidence. (28 U.S.C. Section 1732)

TYPES OF AUTHORITIES FOR QUESTIONS OF LAW

It is respectfully submitted that either Proposed Regulations Section 1.6661-3(b)(2) be amended to expand the listing of what constitutes an

authority for the purpose of determining the existence of "substantial authority" or that good faith reliance on the following additional sources results in an automatic waiver of the Section 6661 penalty.

Included in this expanded listing should be statements made by the Secretary of the Treasury or his representative at a congressional hearing on the legislation, if such statements constitute an interpretation of the statutory language as finally enacted into law. This source of authority would be particularly important to taxpayers in the absence of Congressional committee reports dealing with the same matter, regulations, or applicable court cases. Certainly a taxpayer whose situation is akin to that covered in the testimony of the Secretary of the Treasury should be permitted to rely on the Secretary's statements as to the appropriate handling of such a matter, if the statements relate to the law as finally enacted.

Discussion of the term "Congressional intent", in the proposed regulations, should be expanded to include statements made on the floor of the House or Senate by either the sponsors of the relevant statutory language or statements made by the chairmen of the appropriate tax writing committees or subcommittees. Again, this is particularly important where a taxpayer must determine the existence of substantial authority with respect to a relatively new statute. Absent definitive guidelines in the key committee reports, regulations, or a relevant judicial determination, this authority should be permitted to be relied on by a taxpayer.

To the extent positions taken in a Revenue Agent's report covering a taxpayer's returns for prior years are followed by the taxpayer in a subsequent year and no change has occurred in the relevant statute, the taxpayer should not be subject to the Section 6661 penalty. In fact, for the taxpayer to take a position contrary to a position taken in a Revenue Agent's report for a prior year (assuming such position not to have been overturned), could subject the taxpayer to a charge of negligence. The taxpayer should not be placed in such an untenable position.

Taxpayers should be able to rely on the advice they receive from their tax advisers. While the legislative history of Section 6661 indicates that courts should not be bound by "opinion letters", both the Finance Committee Report, at page 273, and the Joint Committee Report, at page 216, focus on opinions which, although sheltering taxpayers from the fraud and negligence penalties, conclude that if the issue should be challenged by the IRS, the taxpayer would probably lose the contest. Senator Armstrong further clarified the legislative intent by discussing the need to have "more than the unsupported opinion of a tax adviser." (Congressional Record of July 21, 1982, at S. 8810.)

In the context of attempting to assure taxpayers that those who endeavor in good faith to fairly assess themselves are not penalized, we urge that opinion letters, from either outside or in-house tax advisers, that include the citation and discussion of authorities supporting the tax treatment of an item and do not conclude that it is unlikely such treatment would be ultimately sustained in court, should constitute authority upon which the taxpayer may rely. (This should certainly be true where the opinion indicates the weight of authority supports the taxpayer's position.) This is not the mere "unsupported opinion" referred to by Senator Armstrong. To deny a taxpayer such relief means each taxpayer in this country must himself become a tax law expert. In fact, referring for a moment to Proposed Regulations Section 1.6661-3(b)(4), he must apparently achieve a degree of tax law sophistication beyond that of a member of the federal judiciary. Frankly, this is a burden which is simply unconscionable. How are the tens of thousands of "small businessmen" in this country to operate under the self-assessment system if they cannot rely upon the purportedly well-reasoned opinions of tax advisers? Under our general system of "rule of law" rather than "rule by men", such taxpayers can take little solace in the fact the Secretary may waive all or a portion of the penalty.

NATURE OF ANALYSIS AND SPECIAL RULES RE SUBSTANTIAL AUTHORITY

Proposed Regulations Section 1.6661-3(b)(3) provides that taxpayers cannot rely on authorities that can be "distinguished" from the situation in question. Example (1) under Proposed Regulations Section 1.6661-3(c) refers to two cases that are "identical to the facts in question." It is respectfully submitted that the regulations should be modified to reflect the fact that some distinctions are not relevant or material to the outcome of an issue. Specifically, the regulations should provide that a taxpayer may rely on an authority as long as the relevant facts at issue are not dissimilar from the material facts recited in that authority. In this regard, it is suggested the second sentence of Proposed Regulations Section 1.6661-3(b)(3) be revised to read as follows:

> "Therefore, a case or revenue ruling having some facts in common with the situation in question will not by itself constitute substantial authority if, for example, ~~the authority is distinguishable on its facts, or otherwise is not applicable to~~ the facts recited in the case or ruling and bearing on the question at issue are materially dissimilar to the facts of the situation in question."

Similarly, the second sentence of Example (1) under Proposed Regulations Section 1.6661-3(c) should be modified, so as to read as follows:

> "The facts of both cases are ~~identical~~ similar in all material respects to the facts in question."

It is further submitted that a standing (uncontested) court decision should always constitute substantial authority, absent a change in the statute, irrespective of the existence of contrary decisions. If the government chooses not to appeal a decision, a taxpayer should not be subjected to a penalty if his treatment of an item is supported by such decision. (Interestingly, under the proposed regulations, a taxpayer could win a court case and the government not appeal. If the taxpayer then takes a consistent position on the following year's return, but such position is disavowed by a preponderance of judicial opinions in other Circuits, the taxpayer lacks "substantial authority" for his position and is subject to the penalty.) To permit a taxpayer to rely on a standing court decision is consistent with the dialog among Senators Armstrong, Grassley, and Dole. (Congressional Record of July 21, 1982, at S. 8809-10). To subject a taxpayer to a penalty for only having legal reasoning power equivalent to that of a member of the federal judiciary is clearly inappropriate. Example (2) of Proposed Regulations Section 1.6661-3(c) should be modified to reflect this view.

TIMING RE EXISTENCE OF SUBSTANTIAL AUTHORITY

Proposed Regulations Section 1.6661-3(b)(4)(iii) appears to be in direct conflict with IRC Section 6661(b)(2)(B)(i), which provides that the tax treatment of an item by a taxpayer will not give rise to a penalty "if there is or was substantial authority for such treatment." (Our emphasis.) Such alternative tests have been disregarded in the proposed regulations, which provide that the test can be met only at the time the taxpayer's return was filed. We urge that the unambiguous statutory language, permitting the treatment of an item on a tax return to be supported by substantial authority that "was" in existence at the time the return was filed or "is" in existence at the time the penalty is to be imposed, be followed. As stated on page 219 of the Joint Committee Report:

> "In litigation concerning liability for the penalty (including whether there is or was substantial authority for a position), the burden of proof falls upon the taxpayer." (Our emphasis.)

Clearly, the Committee is focusing on the time the return was filed (the time the taxpayer's "position" was taken) or at the time there is litigation (the time the position is alleged to give rise to the imposition of a penalty). To restrict the taxpayer's ability to meet the burden of proof by denying him the benefit of authority that develops after the return has been filed appears both unduly harsh and clearly contrary to the statute.

ADEQUATE DISCLOSURE WITH RESPECT TO RECURRING ITEMS

The requirement in Proposed Regulations Section 1.6661-4(a) for continuing disclosure of an item on tax returns for periods subsequent to the year in which the transaction was closed appears unreasonable and unduly

burdensome on taxpayers. Certain items, such as the acquisition of buildings, could result in disclosures being repeatedly required for 15 or 20 years.

It is respectfully submitted the disclosure provisions of Proposed Regulations Section 1.6661-4(d) relating to years covered by Section 6661 should be adopted. Thereunder, disclosure is deemed adequate with respect to an item resulting in a carryforward or carryback if it is made on the return or in a statement attached to the return for the taxable year in which the item arises. No useful purpose is served by requiring unnecessary paperwork. The suggested change is particularly appropriate where the return covering the year in which the initial transaction was closed has been examined by the IRS. It is respectfully submitted, however, that if a taxpayer makes the disclosure in the year of the transaction and the IRS does not choose to audit that year, the taxpayer should not be subjected to years of additional reporting.

SPECIFICITY OF DISCLOSURE

Proposed Regulations Section 1.6661-4(b)(4) provides that a disclosure is not adequate unless it apprises the Internal Revenue Service of the identity of the item, its amount, and the potential controversy concerning the item. Again, the proposed regulations appear to deviate from the clear statutory language which requires only that the relevant facts be adequately disclosed.

In the Joint Committee Report at page 218, disclosure is deemed adequate "if the taxpayer discloses facts sufficient to enable the Internal Revenue Service to identify the potential controversy, if it analyzed that information." Clearly, it is the responsibility of the Internal Revenue Service to identify the potential controversy, based on the disclosed facts, and not the taxpayer. In an article appearing in the January 31, 1983 issue to Tax Notes, at page 386, John Andre LeDuc, a tax lawyer on the staff of the Senate Committee on Finance, in considering the adequate disclosure requirement, states:

> "Taxpayers need only ask themselves whether an IRS agent, knowing the law who read the return and associated disclosure, could recognize the issue raised. To recognize the issue, of course, it is not necessary that all the facts of even arguable relevance be included; additional information can be provided in an audit."

Neither the statute nor its legislative history requires the taxpayer to do more than set out sufficient relevant facts so as to permit IRS agents, assumed to know the law, to recognize the issue. The proposed regulations should not attempt to further increase the taxpayer's burden.

ADEQUATE DISCLOSURE ON TAX RETURNS

Proposed Regulations Section 1.6661-4(c) appears to limit the relief afforded taxpayers who make a disclosure of the relevant facts in the taxpayer's return. We believe that all items disclosed on the tax return, itself, meet the return disclosure requirement. At a minimum, pursuant to the invitation of the Treasury to comment on additional circumstances in which disclosure on the return will be considered adequate, we suggest adding the following items to those listed in Revenue Procedure 83-21 as constituting adequate disclosure:

A. The disclosures reflected in answers to questions on Form 1120, under the caption "Additional Information."

B. Items reflected by itemization on Form 1120--Schedule M-1. (Certainly these items are clearly shown as deviations from the corporation's computation of financial income and already serve the purpose of providing an audit checklist for IRS personnel.)

C. Investment tax credit: Amounts shown on Form 3468.

D. Investment credit recapture: Amounts shown on Form 4255.

E. Minimum tax liability: Amounts shown on Form 4626.

F. Casualty and theft gains and losses: Summary amounts shown on Form 4684.

G. Capital gains and losses: Summary amounts shown on Schedule D.

H. Gains and losses from the sale of non-inventory property: Summary amounts shown on Form 4797.

I. Jobs credits and WIN credit carryovers: Amounts shown on Form 5884.

J. Research and experimental credit: Amounts shown on Form 6765.

K. International boycott transactions: Transactions disclosed on Form 5713.

L. Foreign taxes paid or accrued: Summary amounts shown on Form 1118.

M. Subpart F Income: Amounts shown on Form 5471 or Form 3646.

N. The amount of investment in U.S. property: Amounts shown on Form 5471 or Form 3646.

O. Intercompany transactions: Transactions and amounts shown on Form 5471 or Form 2952. (This is very important for multinational companies. The information on the new or predecessor form already serves as an audit guide for IRS International Examiners.)

P. Section 367 transactions: Information and amounts shown on Form 959 or Form 5471.

Q. Depreciation: Summary amounts shown on Form 4562.

R. Installment Sales Income: Amounts shown on Form 6252.

S. Adjustments to Basis Under Section 1017: Amounts shown on Form 982.

T. Earnings and Profits: Amounts shown on Form 1118.

U. Gasoline and lubricating oil credit: Amounts shown on Form 4136.

V. Transactions disclosed in an attached private letter ruling.

ADEQUATE DISCLOSURE OF CARRYFORWARDS FROM PRIOR YEARS

Proposed Regulations Section 1.6661-4(d) requires that as to a carryover attributable to the tax treatment of an item on a return to which Section 6661 does not apply, disclosure must be made on the return or in a statement attached thereto for the taxable year in which the carryover attributable to the item is taken into account. As previously stated, we believe this provision is contrary to both the scope of the statute and the underlying legislative intent. Please see our prior analysis of Proposed Regulations Section 1.6661-2(d)(5)(i), under the caption "CARRYOVERS ATTRIBUTABLE TO PRE-SECTION 6661 YEARS", beginning on page 2.

DEFINITION OF THE TERM "TAX SHELTER"

The last sentence of Proposed Regulations Section 1.6661-5(b)(1)(iii) should be stricken. It provides no clarification and may even create added uncertainties. Preferably, such sentence would be rewritten to state: "The presence of substantial economic substance is sufficient to avoid tax shelter characterization."

EXCLUSION FROM "TAX SHELTER" CHARACTERIZATION

To avoid the implication that the enumerated tax benefits provided by the Internal Revenue Code is an exclusive listing, the introductory language of the second sentence of Proposed Regulations Section 1.6661-5(b)(2) should be modified to read as follows:

"For example, an entity, plan or arrangement will not be considered to have as its principal purpose the avoidance or evasion of Federal income tax merely as a result of the ~~following~~ uses of tax benefits provided by the Internal Revenue Code, such as:"

Additionally, the list that follows should be expanded to include:

1. The claiming of alternate energy tax credits.

2. The claiming of research and experimental tax credits.

3. The claiming of jobs tax credits.

4. A partnership consisting solely of corporations.

WAIVER OF THE PENALTY—IN GENERAL

To ensure that the varied tax compliance burdens placed upon taxpayers are taken into consideration for purposes of the penalty, the second sentence of Proposed Regulations Section 1.6661-6(a) should be modified to read as follows:

"In making a determination regarding waiver of the penalty under section 6661, the most important factor in all cases will be the extent of the taxpayer's good faith effort to assess the taxpayer's proper tax liability under the law, considering all the facts and circumstances, including the size and complexity of the return."

AUTOMATIC WAIVER OF THE PENALTY

Proposed Regulations Section 1.6661-6 should be expanded to include the following additional circumstances with respect to which the penalty will be automatically waived.

Where an understatement is attributable to a subsequent change in facts or in foreign law that has retroactive effect, the penalty should automatically be waived. Obviously, in such circumstances there has been no attempt "to play the audit lottery." Examples of this type of situation are a retroactive change in a taxpayer's foreign tax credits due to the results of a foreign tax audit; a decision of a foreign court; a change in foreign tax legislation (e.g., the U.K. retroactive forgiveness of the previously deferred taxes attributable to inventory growth); and the ratification of a bilateral tax treaty between the United States and a foreign country, which has retroactive application. Additionally, a net operating loss carryback of a foreign affiliated company could retroactively change the amount of foreign taxes paid by such company and thus the amount of the taxpayer's foreign tax credit. A non-foreign related example would be the expensing of legal fees or

investment advisory services where a proposed acquisition does not go forward. In a subsequent year, the acquisition is reactivated and goes forward--requiring a capitalization of the previously deducted legal fees or investment advisory services that ultimately resulted in the acquisition.

An automatic waiver of the penalty should also be granted where the understatement is attributable to a good faith factual determination by the taxpayer. For instance, the Joint Committee Report, at page 219, gives the example of a good faith mistake in deciding the proper timing of a deduction. Other good faith factual determinations by a taxpayer could result in subsequent adjustments to income in situations involving a mathematical error on the tax return; the appropriate year a doubtful account is to be written off; arms length pricing adjustments; a redetermination of the tax basis of assets received in the dissolution of a domestic subsidiary; etc. In several of these situations, no method exists to arrive at a precise determination of a correct amount (e.g., what is the appropriate arms length pricing between a foreign subsidiary and its U.S. parent?). The intent of the law clearly focuses on excessive extensions of legal interpretations to particular situations and not on honest differences of opinion with respect to questions of fact.

The automatic waiver of the penalty should also occur where the tax return reflects the treatment of an item that has been examined but not challenged by the IRS on a prior audit of the taxpayer and no change in the applicable statute or regulations has occurred in the intervening period. Taxpayers who are audited by the IRS should be able to rely upon consistent treatment of an item by the IRS, at least in the context of whether a penalty should apply to such taxpayer.

Similarly, an automatic waiver of the penalty should occur where the treatment of an item has been imposed on the taxpayer by Revenue Agents in prior years. If the IRS was in error in its treatment, certainly the taxpayer should not be held accountable. Not to follow such IRS imposed treatment of an item could subject the taxpayer to the possible charge of changing his method of accounting without obtaining advance permission from the IRS or even a charge of negligence.

Finally, where the taxpayer voluntarily discloses items to Revenue Agents at the commencement of an audit and such taxpayer has regularly been examined by the IRS (e.g., is encompassed within the Coordinated Examination Program) and has no reason to believe he would not be examined for the year in question, an automatic waiver should be granted. This method of disclosure is fairly routine in coordinated examination audits and should be encouraged, rather than discouraged. To require such taxpayer to file an amended tax return would serve no useful purpose, but merely add to the already excessive paperwork with which both the government and the taxpayer must deal. Furthermore, the taxpayer might obtain additional factual information after he has been notified the audit is to commence.

In addition to the items discussed above, those discussed in our analysis of Proposed Regulations Section 1.6661-3(b)(2), under the caption "TYPES OF AUTHORITIES FOR QUESTIONS OF LAW", beginning on page 3, should be included if they are not added to an expanded definition of authorities for the purpose of determining the existence of substantial authority.

CONCLUSION

Although in certain areas the proposed regulations do reflect concern for the purpose for which this legislation was enacted (e.g., the granting of an automatic waiver where a qualified amended return has been filed), in large part the proposed regulations go far beyond the intent, if not the precise language, of the statute by placing undue and harsh additional burdens on taxpayers. Businessmen, especially those managing "small businesses", cannot be expected to research the tax laws and develop a degree of tax expertise which exceeds that of a member of the federal judiciary so as to avoid the penalty. They must be permitted to rely on purportedly well reasoned opinions of their tax advisers, where such opinions contain citations of supporting legal authorities. Large multi-division and multi-national companies cannot be expected to perform a complete tax audit of their financial books and records and yet file timely tax returns.

A number of the aforementioned problems arise because the proposed regulations generally fail to establish reasonable, objective, and definitive criteria on which taxpayers may rely to come within the "adequate disclosure" and "substantial authority" relief provisions. In lieu thereof, taxpayers have been asked to rely on the beneficence of IRS examining agents and their supervisors in the hope that they will choose not to impose the penalty on a particular taxpayer in a given situation. This is not an acceptable alternative.

We again urge adherence to the principle enunciated in the Joint Committee Report, at pages 217 and 218, indicating adoption of a "standard under which the courts may assure that taxpayers...who endeavor in good faith to fairly assess are not penalized." (Our emphasis.) We ask that the proposed regulations be substantially redrafted so as to conform to this avowed purpose.

**Statement of**

**International Union, UAW**

**on the subject of**

**Fiscal Year 1984 Budget Proposals Related to Medicare and Medicaid Cost Sharing Requirements**

The International Union, UAW long has been on record calling for reform of the American health care system in order to control inflation and improve delivery of services to the people. We have expressed our concern about the millions in our society, including families of the unemployed, who are denied access to decent health services because they have no insurance coverage and are unable to pay. We have protested the inefficiency, disorganization and wastefulnesss of the health care delivery system. We have stated our alarm as health care expenditures have continued to consume an ever larger portion of our nation's scarce economic resources.

National health expenditures now consume 10.4% of Gross National Product, a number projected by the government to grow to 12% of GNP by 1990 if nothing is done. The impact of such rising costs on our negotiated health benefit programs has been acute; it has complicated the collective bargaining process, and has contributed to rising labor costs in a manner not experienced by other countries with better organized medical care systems.

We now see the impact of such soaring costs on the federal budget, and particularly on the Medicare program for the elderly and disabled and on the Medicaid program serving the needy. The prospective deficits in the Hospital Insurance Trust Fund, which finances Medicare Part A benefits, are of great concern and must be addressed. However, we deplore budget proposals of the Reagan Administration which would increase cost sharing requirements to the patients covered by these essential programs. Rather than begin to address the root causes of skyrocketing health care costs, the Administration would prefer merely to transfer the liability for such costs to the elderly, the poor and the sick who already are the victims of medical care inflation.

**Reagan Proposals**

The Administration's most far reaching and damaging proposal is to convert Medicare coverage to a catastrophic benefit by charging $28 per day from the second

through 15th day in the hospital and $17.50 from the 16th day through 60th day, while providing improved coverage for the very small number who remain in the hospital longer than that. This would sharply increase patient cost sharing for about 98% of Medicare beneficiaries while providing some sugar coating to the pill in the form of catastrophic illness benefits for the other 2%. Net increases in patient cost sharing would cost beneficiaries and/or their private insurers some $710 million in 1984 and a total of $6.8 billion over the period 1984-1988. The patient cost sharing liability for an average 11 day stay under Medicare would increase from $350 to $630 in 1984. This also would represent another in a string of Administration proposals to shirk government responsibility and to transfer costs to the private sector, including negotiated benefit programs which typically provide coverage to fill in the gaps of the Medicare program.

Some in the Administration appear to believe that part of the problem is that Medicare patients have too much coverage and should be made to pay more. This is utter nonsense. It is well known that Medicare covers only about 40% of the cost of health services for the elderly. Furthermore, it has been shown that senior citizens are spending the same percentage of their income on medical care, 20%, as they did in 1965 before Medicare was implemented. How much more does the Administration think they should pay to keep feeding a medical care system marked by excess and inefficiency?

For the same reasons, we oppose proposals to increase the Medicare Part B deductible. We also object to proposals to increase drastically the Medicare Part B Premium in a series of steps until it would amount to $31.60 in 1988, compared to $12.20 today. Social Security beneficiaries will experience sufficient loss of purchasing power as the result of the delay in the cost-of-living increase in the 1983 Social Security Amendments. They should not suffer inflated Medicare premiums.

Another Administration proposal amounts to a back door increase in patient cost sharing by proposing to freeze doctor's fees recognized by Medicare for one year. Inasmuch as physicians are not required to accept assignment of Medicare fees, and fewer than half do, the freeze may save the government $700 million in 1984, but it also allows doctors to pass on additional charges to patients and their private insurers, including negotiated benefit plans. This proposal also would undoubtedly cause further erosion in the number of doctors accepting assignment.

We also oppose the so-called Medicare "voucher" proposal of the Administration which could result in less coverage and more out-of-pocket expenses to Medicare beneficiaries who are turned over to the private insurance system which was unable to meet their needs prior to the enactment of Medicare.

We note that the Administration was not content with last year's budget provisions that gave states discretionary authority to impose certain copayments on poor people under the Medicaid program. Now the Administration wants to make copayments mandatory "to deter unnecessary use of medical services," according to the justification in the budget. Again this Administration attempts to penalize the weakest and sickest, rather than going after those who reap profits from the medical care system.

**Effects of Cost Sharing**

The experience of our Union and of others we have reviewed in regard to the effects of out-of-pocket cost sharing has led to the following general conclusions:

1. There is no study which indicates that cost sharing has any long term effectiveness at reducing total health care costs.

One only has to look to the federal Medicare program to see the ineffectiveness of cost sharing in controlling costs. Medicare has had extensive deductibles and coinsurance since the beginning in 1966, and both have increased over the years. Yet the cost of the program to the federal government has risen from $4.5 billion in 1967 to nearly $60 billion in 1984.

2. The effect of cost sharing on health status is uncertain. In fact, there is some evidence that patient cost sharing can serve as a barrier to early treatment and actually increase costs because more expensive treatment is required for conditions which have deterioriated due to postponement of care.

3. After the patient makes the decision to go to the doctor in the first place, virtually all decisions about what services are to be provided are made by doctors and other providers. Deductibles and copayments have been shown to have little effect on treatment decisions made by doctors.

4. Cost sharing has been shown to have almost no effect on the prices doctors and hospitals choose to place on their services. Providers decide the price of their services, not some free market.

5. The greatest increases in health care costs in recent years have been in the hospital sector. Yet patient cost sharing has been shown to have even less impact on use of hospital services than other kinds of health care.

6. Patient cost sharing discourages access to care by lower income persons. Study after study has shown that the burden of cost sharing falls inequitably on the poor, on blue collar workers, on minorities, and on those with large families.

The principal effect of patient cost sharing is to penalize consumers and to distract focus from the more politically difficult issue of holding our health care system accountable to public and consumer goals.

Cost sharing proposals are based on mistaken notions about health care economics, about physician and patient behavior, and about the true causes of rising health care costs. Proponents of cost sharing fail to realize that:

- Consumers do not admit themselves to the hospital or arrange for their discharges.
- The consumer does not make the decision to stay in the hospital for an inordinate amount of time.
- Consumers do not write prescriptions for themselves.
- Consumers do not order an array of unnecessary tests and services for themselves.
- The consumer does not decide to build unnecessary hospital beds.
- The consumer does not decide to keep beds on line that should be closed down.
- The consumer does not permit the continued existence of hospitals that should be closed.
- The consumer does not decide to acquire additional expensive equipment already available within the community.

**A Constructive Approach**

A more constructive and effective approach to the problem of rising Medicare and Medicaid costs is to begin to reform the financing structure of the overall health care system. Ultimately such reform will be accomplished only under a comprehensive national health security program. In the short run, we favor an approach by which states would establish, within broad federal guidelines, "all payor" systems of prospective hospital reimbursement , negotiated fee schedules for doctors, and fixed diagnostic and laboratory fees. In addition, alternative forms of delivery, such as health maintenance organizations, should be encouraged.

A serious example of such an approach is the HALT program developed by the Health Security Action Council. Senator Edward Kennedy has introduced a version of this bill, S. 814.

We urge this Committee to consider such legislation as a positive alternative to Administration proposals to reduce benefits and services to the elderly, poor and disabled, who need them the most. Our approach will not simply shift costs from the public to the private sector. Instead it will provide a measure of fiscal stability for Medicare and Medicaid by containing escalating health care costs in the overall health care system through reduction of inefficiencies and excessive profits which characterize much of the health care industry.

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